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Federal Register

Friday,
November 24, 2006

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 416 et al.

Medicare Program—Revisions to Hospital Outpatient Prospective Payment System and Calendar Year 2007 Payment Rates; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 416, 419, 421, 485, and 488

[CMS–1506–FC; CMS–4125–F]

RIN 0938–AO15

Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates; CY 2007 Update to the Ambulatory Surgical Center Covered Procedures List; Medicare Administrative Contractors; and Reporting Hospital Quality Data for FY 2008 Inpatient Prospective Payment System Annual Payment Update Program—HCAHPS Survey, SCIP, and Mortality

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

ACTION: Final rule with comment period and final rule.

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, and to implement certain related provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and the Deficit Reduction Act (DRA) of 2005. In this final rule with comment period, we describe 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, 2007. In addition, this final rule with comment period implements future CY 2009 required reporting on quality measures for hospital outpatient services paid under the prospective payment system.

This final rule with comment period revises the current list of procedures that are covered when furnished in a Medicare-approved ambulatory surgical center (ASC), which are applicable to services furnished on or after January 1, 2007.

This final rule with comment period revises the emergency medical screening requirements for critical access hospitals (CAHs).

This final rule with comment period supports implementation of a restructuring of the contracting entities responsibilities and functions that support the adjudication of Medicare fee-for-service (FFS) claims. This restructuring is directed by section 1874A of the Act, as added by section 911 of the MMA. The prior separate Medicare intermediary and Medicare carrier contracting authorities under Title XVIII of the Act have been replaced with the Medicare Administrative Contractor (MAC) authority.

This final rule continues to implement the requirements of the DRA that require that we expand the ''starter set'' of 10 quality measures that we used in FY 2005 and FY 2006 for the hospital inpatient prospective payment system (IPPS) Reporting Hospital Quality Data for the Annual Payment Update (RHQDAPU) program. We began to adopt expanded measures effective for payments beginning in FY 2007. In this rule, we are finalizing additional quality measures for the expanded set of measures for FY 2008 payment purposes. These measures include the HCAHPS survey, as well as Surgical Care Improvement Project (SCIP, formerly Surgical Infection Prevention (SIP)), and Mortality quality measures.

DATES: *Effective Date:* The provisions of these final rules are effective on January 1, 2007.

Comment Period: We will consider comments on the payment classification assigned to HCPCS codes identified in Addendum B with the NI comment code, and other areas specified throughout the preamble, at the appropriate address, as provided below, no later than 5 p.m. January 23, 2007.

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 close of business April 1, 2007.

ADDRESSES: In commenting, please refer to file code CMS–1506–FC. 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–1506–FC, P.O. Box 8011, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1506–FC, 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) 786–7195 in advance to schedule your arrival with one of our staff members.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

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.

FOR FURTHER INFORMATION CONTACT:

Alberta Dwivedi, (410) 786–0378, Hospital outpatient prospective payment issues.

Dana Burley, (410) 786–0378, Ambulatory surgery center issues.

Suzanne Asplen, (410) 786–4558, Partial hospitalization and community mental health centers issues.

Mary Collins, (410) 786–3189, Critical access hospital emergency medical planning issues.
Sandra M. Clarke, (410) 786–6975, Medicare Administrative Contractors issues.
Mark Zobel, (410) 786–6905, Medicare Administrative Contractors issues.
Liz Goldstein, (410) 786–6665, FY 2008 IPPS RHQDAPU HCAHPS issues.
Bill Lehrman, (410) 786–1037, FY 2008 IPPS RHQDAPU HCAHPS issues.
Sheila Blackstock, (410) 786–3506, FY 2008 IPPS RHQDAPU SCIP and mortality issues.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on the payment classification and status indicator assigned to HCPCS codes identified in Addendum B of this final rule with comment period with comment indicator NI and on the ambulatory surgical center procedures that were not proposed for addition to the ambulatory surgical center list in the CY 2007 OPPS proposed rule to assist us in fully considering issues and developing policies. You can assist us by referencing filed code CMS–1506–FC.

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 4:00 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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Alphabetical List of Acronyms Appearing in the Final Rule

ACEP American College of Emergency Physicians
AHA American Hospital Association
AHIMA American Health Information Management Association
AMA American Medical Association
APC Ambulatory payment classification
AMP Average manufacturer price
ASC Ambulatory Surgical Center
ASP Average sales price
AWP Average wholesale price
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BCA Blue Cross Association
BCBSA Blue Cross and Blue Shield Association
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
CAH Critical access hospital
CBSA Core-Based Statistical Area
CCR Cost-to-charge ratio
CMHC Community mental health center
CMS Centers for Medicare & Medicaid Services
CNS Clinical nurse specialist
CORF Comprehensive outpatient rehabilitation facility
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2006, 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
FY Federal fiscal year
GAO Government Accountability Office
HCPCS Healthcare Common Procedure Coding System
HCRIS Hospital Cost Report Information System
HHA Home health agency
HIPAA Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IDE Investigational device exemption
IOL Intraocular lens
IPPS [Hospital] Inpatient prospective payment system
IVIG Intravenous immune globulin
MAC Medicare Administrative Contractors
MedPAC Medicare Payment Advisory Commission
MDH Medicare-dependent, small rural hospital
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MPFS Medicare Physician Fee Schedule
MSA Metropolitan Statistical Area
NCCI National Correct Coding Initiative
NCD National Coverage Determination
NTIOL New technology intraocular lens
OCE Outpatient Code Editor
OMB Office of Management and Budget
OPD [Hospital] Outpatient department
OPPS [Hospital] Outpatient prospective payment system
PHP Partial hospitalization program
PM Program memorandum
PPI Producer Price Index
PPS Prospective payment system
PPV Pneumococcal pneumonia (virus)
PRA Paperwork Reduction Act
QIO Quality Improvement Organization
RFA Regulatory Flexibility Act
RHQDAPU Reporting hospital quality data for annual payment update
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

In this document, we address three payment systems under the Medicare program: the hospital outpatient prospective payment system (OPPS), the hospital inpatient prospective payment system (IPPS), and the ambulatory surgical center (ASC) payment system. The provisions relating to the OPPS are included in sections I. through XIII., XV., XVI., XIX., XXIII., XXIV., XXV., and XXVI. of the preamble and in Addenda A, B, C (Addendum C is available on the Internet only; see section XXIII. of the preamble of this final rule with comment period), D1, D2, and E of this final rule with comment period. The provisions related to the IPPS are included in sections XXII. and XXVI.E. of the preamble. The provisions related to ASCs are included in sections XVII. and XXV., and XXVI.C. of the preamble and in Addenda AA of this final rule with comment period.

In addition, in this document, we address our implementation of the Medicare contracting reform provisions of the MMA that replace the prior Medicare intermediary and carrier authorities formerly found in sections 1816 and 1842 of the Act with Medicare administrative contractor (MAC) authority under a new section 1874A of the Act. The provisions relating to MACs are included in sections XVIII. and XXV.D. of this preamble. To assist readers in referencing sections contained in this document, we are providing the following table of contents:

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Addenda

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Addendum AA—List of Medicare Approved ASC Procedures for CY 2007 With Additions and Payment Rates; Including Rates That Result From Implementation of Section 5103 of the DRA
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I. Background for the OPPS

A. Legislative and Regulatory Authority for the Hospital Outpatient Prospective Payment System

When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the reasonable cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act (BBA) of 1997 (Pub. L. 105–33), added section 1833(t)

to the Social Security Act (the Act) authorizing implementation of a PPS for hospital outpatient services (OPPS).

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113), made major changes in the hospital OPPS. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554), made further changes in the OPPS. Section 1833(t) of the Act was also amended by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Pub. L. 108–173). The Deficit Reduction Act (DRA) of 2005 (Pub. L. 109–171), enacted on February 8, 2006, made additional changes in the OPPS. A discussion of the provisions contained in Pub. L. 109–171 that are specific to the calendar year (CY) 2007 OPPS is included in section II.F. of this preamble.

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 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 preamble. 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 inpatient hospital wage index value for the locality in which the hospital or CMHC is located.

All services and items within an APC group are comparable clinically and with respect to resource use (section 1833(t)(2)(B) of the Act). In accordance with section 1833(t)(2) of the Act, subject to certain exceptions, services and items within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the APC group is more than 2 times greater than the lowest median cost for an item or service within the same APC group (referred to as the ''2 times rule''). In implementing this provision, we use the median cost of the item or service assigned to an APC group.

Special payments under the OPPS may be made for new technology items and services in one of two ways. Section 1833(t)(6) of the Act provides for temporary additional payments which we refer to as ''transitional pass-through payments'' for at least 2 but not more than 3 years for certain drugs, biological agents, brachytherapy devices used for the treatment of cancer, and categories of other medical devices. For new technology services that are not eligible for transitional pass-through payments and for which we lack sufficient data to appropriately assign them to a clinical APC group, we have established special APC groups based on costs, which we refer to as new technology APCs. These new technology APCs are designated by cost bands which allow us to provide appropriate and consistent payment for designated new procedures that are not yet reflected in our claims data. Similar to pass-through payments, an assignment to a new technology APC is temporary; that is, we retain a service within a new technology APC until we acquire sufficient data to assign it to a clinically appropriate APC group.

B. Excluded OPPS Services and Hospitals

Section 1833(t)(1)(B)(i) of the Act authorizes the Secretary to designate the hospital outpatient services that are paid under the OPPS. While most hospital outpatient services are payable under the OPPS, section 1833(t)(1)(B)(iv) of the Act excludes payment for ambulance, physical and occupational therapy, and speech-language pathology services, for which payment is made under a fee schedule. Section 614 of Pub. L. 108–173 amended section 1833(t)(1)(B)(iv) of the Act to exclude OPPS payment for screening and diagnostic mammography services. The Secretary exercised the authority granted under the statute to exclude from the OPPS those services that are paid under fee schedules or other payment systems. Such excluded services include, for example, the professional services of physicians and nonphysician practitioners paid under the Medicare Physician Fee Schedule (MPFS); laboratory services paid under the clinical diagnostic laboratory fee schedule; services for beneficiaries with end-stage renal disease (ESRD) that are paid under the ESRD composite rate; and, services and procedures that require an inpatient stay that are paid under the hospital inpatient prospective payment system (IPPS). We set forth the services that are excluded from payment under the OPPS in § 419.22 of the regulations.

Under § 419.20(b) of the regulations, we specify the types of hospitals and entities that are excluded from payment under the OPPS. These excluded entities include Maryland hospitals, but only for services that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act; critical access hospitals (CAHs); hospitals located outside of the 50 States, the District of Columbia, and Puerto Rico; and Indian Health Service hospitals.

C. Prior Rulemaking

On April 7, 2000, we published in the **Federal Register** a final rule with comment period (65 FR 18434) to implement a prospective payment system for hospital outpatient services. The hospital OPPS was first implemented for services furnished on or after August 1, 2000. Section 1833(t)(9) of the Act requires the Secretary to review certain components of the OPPS not less often than annually and to revise the groups, relative payment weights, and other adjustments 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.

Since initially implementing the OPPS, we have published final rules in the **Federal Register** annually to implement statutory requirements and changes arising from our experience with this system. We last published such a document on November 10, 2005 (70 FR 68516). In that final rule with comment period, we revised the OPPS to update the payment weights and conversion factor for services payable under the CY 2006 OPPS on the basis of claims data from January 1, 2004, through December 31, 2004, and to implement certain provisions of Pub. L. 108–173. In addition, we responded to public comments received on the provisions of November 15, 2004 final rule with comment period pertaining to

the APC assignment of HCPCS codes identified in Addendum B of that rule with the new interim (NI) comment indicators; and public comments received on the July 25, 2005 OPPS proposed rule for CY 2006 (70 FR 42674).

We published a correction of the November 10, 2005 final rule with comment period on December 23, 2005 (70 FR 76176). This correction document corrected a number of technical errors that appeared in the November 10, 2005 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, requires that we consult with an outside panel of experts to review the clinical integrity of the payment groups and their weights under the OPPS. The Act further specifies that the panel will act in an advisory capacity. The Advisory Panel on Ambulatory Payment Classification (APC) Groups (the APC Panel), discussed under section I.D.2. of this preamble, fulfills these requirements. The APC Panel is not restricted to using data compiled by CMS and may use data collected or developed by organizations outside the Department in conducting its review.

2. Establishment of the APC Panel

On November 21, 2000, the Secretary signed the initial charter establishing the APC Panel. This expert panel, which may be composed of up to 15 representatives of providers subject to the OPPS (currently employed full-time, not as consultants, in their respective areas of expertise), reviews and advises CMS about the clinical integrity of the APC groups and their weights. For purposes of this Panel, consultants or independent contractors are not considered to be full-time employees. The APC Panel is technical in nature and is governed by the provisions of the Federal Advisory Committee Act (FACA). Since its initial chartering, the Secretary has twice renewed the APC Panel's charter: on November 1, 2002, and on November 1, 2004. The current charter indicates, among other requirements, that the APC Panel continues to be technical in nature; is 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 who also serves as a CMS medical officer.

The current APC Panel membership and other information pertaining to the Panel, including its charter, **Federal Register** notices, meeting dates, agenda topics, and meeting reports can be viewed on the CMS Web site at *http://www.cms.hhs.gov/FACA/05AdvisoryPanelonAmbulatoryPaymentClassificationGroups.as#TopOFPage.*

3. APC Panel Meetings and Organizational Structure

The APC Panel first met on February 27, February 28, and March 1, 2001. Since that initial meeting, the APC Panel has held 10 subsequent meetings, with the last meeting taking place on August 23 and 24, 2006. (The APC Panel did not meet on August 25, 2006, as announced in the meeting notice published on June 23, 2006 (71 FR 36118).) Prior to each meeting, we publish a notice in the **Federal Register** to announce the meeting and, when necessary, to solicit and announce nominations for APC Panel membership.

The APC Panel has established an operational structure that, in part, includes the use of three subcommittees to facilitate its required APC review process. The three current subcommittees are the Data Subcommittee, the Observation 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 Subcommittee reviews and makes recommendations to the APC Panel on all issues pertaining to observation services paid under the OPPS, such as coding and operational issues. The Packaging Subcommittee studies and makes recommendations on issues pertaining to services that are not separately payable under the OPPS, but are bundled or packaged APC payments. Each of these subcommittees was established by a majority vote of the APC Panel during a scheduled APC Panel meeting and their continuation as subcommittees was approved at the August 2006 APC Panel meeting. All subcommittee recommendations are discussed and voted upon by the full APC Panel.

Discussions of the recommendations resulting from the APC Panel's March 2006 and August 2006 meetings are included in the sections of this preamble that are specific to each recommendation. For discussions of earlier APC Panel meetings and recommendations, we reference previous hospital OPPS final rules or the Web site mentioned earlier in this section.

E. Provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Pub. L. 108–173, made changes to the Act relating to the Medicare OPPS. In the January 6, 2004 interim final rule with comment period and the November 15, 2004 final rule with comment period, we implemented provisions of Pub. L. 108–173 relating to the OPPS that were effective for services provided in CY 2004 and CY 2005, respectively. In the November 10, 2005 final rule with comment period, we implemented provisions of Pub. L. 108–173 relating to the OPPS that went into effect for services provided in CY 2006 (70 FR 68521). We note below those provision of Pub. L. 108–173 that will expire at the end of CY 2006.

1. Reduction in Threshold for Separate APCs for Drugs

Section 621(a)(2) of Pub. L. 108–173 amended section 1833(t)(16) of the Act to set a threshold of $50 per administration for the establishment of separate APCs for drugs and biologicals furnished from January 1, 2005, through December 31, 2006. Because this statutory provision will no longer be in effect for CY 2007, we have included in section V. of this preamble a discussion of the methodology that we will use to determine a threshold for establishing separate APCs for drugs and biologicals for CY 2007.

2. Special Payment for Brachytherapy

Section 621(b)(1) of Pub. L. 108–173 amended section 1833(t)(16) of the Act to require that payment for brachytherapy devices consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before January 1, 2007, be paid based on the hospital's charge for each device furnished, adjusted to cost. Because this statutory provision will no longer be in effect for CY 2007, we discuss our methodology for payment for brachytherapy devices for CY 2007 in section VII.B. of this preamble.

F. Provisions of the Deficit Reduction Act (DRA) of 2005

The Deficit Reduction Act (DRA) of 2005, Pub. L. 109–171, enacted on February 8, 2006, included three provisions affecting the OPPS, as discussed below.

1. 3-Year Transition of Hold Harmless Payments

Section 5105 of Pub. L. 109–171 provides a 3-year transition of hold harmless OPPS payments for hospitals

located in a rural area with not more than 100 beds that are not defined as sole community hospitals (SCHs). This provision provides an increased payment for such hospitals for covered OPD services furnished on or after January 1, 2006, and before January 1, 2009, if the OPPS payment they receive is less than the pre-BBA payment amount that they would have received for the same covered OPD services. This provision specifies that, in such cases, the amount of payment to the specified hospitals shall be increased by the applicable percentage of such difference. Section 5105 specifies the applicable percentage as 95 percent for CY 2006, 90 percent for CY 2007, and 85 percent for CY 2008. This provision is discussed in section II.F.1. of the preamble.

2. Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms (AAAs)

Section 5112 of Pub. L. 109–171 amended section 1861 of the Act to include coverage of ultrasound screening for abdominal aortic aneurysms for certain individuals on or after January 1, 2007. The provision will apply to individuals (a) who receive a referral for such an ultrasound screening as a result of an initial preventive physical examination; (b) who have not been previously furnished with an ultrasound screening under Medicare; and (c) who have a family history of abdominal aortic aneurysm or manifest risk factors included in a beneficiary category recommended for screening (as determined by the United States Preventive Services Task Force). Ultrasound screening for abdominal aortic aneurysm will be included in the initial preventive physical examination. Section 5112 also added ultrasound screening for abdominal aortic aneurysm to the list of services for which the beneficiary deductible does not apply. These amendments apply to services furnished on or after January 1, 2007. See section XIII.B. of this preamble for a detailed discussion of this provision.

3. Colorectal Cancer Screening

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 does not apply. This provision applies to services furnished on or after January 1, 2007. See the Medicare Physician Fee Schedule (MPFS) CY 2007 final rule for a detailed discussion of this provision.

G. Summary of the Provisions of the CY 2007 OPPS Proposed Rule

On August 23, 2006, we published a proposed rule in the **Federal Register** (71 FR 49506) that set forth proposed changes to the Medicare hospital OPPS for CY 2007 to implement statutory requirements and changes arising from our continuing experience with the system and to implement certain provisions of Pub. L. 109–171 specified in sections II.F.1. and XIII.B. of this preamble. We also proposed to revise the standard for critical access hospital personnel that are allowed to perform emergency medical screenings. In addition, we proposed changes to the Medicare ASC payment system for CY 2007 and CY 2008 and to the way we process fee-for-service (FFS) claims under Medicare Part A and Part B.

Finally, we set forth a proposed rule seeking comments on the RHQDAPU program under the Medicare hospital IPPS for FY 2008. These changes will be effective for payments beginning with FY 2008. The following is a summary of the major changes included in the CY 2007 OPPS proposed rule:

1. Updates to the OPPS' Payments for CY 2007

In the proposed rule, we set forth—

- The methodology used to recalibrate the proposed APC relative payment weights and the proposed median costs for CY 2007.
- The proposed payment for partial hospitalization, including the proposed separate threshold for outlier payments for CMHCs.
- The proposed update to the conversion factor used to determine payment rates under the OPPS for CY 2007.
- The proposed retention of our current policy to apply the IPPS wage indices to wage adjust the APC median costs in determining the OPPS payment rate and the copayment standardized amount for CY 2007.
- The proposed update of statewide average default cost-to-charge ratios.
- Proposed changes relating to the hold harmless payment provision and § 419.70(d).
- Proposed changes relating to payment for rural SCHs, including Essential Access Community Hospitals (EACHs) for CY 2007.
- The proposed retention of our current policy for calculating hospital outpatient outlier payments for CY 2007.
- Calculation of the proposed national unadjusted Medicare OPPS payment.
- The proposed beneficiary copayment for OPPS services for CY 2007.

2. Ambulatory Payment Classification (APC) Group Policies

In the proposed rule, we discussed establishing a number of new APCs and making changes to the assignment of HCPCS codes under a number of existing APCs based on our analyses of Medicare claims data and recommendations of the APC Panel. We also discussed the application of the 2 times rule and proposed exceptions to it; proposed changes for specific APCs; proposed movement of procedures from the New Technology APCs; and the proposed additions of new procedure codes to the APC groups.

3. Payment Changes for Devices

In the proposed rule, we discussed proposed changes to the device-dependent APCs and to payment for pass-through devices. We also discussed the proposed payment policy for devices that are replaced without cost or credit to the hospital for a replaced device and the proposed related regulation under § 419.45.

4. Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

In the proposed rule, we discussed proposed payment changes for drugs, biologicals, and radiopharmaceuticals.

5. Estimate of Transitional Pass-Through Spending in CY 2007 for Drugs, Biologicals, and Devices

In the proposed rule, we discussed the proposed methodology for estimating total pass-through spending and whether there should be a pro rata reduction for transitional pass-through drugs, biologicals, radiopharmaceuticals, and categories of devices for CY 2007.

6. Brachytherapy Payment Changes

In the proposed rule, we included a discussion of our proposal concerning coding and payment for the sources of brachytherapy.

7. Coding and Payment for Drugs Administration

In the proposed rule, we discussed our proposed coding and payment changes for drug administration services.

8. Hospital Coding and Payments for Visits

In the proposed rule, we discussed our analyses of various guidelines for coding hospital visits and the proposed HCPCS codes and payment policy for those visits.

9. Payment for Blood and Blood Products

In the proposed rule, we discussed our proposed criteria and coding changes for the blood and blood products.

10. Payment for Observation Services

In the proposed rule, we discussed our proposed continuation of applying the criteria for separate payment for observation services and the coding methodology for observation services implemented in CY 2006.

11. Procedures That Will Be Paid Only as Inpatient Services

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

12. Nonrecurring Policy Changes

In the proposed rule, we discussed a proposed technical change to § 419.21(d) of the regulations related to Comprehensive Outpatient Rehabilitation Facility (CORF) services and proposed coding and payment for ultrasound screening for abdominal aortic aneurysms (AAAs) as a new service paid under the OPPS in CY 2007.

13. Emergency Medical Screening in Critical Access Hospitals (CAHs)

In the proposed rule, we discussed our proposal to revise § 485.618(d) of the regulations pertaining to the standards for critical access hospital personnel available to perform emergency medical screening services.

14. Payment Status and Comment Indicator Assignments

In the proposed rule, we discussed our list of status indicators assigned to APCs and presented our comment indicators that we proposed to use in this final rule with comment period.

15. OPPS Policy and Payment Recommendations

In the proposed rule, we addressed recommendations made by MedPAC, the APC Panel, and the GAO regarding the OPPS for CY 2007.

16. Policies Affecting Ambulatory Surgical Centers (ASCs) for CY 2007

In the proposed rule, we discussed changes to the ASC list of covered procedures for CY 2007; implementation of section 5103 of Pub. L. 108–173; our proposal for modifying the current ASC process for adjusting payment for new technology intraocular lenses; and related regulatory changes.

17. Revised ASC Payment System for Implementation January 1, 2008

In the proposed rule, we set forth our proposal to revise the current ASC payment system in accordance with Pub. L. 108–173, effective January 1, 2008. We note that we are not finalizing this proposal in this final rule with comment period. Rather, we will issue a separate document in the **Federal Register** that will address public comments received and finalize the ASC payment system effective January 1, 2008.

18. Medicare Contracting Reform Mandate

In the proposed rule, we set forth changes to the way we process FFS claims under Medicare Part A and Part B.

19. Reporting Quality Data for Improved Quality and Costs Under the OPPS

In the proposed rule, we proposed to adapt the quality improvement mechanism provided by the IPPS RHQDAPU program for use under the OPPS.

20. Promoting Effective Use of Health Information Technology

In the proposed rule, we discussed our plans to promote and adopt effective use of health information technology to improve the quality of care for Medicare beneficiaries.

21. Health Care Information Transparency Initiative

In the proposed rule, we announced our plans to launch a major health care transparency initiative in 2006.

22. Additional Quality Measures and Procedures for Hospital Reporting of Quality Data for FY 2008 IPPS Annual Payment Update

In the proposed rule, we discussed our proposal to expand the IPPS Reporting Hospital Quality Data for Annual Payment program measurement set for FY 2008 beyond the measures adopted for the FY 2007 IPPS update.

23. Impact Analysis

In the proposed rule, we set forth an analysis of the impact that the proposed changes will have on affected entities and beneficiaries.

H. Public Comments Received in Response to the CY 2007 OPPS Proposal Rule and on the Reporting Hospital Quality Data for FY 2008 IPPS Annual Payment Update Program—HCAHPS Survey, SCIP, and Mortality Proposed Rule

We received approximately 1,100 timely items of correspondence containing multiple comments on the CY 2007 OPPS proposed rule. We note that we received some comments that were outside of the scope of the CY 2007 OPPS proposed rule. These comments are not addressed in the CY 2007 final rule. We also received approximately 20 timely items of correspondence on Reporting Hospital Quality Data for FY 2008 Inpatient Prospective Payment System Annual Payment Update Program—HCAHPS Survey, SCIP, and Mortality proposed rule. Summaries of the public comments and our responses to those comments are set forth under the appropriate headings.

I. Public Comments Received on the November 10, 2005 OPPS Final Rule with Comment Period

We received approximately 41 timely items of correspondence on the November 10, 2005 OPPS final rule with comment period, some of which contained multiple comments on the APC assignment of HCPCS codes identified with the NI comment indicator in Addendum B of that final rule with comment period. Summaries of those public comments and our responses to those comments are set forth in the various sections under the appropriate headings.

II. Updates Affecting OPPS Payments for CY 2007

A. Recalibration of APC Relative Weights for CY 2007

1. Database Construction

a. Database Source and Methodology

Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually. In the April 7, 2000 OPPS final rule with comment period (65 FR 18482), we explained in detail how we calculated the relative payment weights that were implemented on August 1, 2000, for each APC group. Except for some reweighting due to a small number of APC changes, these relative payment weights continued to be in effect for CY 2001. This policy is discussed in the November 13, 2000 interim final rule (65 FR 67824 through 67827).

In the CY 2007 OPPS proposed rule, we proposed to use the same basic methodology that we described in the April 7, 2000 final rule with comment period to recalibrate the APC relative payment weights for services furnished on or after January 1, 2007, and before January 1, 2008. That is, we would 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 APC relative payment weights for CY 2007, we used approximately 142.5 million final action claims for hospital OPD services furnished on or after January 1, 2005, and before January 1, 2006. Of the 142.5 million final action claims for services provided in hospital outpatient settings, 110.2 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 110.2 million claims, approximately 51.7 million were not for services paid under the OPPS or were excluded as not appropriate for use (for example, erroneous cost-to-charge ratios or no HCPCS codes reported on the claim). We were able to use 54.1 million whole claims of the remaining 58.5 million claims to set the OPPS APC relative weights for CY 2007 OPPS. From the 54.1 million whole claims, we created 98.5 million single records, of which 68.5 million were ''pseudo'' single claims (created from multiple procedure claims using the process we discuss in this section).

As proposed, the final APC relative weights and payments for CY 2007 in Addenda A and B to this final rule with comment period were calculated using claims from this period that had been processed before June 30, 2006, 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.

Comment: Several commenters supported the use of the most recent claims and cost report data to calculate the median costs for use in the CY 2007 OPPS.

Response: We appreciate the commenters' support and have used the claims for services paid under the CY 2005 OPPS as processed through the common working file as of June 30, 2006, in the calculation of the median costs on which the CY 2007 OPPS rates are based. In addition, we have used the most recently submitted cost report data as reported to the HCRIS system as of June 30, 2006, to calculate the cost-to-charge ratios (CCRs) used to reduce the billed charges to costs for purposes of calculating the median costs on which the CY 2007 OPPS rates are based.

After carefully considering all comments received, we are finalizing our data source and methodology for the recalibration of CY 2007 APC relative payment weights as proposed without modification, as described in this section.

b. Use of Single and Multiple Procedure Claims

For CY 2007, we proposed to continue to use single procedure claims to set the medians on which the APC relative payment weights would be based. We have received many requests asking that we ensure that the data from claims that contain charges for multiple procedures are included in the data from which we calculate the relative payment weights. Requesters believe that relying solely on single procedure claims to recalibrate APC relative payment weights fails to take into account data for many frequently performed procedures, particularly those commonly performed in combination with other procedures. They believe that, by depending upon single procedure claims, we base relative payment weights on the least costly services, thereby introducing downward bias to the medians on which the weights are based.

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 with multiple procedures. We generally use single procedure claims to set the median costs for APCs 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. However, by bypassing specified codes that we believe do not have significant packaged costs, we are able to use more data from multiple procedure claims. In many cases, this enables us to create multiple ''pseudo'' single claims from claims that, as submitted, contained multiple separately paid procedures on the same claim. For the CY 2007 OPPS, we proposed to use the date of service on the claims and a list of codes to be bypassed to create ''pseudo'' single claims from multiple procedure claims, as we did in recalibrating the CY 2006 APC relative payment weights. We refer to these newly created single procedure claims as ''pseudo'' single claims because they were submitted by providers as multiple procedure claims.

For CY 2003, we created ''pseudo'' single claims by bypassing HCPCS codes 93005 (Electrocardiogram, tracing), 71010 (Chest x-ray), and 71020 (Chest x-ray) on a submitted claim. However, we did not use claims data for the bypassed codes in the creation of the median costs for the APCs to which these three codes were assigned because the level of packaging that would have remained on the claim after we selected the bypass code was not apparent and, therefore, it was difficult to determine if the medians for these codes would be correct.

For CY 2004, we created ''pseudo'' single claims by bypassing these three codes and also by bypassing an additional 269 HCPCS codes in APCs. We selected these codes based on a clinical review of the services and because it was presumed that these codes had only very limited packaging and could appropriately be bypassed for the purpose of creating ''pseudo'' single claims. The APCs to which these codes were assigned were varied and included mammography, cardiac rehabilitation, and Level I plain film x-rays. To derive more ''pseudo'' single claims, we also split the claims where there were dates of service for revenue code charges on that claim that could be matched to a single procedure code on the claim on the same date.

For the CY 2004 OPPS, as in CY 2003, we did not include the claims data for the bypassed codes in the creation of the APCs to which the 269 codes were assigned because, again, we had not established that such an approach was appropriate and would aid in accurately estimating the median costs for those APCs. For CY 2004, from approximately 16.3 million otherwise unusable claims, we used approximately 9.5 million multiple procedure claims to create approximately 27 million ''pseudo'' single claims. For CY 2005, we identified 383 bypass codes and from approximately 24 million otherwise unusable claims, we used approximately 18 million multiple procedure claims to create approximately 52 million ''pseudo'' single claims. For CY 2005, we used the claims data for the bypass codes combined with the single procedure claims to set the median costs for the bypass codes.

For CY 2006, we continued using the codes on the CY 2005 OPPS bypass list and expanded it to include 404 bypass codes, including 3 bladder catheterization codes (CPT codes 51701, 51702, and 51703), which did not meet the empirical criteria discussed below for the selection of bypass codes. We added these three codes to the CY 2006

bypass list because a decision to change their payment status from packaged to separately paid would have resulted in a reduction of the number of single bills on which we could base median costs for other major separately paid procedures that were billed on the same claim with these three procedure codes. That is, single bills which contained other procedures would have become multiple procedure claims when these bladder catheterization codes were converted to separately paid status. We believed and continue to believe that bypassing these three codes does not adversely affect the medians for other procedures because we believe that when these services are performed on the same day as another separately paid service, any packaging that appears on the claim would be appropriately associated with the other procedure and not with these codes.

Consequently, for CY 2006, we identified 404 bypass codes for use in creating ''pseudo'' single claims and used some part of 90 percent of the total claims that were eligible for use in OPPS ratesetting and modeling in developing the final rule with comment period. This process enabled us to use, for the CY 2006 OPPS, 88 million single bills for ratesetting: 55 million ''pseudo'' singles and 34 million ''natural'' single bills (bills that were submitted containing only one separately payable major HCPCS code). (These numbers do not sum to 88 million because more than 800,000 single bills were removed when we trimmed at the HCPCS level at +/-3 standard deviations from the geometric mean.)

For CY 2007, we proposed to continue using date-of-service matching as a tool for creation of ''pseudo'' single claims and to continue the use of a bypass list to create ''pseudo'' single claims. The process we proposed for the CY 2007 OPPS resulted in our being able to use some part of 92.6 percent of the total claims that are eligible for use in the OPPS ratesetting and modeling in developing this final rule with comment period. This process enabled us to use, for CY 2007, 68.5 million ''pseudo'' singles and 31.6 million ''natural'' single bills.

We proposed to bypass the 454 codes identified in Table 1 of the proposed rule (71 FR 49517) to create new single claims and to use the line-item costs associated with the bypass codes on these claims, together with the single procedure claims, in the creation of the median costs for the APCs into which they are assigned. Of the codes on this list, 404 codes were used for bypass in CY 2006. We proposed to continue the use of the codes on the CY 2006 OPPS bypass list and to expand it by adding codes that, using data presented to the APC Panel at its March 2006 meeting, meet the same empirical criteria as those used in CY 2006 to create the bypass list, or which our clinicians believe would contain minimal packaging if the services were correctly coded (for example, ultrasound guidance). (Bypass codes shown in Table 1 with an asterisk indicated the HCPCS codes we proposed to add to the CY 2006 OPPS listed codes for bypass in CY 2007.) Our examination of the data against the criteria for inclusion on the bypass list, as discussed below for the addition of new codes, shows that the empirically selected codes used for bypass for the CY 2006 OPPS generally continue to meet the criteria or come very close to meeting the criteria, and we have received no comments against bypassing them.

As proposed, the following empirical criteria that we used to determine the additional codes to add to the CY 2006 OPPS bypass list to create the bypass list for the CY 2007 OPPS were developed by reviewing the frequency and magnitude of packaging in the single claims for payable codes other than drugs and biologicals. We assumed that the representation of packaging on the single claims for any given code is comparable to packaging for that code in the multiple claims:

- There were 100 or more single claims for the code. This number of single claims ensured that observed outcomes were sufficiently representative of packaging that might occur in the multiple claims.
- Five percent or fewer of the single claims for the code had packaged costs on that single claim for the code. This criterion results in limiting the amount of packaging being redistributed to the payable procedure remaining on the claim after the bypass code is removed and ensures that the costs associated with the bypass code represent the cost of the bypassed service.
- The median cost of packaging observed in the single claims was 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 contain minimal packaging and codes for specified drug administration services for which hospitals have requested separate payment but for which it is not possible to acquire median costs unless we add these codes to the bypass list. A more complete discussion of the effects of adding these drug administration codes to the bypass list is contained in the discussion of drug administration payment changes in section VIII.C. of this preamble.

In the CY 2007 OPPS proposed rule, we specifically invited public comment on the ''pseudo'' single process, including the bypass list and the criteria.

Comment: The commenters urged CMS to continue to find ways to use all data from multiple procedure claims to set the median costs on which the payment rates are based. Many commenters supported the bypass list as a vehicle to enable use of all claims data. However, some commenters were concerned that placing HCPCS codes on the bypass list would lead to those codes being undervalued because no packaging from the multiple procedure bill is attributed to them. These commenters urged CMS to validate that these services were not being systematically undervalued by being bypassed and thus having many units of the service used for median setting with no attribution of packaging to the code. In many cases, the commenters did not offer specific discussion of what packaging they believe would be appropriately attached to the codes on the bypass list. One commenter suggested that CMS add CPT code 77421 (Steroscopic X-ray guidance for localization of target volume for the delivery of radiation therapy) to secure more single procedure claims data for median setting. Another commenter asked that CMS add CPT code 88307 (Level V-Surgical pathology, gross and microscopic examination) to the bypass list because it would be consistent with the inclusion of CPT codes 88304 (Level III-Surgical pathology, gross and microscopic examination) and 88305 (Level IV-Surgical pathology, gross and microscopic examination) on the bypass list.

Response: We agree that the bypass list has been very useful in enabling us to use data from multiple procedure claims to set median costs for many services. The use of date of service stratification and the bypass list enabled us to create 68.5 million ''pseudo'' single claims that would not otherwise have been used to set median costs for the CY 2007 OPPS. However, we recognize that it is necessary to be cautious in this approach to minimize the possibility that we could mistakenly apply packaging on the claim to the wrong service. For that reason, each year we investigate the amount of packaging on natural single bills and consider whether changes should be made to the bypass list. However, in some cases, we know that the natural single bills are incorrect, and it is not

reasonable to base a decision on their level of packaging from what we believe are incorrectly coded claims. In these cases, we use clinical judgment to determine whether, on a correctly coded claim, the packaging would be associated with the code as defined or whether the packaging would more appropriately be associated with other procedures. For example, a single procedure bill for an ultrasound guidance service which is used only for guidance during an associated surgical procedure would not be correctly coded and therefore, clinically, we would not expect the packaged costs observed on these single claims to be correctly attributed to the guidance procedure. We believe that the ultrasound guidance procedure itself could not be the service that required the drugs, devices, or operating room use that would usually also be billed on a correctly coded claim. In these cases, we would place the ultrasound guidance procedure on the bypass list and attribute the packaged costs that appear on the same claim to the surgical procedure on the claim.

We have been actively investigating options for using all claims data in the establishment of median costs, and we intend to be ready to discuss our findings in the CY 2008 OPPS proposed rule. With respect to the suggestions for additions to the bypass list, we will evaluate the potential for adding CPT codes 77421 and 88307 to the bypass list for purposes of the CY 2008 OPPS ratesetting.

Comment: One commenter asked that CMS use all claims data on multiple procedure claims by allocating the packaging on a claim with multiple surgical procedures based on the currently existing relative weights to create ''pseudo'' single claims from all multiple procedure claims. The commenter suggested that if CMS is concerned about that process causing the weights being calculated to not reflect changes in cost, CMS might use this process only in cases in which the number of units for HCPCS codes on natural single bills are below some tolerance so that these claims would be used only on low volume procedures.

Response: We are concerned that use of the current relative weights to allocate the packaging on multiple procedure claims may cause packaging to be allocated inappropriately in some cases. As we indicate above, we are continuing to explore ways that packaging could be allocated on multiple procedure claims in such a way that we would have confidence in the allocation.

Comment: One commenter requested that CMS remove CPT code 76942 (Ultrasonic guidance for needle placement (eg biopsy, aspiration, injection, localization device), imaging supervision and interpretation) from the bypass list, because the commenter believed it would raise the median cost for APC 0268, the APC where CPT code 76942 is assigned for CY 2007. According to the commenter, the natural single claims for CPT code 76942 have a higher median cost than the ''pseudo'' single claims. The commenter indicated that when all packaged costs are removed from the natural singles, their median is close to the median for the ''pseudo'' single claims. If removing this code from the bypass list altogether results in too few ''pseudo'' single claims, the commenter requested that CMS calculate the median cost for APC 0268 using only natural single claims.

Response: We agree with the commenter that the median of APC 0268 is higher with the exclusion of ''pseudo'' singles that are created from claims that include CPT code 76942 than it would be if we only used true single claims that include CPT code 76942. However, we believe that the single bills for CPT code 76942 are miscoded and, therefore, inappropriately attribute the procedural costs (for example, the needle placement for biopsy and injection) to ultrasound guidance rather than the biopsy or aspiration procedures. We note that CPT code 76942 is the code with the highest frequency in APC 0268 and, therefore, contributes greatly to the median cost of the APC. The commenter provided no information regarding the specific packaging associated with CPT code 76942; therefore, we continue to believe that its inclusion on the bypass list, and the resulting calculation of the APC median cost for APC 0268, is appropriate.

After carefully considering all public comments received on our proposal, we are adopting as final the proposed ''pseudo'' single process and the bypass codes listed in Table 1.

BILLING CODE 4120–01–P

Table 1.--CY 2007 HCPCS Bypass Codes for Creating "Pseudo" Single Claims for Calculating Median Costs

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
11056	Trim skin lesions, 2 to 4	T	0012	
11057	Trim skin lesions, over 4	T	0013	
11719	Trim nail(s)	T	0009	
11720	Debride nail, 1-5	T	0009	
11721	Debride nail, 6 or more	T	0009	
17003	Destroy lesions, 2-14	T	0010	
31231	Nasal endoscopy, dx	T	0072	
31579	Diagnostic laryngoscopy	T	0073	
51701	Insert bladder catheter	X	0340	
51702	Insert temp bladder cath	X	0340	
51703	Insert bladder cath, complex	T	0164	
51798	Us urine capacity measure	X	0340	
54240	Penis study	T	0164	
67820	Revise eyelashes	S	0698	
70030	X-ray eye for foreign body	X	0260	
70100	X-ray exam of jaw	X	0260	
70110	X-ray exam of jaw	X	0260	
70130	X-ray exam of mastoids	X	0260	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
70140	X-ray exam of facial bones	X	0260	
70150	X-ray exam of facial bones	X	0260	
70160	X-ray exam of nasal bones	X	0260	
70200	X-ray exam of eye sockets	X	0260	
70210	X-ray exam of sinuses	X	0260	
70220	X-ray exam of sinuses	X	0260	
70250	X-ray exam of skull	X	0260	
70260	X-ray exam of skull	X	0261	
70328	X-ray exam of jaw joint	X	0260	
70330	X-ray exam of jaw joints	X	0260	
70336	Magnetic image, jaw joint	S	0335	
70355	Panoramic x-ray of jaws	X	0260	
70360	X-ray exam of neck	X	0260	
70370	Throat x-ray & fluoroscopy	X	0272	
70371	Speech evaluation, complex	X	0272	
70450	Ct head/brain w/o dye	S	0332	
70480	Ct orbit/ear/fossa w/o dye	S	0332	
70486	Ct maxillofacial w/o dye	S	0332	
70544	Mr angiography head w/o dye	S	0336	
70551	Mri brain w/o dye	S	0336	
71010	Chest x-ray	X	0260	
71015	Chest x-ray	X	0260	
71020	Chest x-ray	X	0260	
71021	Chest x-ray	X	0260	
71022	Chest x-ray	X	0260	
71023	Chest x-ray and fluoroscopy	X	0272	
71030	Chest x-ray	X	0260	
71034	Chest x-ray and fluoroscopy	X	0272	
71035	Chest x-ray	X	0260	N
71090	X-ray & pacemaker insertion	X	0272	
71100	X-ray exam of ribs	X	0260	
71101	X-ray exam of ribs/chest	X	0260	
71110	X-ray exam of ribs	X	0260	
71111	X-ray exam of ribs/chest	X	0261	
71120	X-ray exam of breastbone	X	0260	
71130	X-ray exam of breastbone	X	0260	
71250	Ct thorax w/o dye	S	0332	
72040	X-ray exam of neck spine	X	0260	
72050	X-ray exam of neck spine	X	0261	
72052	X-ray exam of neck spine	X	0261	
72069	X-ray exam of trunk spine	X	0260	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
72070	X-ray exam of thoracic spine	X	0260	
72072	X-ray exam of thoracic spine	X	0260	
72074	X-ray exam of thoracic spine	X	0260	
72080	X-ray exam of trunk spine	X	0260	
72090	X-ray exam of trunk spine	X	0261	
72100	X-ray exam of lower spine	X	0260	
72110	X-ray exam of lower spine	X	0261	
72114	X-ray exam of lower spine	X	0261	
72120	X-ray exam of lower spine	X	0261	
72125	Ct neck spine w/o dye	S	0332	
72128	Ct chest spine w/o dye	S	0332	
72141	Mri neck spine w/o dye	S	0336	
72146	Mri chest spine w/o dye	S	0336	
72148	Mri lumbar spine w/o dye	S	0336	
72170	X-ray exam of pelvis	X	0260	
72190	X-ray exam of pelvis	X	0260	
72192	Ct pelvis w/o dye	S	0332	
72220	X-ray exam of tailbone	X	0260	
73000	X-ray exam of collar bone	X	0260	
73010	X-ray exam of shoulder blade	X	0260	
73020	X-ray exam of shoulder	X	0260	
73030	X-ray exam of shoulder	X	0260	
73050	X-ray exam of shoulders	X	0260	
73060	X-ray exam of humerus	X	0260	
73070	X-ray exam of elbow	X	0260	
73080	X-ray exam of elbow	X	0260	
73090	X-ray exam of forearm	X	0260	
73100	X-ray exam of wrist	X	0260	
73110	X-ray exam of wrist	X	0260	
73120	X-ray exam of hand	X	0260	
73130	X-ray exam of hand	X	0260	
73140	X-ray exam of finger(s)	X	0260	
73200	Ct upper extremity w/o dye	S	0332	N
73218	Mri upper extremity w/o dye	S	0336	
73221	Mri joint upr extrem w/o dye	S	0336	
73510	X-ray exam of hip	X	0260	
73520	X-ray exam of hips	X	0261	
73540	X-ray exam of pelvis & hips	X	0260	
73550	X-ray exam of thigh	X	0260	
73560	X-ray exam of knee, 1 or 2	X	0260	
73562	X-ray exam of knee, 3	X	0260	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
73564	X-ray exam, knee, 4 or more	X	0260	
73565	X-ray exam of knees	X	0260	
73590	X-ray exam of lower leg	X	0260	
73600	X-ray exam of ankle	X	0260	
73610	X-ray exam of ankle	X	0260	
73620	X-ray exam of foot	X	0260	
73630	X-ray exam of foot	X	0260	
73650	X-ray exam of heel	X	0260	
73660	X-ray exam of toe(s)	X	0260	
73700	Ct lower extremity w/o dye	S	0332	
73718	Mri lower extremity w/o dye	S	0336	
73721	Mri jnt of lwr extre w/o dye	S	0336	
74000	X-ray exam of abdomen	X	0260	
74010	X-ray exam of abdomen	X	0260	
74150	Ct abdomen w/o dye	S	0332	N
74210	Contrst x-ray exam of throat	S	0276	
74220	Contrast x-ray, esophagus	S	0276	
74230	Cine/vid x-ray, throat/esoph	S	0276	
74235	Remove esophagus obstruction	S	0296	
74240	X-ray exam, upper gi tract	S	0276	
74245	X-ray exam, upper gi tract	S	0277	
74246	Contrst x-ray uppr gi tract	S	0276	
74247	Contrst x-ray uppr gi tract	S	0276	
74249	Contrst x-ray uppr gi tract	S	0277	
74250	X-ray exam of small bowel	S	0276	
74300	X-ray bile ducts/pancreas	X	0263	
74301	X-rays at surgery add-on	X	0263	
74305	X-ray bile ducts/pancreas	X	0263	
74327	X-ray bile stone removal	S	0296	
74340	X-ray guide for GI tube	X	0272	
74350	X-ray guide, stomach tube	X	0263	
74355	X-ray guide, intestinal tube	X	0263	
74360	X-ray guide, GI dilation	S	0296	
74363	X-ray, bile duct dilation	S	0297	
74475	X-ray control, cath insert	S	0297	
74480	X-ray control, cath insert	S	0296	
74485	X-ray guide, GU dilation	S	0296	
75894	X-rays, transcath therapy	S	0297	
75898	Follow-up angiography	X	0263	
75901	Remove cva device obstruct	X	0263	
75902	Remove cva lumen obstruct	X	0263	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
75945	Intravascular us	S	0267	
75960	Transcath iv stent rs&i	S	0668	
75961	Retrieval, broken catheter	S	0668	
75962	Repair arterial blockage	S	0668	
75964	Repair artery blockage, each	S	0668	
75966	Repair arterial blockage	S	0668	
75968	Repair artery blockage, each	S	0668	
75970	Vascular biopsy	S	0668	
75978	Repair venous blockage	S	0668	
75980	Contrast xray exam bile duct	S	0297	
75982	Contrast xray exam bile duct	S	0297	
75984	Xray control catheter change	X	0263	
75992	Atherectomy, x-ray exam	S	0279	
75993	Atherectomy, x-ray exam	S	0279	
75994	Atherectomy, x-ray exam	S	0279	N
75995	Atherectomy, x-ray exam	S	0279	N
76012	Percut vertebroplasty fluor	S	0274	
76013	Percut vertebroplasty, ct	S	0274	
76040	X-rays, bone evaluation	X	0261	
76061	X-rays, bone survey	X	0261	
76062	X-rays, bone survey	X	0261	
76066	Joint survey, single view	X	0260	
76070	Ct bone density, axial	S	0288	
76071	Ct bone density, peripheral	S	0282	N
76075	Dxa bone density, axial	S	0288	
76076	Dxa bone density/peripheral	S	0665	
76077	Dxa bone density/v-fracture	X	0260	N
76078	Radiographic absorptiometry	X	0260	
76095	Stereotactic breast biopsy	X	0264	
76096	X-ray of needle wire, breast	X	0263	
76100	X-ray exam of body section	X	0261	
76101	Complex body section x-ray	X	0263	
76355	Ct scan for localization	S	0283	N
76360	Ct scan for needle biopsy	S	0283	
76362	Ct guide for tissue ablation	S	0333	N
76370	Ct scan for therapy guide	S	0282	N
76380	CAT scan follow-up study	S	0282	
76393	Mr guidance for needle place	S	0335	
76394	MRI for tissue ablation	S	0335	N
76511	Ophth us, quant a only	S	0266	
76512	Ophth us, b w/non-quant a	S	0266	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
76513	Echo exam of eye, water bath	S	0266	N
76514	Echo exam of eye, thickness	X	0340	N
76516	Echo exam of eye	S	0265	
76519	Echo exam of eye	S	0266	
76536	Us exam of head and neck	S	0266	
76645	Us exam, breast(s)	S	0265	
76700	Us exam, abdom, complete	S	0266	
76705	Echo exam of abdomen	S	0266	
76770	Us exam abdo back wall, comp	S	0266	
76775	Us exam abdo back wall, lim	S	0266	
76778	Us exam kidney transplant	S	0266	
76801	Ob us < 14 wks, single fetus	S	0266	
76811	Ob us, detailed, sngl fetus	S	0267	
76816	Ob us, follow-up, per fetus	S	0265	N
76817	Transvaginal us, obstetric	S	0266	
76830	Transvaginal us, non-ob	S	0266	
76856	Us exam, pelvic, complete	S	0266	
76857	Us exam, pelvic, limited	S	0265	
76870	Us exam, scrotum	S	0266	
76880	Us exam, extremity	S	0266	
76930	Echo guide, cardiocentesis	S	0268	N
76932	Echo guide for heart biopsy	S	0268	N
76936	Echo guide for artery repair	S	0268	N
76940	Us guide, tissue ablation	S	0268	N
76941	Echo guide for transfusion	S	0268	N
76942	Echo guide for biopsy	S	0268	N
76945	Echo guide, villus sampling	S	0268	N
76946	Echo guide for amniocentesis	S	0268	
76948	Echo guide, ova aspiration	S	0268	N
76950	Echo guidance radiotherapy	S	0268	
76965	Echo guidance radiotherapy	S	0268	N
76970	Ultrasound exam follow-up	S	0265	
76975	GI endoscopic ultrasound	S	0266	N
76977	Us bone density measure	X	0340	
76986	Ultrasound guide intraoper	S	0266	N
77280	Set radiation therapy field	X	0304	
77285	Set radiation therapy field	X	0305	
77290	Set radiation therapy field	X	0305	N
77295	Set radiation therapy field	X	0310	
77300	Radiation therapy dose plan	X	0304	
77301	Radiotherapy dose plan, imrt	X	0310	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
77315	Teletx isodose plan complex	X	0305	
77326	Brachytx isodose calc simp	X	0304	
77327	Brachytx isodose calc interm	X	0305	
77328	Brachytx isodose plan compl	X	0305	
77331	Special radiation dosimetry	X	0304	
77332	Radiation treatment aid(s)	X	0303	
77333	Radiation treatment aid(s)	X	0303	
77334	Radiation treatment aid(s)	X	0303	
77336	Radiation physics consult	X	0304	
77370	Radiation physics consult	X	0304	
77401	Radiation treatment delivery	S	0300	N
77402	Radiation treatment delivery	S	0300	
77403	Radiation treatment delivery	S	0300	
77404	Radiation treatment delivery	S	0300	
77407	Radiation treatment delivery	S	0300	N
77408	Radiation treatment delivery	S	0300	
77409	Radiation treatment delivery	S	0300	
77411	Radiation treatment delivery	S	0301	
77412	Radiation treatment delivery	S	0301	
77413	Radiation treatment delivery	S	0301	
77414	Radiation treatment delivery	S	0301	
77416	Radiation treatment delivery	S	0301	
77417	Radiology port film(s)	X	0260	
77418	Radiation tx delivery, imrt	S	0412	
77470	Special radiation treatment	S	0299	
78350	Bone mineral, single photon	X	0260	
80500	Lab pathology consultation	X	0433	N
80502	Lab pathology consultation	X	0342	
85060	Blood smear interpretation	X	0342	
86585	TB tine test	X	0341	
86850	RBC antibody screen	X	0345	
86870	RBC antibody identification	X	0346	
86880	Coombs test, direct	X	0409	
86885	Coombs test, indirect, qual	X	0409	
86886	Coombs test, indirect, titer	X	0409	
86890	Autologous blood process	X	0347	
86900	Blood typing, ABO	X	0409	
86901	Blood typing, Rh (D)	X	0409	
86905	Blood typing, RBC antigens	X	0345	
86906	Blood typing, Rh phenotype	X	0345	
86930	Frozen blood prep	X	0347	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
86970	RBC pretreatment	X	0345	
88104	Cytopathology, fluids	X	0433	
88106	Cytopathology, fluids	X	0433	
88107	Cytopathology, fluids	X	0433	
88108	Cytopath, concentrate tech	X	0433	
88112	Cytopath, cell enhance tech	X	0343	N
88160	Cytopath smear, other source	X	0433	
88161	Cytopath smear, other source	X	0433	
88162	Cytopath smear, other source	X	0433	N
88172	Cytopathology eval of fna	X	0343	
88182	Cell marker study	X	0344	
88184	Flowcytometry/ tc, 1 marker	X	0344	N
88300	Surgical path, gross	X	0433	
88304	Tissue exam by pathologist	X	0343	
88305	Tissue exam by pathologist	X	0343	
88311	Decalcify tissue	X	0342	
88312	Special stains	X	0433	
88313	Special stains	X	0433	
88321	Microslide consultation	X	0433	
88323	Microslide consultation	X	0343	
88325	Comprehensive review of data	X	0344	
88331	Path consult intraop, 1 bloc	X	0343	
88342	Immunohistochemistry	X	0343	
88346	Immunofluorescent study	X	0343	
88347	Immunofluorescent study	X	0343	
88348	Electron microscopy	X	0661	N
88358	Analysis, tumor	X	0344	N
88360	Tumor immunohistochem/manual	X	0344	N
88365	Insitu hybridization (fish)	X	0344	N
88368	Insitu hybridization, manual	X	0344	N
90781	drug admin subs hour	S	0438	N
90801	Psy dx interview	S	0323	
90804	Psytx, office, 20-30 min	S	0322	
90805	Psytx, off, 20-30 min w/e&m	S	0322	
90806	Psytx, off, 45-50 min	S	0323	
90807	Psytx, off, 45-50 min w/e&m	S	0323	
90808	Psytx, office, 75-80 min	S	0323	
90809	Psytx, off, 75-80, w/e&m	S	0323	
90810	Intac psytx, off, 20-30 min	S	0322	
90818	Psytx, hosp, 45-50 min	S	0323	
90826	Intac psytx, hosp, 45-50 min	S	0323	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
90845	Psychoanalysis	S	0323	
90846	Family psytx w/o patient	S	0324	
90847	Family psytx w/patient	S	0324	
90853	Group psychotherapy	S	0325	
90857	Intac group psytx	S	0325	
90862	Medication management	X	0374	
92002	Eye exam, new patient	V	0601	
92004	Eye exam, new patient	V	0602	
92012	Eye exam established pat	V	0600	
92014	Eye exam & treatment	V	0601	
92020	Special eye evaluation	S	0230	
92081	Visual field examination(s)	S	0230	
92082	Visual field examination(s)	S	0230	
92083	Visual field examination(s)	S	0230	
92135	Opthalmic dx imaging	S	0230	
92136	Ophthalmic biometry	S	0698	
92225	Special eye exam, initial	S	0230	
92226	Special eye exam, subsequent	S	0230	
92230	Eye exam with photos	T	0699	
92240	Icg angiography	S	0231	N
92250	Eye exam with photos	S	0230	
92275	Electroretinography	S	0231	
92285	Eye photography	S	0230	
92286	Internal eye photography	S	0698	
92520	Laryngeal function studies	X	0660	
92541	Spontaneous nystagmus test	X	0363	
92546	Sinusoidal rotational test	X	0660	
92548	Posturography	X	0660	
92552	Pure tone audiometry, air	X	0364	
92553	Audiometry, air & bone	X	0365	
92555	Speech threshold audiometry	X	0364	
92556	Speech audiometry, complete	X	0364	
92557	Comprehensive hearing test	X	0365	
92567	Tympanometry	X	0364	
92582	Conditioning play audiometry	X	0365	
92585	Auditor evoke potent, compre	S	0216	
92604	Reprogram cochlear implt 7 >	X	0366	
93005	Electrocardiogram, tracing	S	0099	
93225	ECG monitor/record, 24 hrs	X	0097	
93226	ECG monitor/report, 24 hrs	X	0097	
93231	Ecg monitor/record, 24 hrs	X	0097	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
93232	ECG monitor/report, 24 hrs	X	0097	
93236	ECG monitor/report, 24 hrs	X	0097	
93270	ECG recording	X	0097	
93271	Ecg/monitoring and analysis	X	0097	N
93278	ECG/signal-averaged	S	0099	
93303	Echo transthoracic	S	0269	
93307	Echo exam of heart	S	0269	
93320	Doppler echo exam, heart	S	0671	
93325	Doppler color flow add-on	S	0697	N
93731	Analyze pacemaker system	S	0690	
93732	Analyze pacemaker system	S	0690	
93733	Telephone analy, pacemaker	S	0690	
93734	Analyze pacemaker system	S	0690	
93735	Analyze pacemaker system	S	0690	
93736	Telephonic analy, pacemaker	S	0690	
93741	Analyze ht pace device sngl	S	0689	
93742	Analyze ht pace device sngl	S	0689	N
93743	Analyze ht pace device dual	S	0689	
93744	Analyze ht pace device dual	S	0689	N
93786	Ambulatory BP recording	X	0097	N
93788	Ambulatory BP analysis	X	0097	N
93797	Cardiac rehab	S	0095	
93798	Cardiac rehab/monitor	S	0095	
93875	Extracranial study	S	0096	
93880	Extracranial study	S	0267	
93882	Extracranial study	S	0267	
93886	Intracranial study	S	0267	
93888	Intracranial study	S	0266	
93922	Extremity study	S	0096	
93923	Extremity study	S	0096	
93924	Extremity study	S	0096	
93925	Lower extremity study	S	0267	
93926	Lower extremity study	S	0266	
93930	Upper extremity study	S	0267	
93931	Upper extremity study	S	0266	
93965	Extremity study	S	0096	
93970	Extremity study	S	0267	
93971	Extremity study	S	0266	
93975	Vascular study	S	0267	
93976	Vascular study	S	0267	
93978	Vascular study	S	0266	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
93979	Vascular study	S	0266	
93990	Doppler flow testing	S	0266	
94015	Patient recorded spirometry	X	0367	
94681	Exhaled air analysis, o2/co2	X	0368	N
95115	Immunotherapy, one injection	X	0352	
95117	Immunotherapy injections	X	0353	
95165	Antigen therapy services	X	0353	
95805	Multiple sleep latency test	S	0209	
95806	Sleep study, unattended	S	0213	
95807	Sleep study, attended	S	0209	
95812	Eeg, 41-60 minutes	S	0213	
95813	Eeg, over 1 hour	S	0213	
95816	Eeg, awake and drowsy	S	0213	
95819	Eeg, awake and asleep	S	0213	
95822	Eeg, coma or sleep only	S	0213	
95864	Muscle test, 4 limbs	S	0218	
95867	Muscle test cran nerv unilat	S	0218	
95872	Muscle test, one fiber	S	0218	
95900	Motor nerve conduction test	S	0215	
95921	Autonomic nerv function test	S	0218	
95925	Somatosensory testing	S	0216	
95926	Somatosensory testing	S	0216	
95930	Visual evoked potential test	S	0216	
95937	Neuromuscular junction test	S	0218	
95950	Ambulatory eeg monitoring	S	0209	
95953	EEG monitoring/computer	S	0209	
95957	EEG digital analysis	S	0214	N
95970	Analyze neurostim, no prog	S	0218	
95972	Analyze neurostim, complex	S	0692	
95974	Cranial neurostim, complex	S	0692	
95978	Analyze neurostim brain/1h	S	0692	N
96000	Motion analysis, video/3d	S	0216	
96100	Psychological testing	X	0382	
96115	Neurobehavior status exam	X	0373	
96117	Neuropsych test battery	X	0382	
96150	Assess hlth/behave, init	S	0432	N
96151	Assess hlth/behave, subseq	S	0432	N
96152	Intervene hlth/behave, indiv	S	0432	N
96412	drug admin subs hour	S	0439	N
96423	drug admin subs hour	S	0439	N
96900	Ultraviolet light therapy	S	0001	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
96910	Photochemotherapy with UV-B	S	0001	
96912	Photochemotherapy with UV-A	S	0001	
96913	Photochemotherapy, UV-A or B	S	0683	
98925	Osteopathic manipulation	S	0060	
98926	Osteopathic manipulation	S	0060	N
98940	Chiropractic manipulation	S	0060	
98941	Chiropractic manipulation	S	0060	N
99212	Office/outpatient visit, est	V	0600	N
99213	Office/outpatient visit, est	V	0601	
99214	Office/outpatient visit, est	V	0602	
99241	Office consultation	V	0600	
99242	Office consultation	V	0600	
99243	Office consultation	V	0601	
99244	Office consultation	V	0602	
99245	Office consultation	V	0602	
99272	Confirmatory consultation	V	0600	N
99273	Confirmatory consultation	V	0601	
99274	Confirmatory consultation	V	0602	
99275	Confirmatory consultation	V	0602	
G0101	CA screen;pelvic/breast exam	V	0600	
G0127	Trim nail(s)	T	0009	
G0130	Single energy x-ray study	X	0260	N
G0166	Extrnl counterpulse, per tx	T	0678	
G0175	OPPS Service,sched team conf	V	0602	
G0344	Initial preventive exam	V	0601	N
Q0091	Obtaining screen pap smear	T	0191	

*Bypass indicator "N" equals new

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c. Revised Overall Cost-to-Charge Ratio (CCR) Calculation

We calculate both an overall CCR and cost center-specific cost-to-charge ratios (CCRs) for each hospital. For the CY 2007 OPPS, we proposed to change the methodology for calculating the overall CCR. The overall CCR is used in many components of the OPPS. We use the overall CCR to estimate costs from charges on a claim when we do not have an accurate cost center CCR. This does not happen very often. For the vast majority of services, we are able to use a cost center CCR to estimate costs from charges. However, we also use the overall CCR to identify the outlier threshold, to model payments for services that are paid at charges reduced to cost, and, during implementation, to determine outlier payments and payments for other services.

As stated in the CY 2007 OPPS proposed rule (71 FR 49528), we have discovered that the calculation of the overall CCR that the fiscal intermediaries are using to determine outlier payments and payments for services paid at charges reduced to cost differs from the overall CCR that we use to model the OPPS. In Program Transmittal A–03–04 on ''Calculating Provider-Specific Outpatient Cost-to-Charge Ratios (CCRs) and Instructions on Cost Report Treatment of Hospital Outpatient Services Paid on a Reasonable Cost Basis'' (January 17, 2003), we revised the overall CCR calculation that the fiscal intermediaries use in determining outlier and other cost payments. Until this point, each fiscal intermediary had used an overall CCR provided by CMS, or calculated an updated CCR at the provider's request using the same calculation. The calculation in Program Transmittal A–03–04, that is, the fiscal intermediary calculation, diverged from the ''traditional'' overall CCR that we used for modeling. It should be noted that the fiscal intermediary overall CCR calculation noted in Program Transmittal A–03–04 was created with feedback and input from the fiscal intermediaries.

CMS' ''traditional'' calculation consists of summing the total costs from Worksheet B, Part I (Column 27), after removing the costs for nursing and paramedical education (Columns 21 and 24), for those ancillary cost centers that we believe contain most OPPS services, summing the total charges from Worksheet C, Part I (Columns 6 and 7) for the same set of ancillary cost centers, and dividing the former by the latter. We exclude selected ancillary cost centers from our overall CCR calculation, such as 5700 Renal Dialysis, because we believe that the costs and

charges in these cost centers are largely paid for under other payment systems. The specific list of ancillary cost centers, both standard and nonstandard, included in our overall CCR calculation is available on our Web site in the revenue center-to-cost center crosswalk workbook: *http://www.cms.hhs.gov/HospitalOutpatientPPS.*

The overall CCR calculation provided in Program Transmittal A–03–04, on the other hand, takes the CCRs from Worksheet C, Part I, Column 9, for each specified ancillary cost center; multiplies them by the Medicare Part B outpatient specific charges in each corresponding ancillary cost center from Worksheet D, Part V (Columns 2, 3, 4, and 5 and subscripts thereof); and then divides the sum of these costs by the sum of charges for the specified ancillary cost centers from Worksheet D, Part V (Columns 2, 3, 4, and 5 and subscripts thereof). The elimination of the reference to Part VI in this final rule with comment period is not a change from the proposed methodology. We used only data from Worksheet D, Part V of the HCRIS electronic cost report to calculate the overall CCRs for both the proposed rule and final rule with comment period. We previously referenced both Part V and Part VI in the proposed rule and in prior rules because both Part V and Part VI appear on the same page in Worksheet D on the paper cost report, although no data from Part VI on the electronic cost report were used in the calculation.

Compared with our ''traditional'' overall CCR calculation that has been used for modeling OPPS and to calculate the median costs, this fiscal intermediary calculation of overall CCR fails to remove allied health costs and adds weighting by Medicare Part B charges.

In comparing these two calculations, we discovered that, on average, the overall CCR calculation being used by the fiscal intermediaries resulted in higher overall CCRs than under our ''traditional'' calculation. Using the most recent cost report data available for every provider with valid claims for CY 2004 as of November 2005, we estimated the median overall CCR using the traditional calculation to be 0.3040 (mean 0.3223) and the median overall CCR using the fiscal intermediary calculation to be 0.3309 (mean 0.3742). There also was much greater variability in the fiscal intermediary calculation of the overall CCR. The standard deviation under the ''traditional'' calculation was 0.1318, while the standard deviation using the fiscal intermediary's calculation was 0.2143. In part, the higher median estimate for the fiscal intermediary calculation is attributable to the inclusion of allied health costs for the over 700 hospitals with allied health programs. It is inappropriate to include these costs in the overall CCR calculation, because CMS already reimburses hospitals for the costs of these programs through cost report settlement. The higher median estimate and greater variability also is a function of the weighting by Medicare Part B charges. Because the fiscal intermediary overall CCR calculation is higher, on average, CMS has underestimated the outlier payment thresholds and, therefore, overpaid outlier payments. We also have underestimated spending for services paid at charges reduced to cost in our budget neutrality estimates.

In examining the two different calculations, we decided that elements of each methodology had merit. Clearly, as noted above, allied health costs should not be included in an overall CCR calculation. However, weighting by Medicare Part B charges from Worksheet D, Part V, makes the overall CCR calculation more specific to OPPS. Therefore, we proposed to adopt a single overall CCR calculation that incorporates weighting by Medicare Part B charges but excludes allied health costs for modeling and payment. Specifically, the proposed calculation removes allied health costs from cost center CCR calculations for specified ancillary cost centers, as discussed above, multiplies them by the Medicare Part B charges on Worksheet D, Part V, and sums these estimated Medicare costs. This sum is then divided by the sum of the same Medicare Part B charges for the same specified set of ancillary cost centers.

As we indicated in the proposed rule (71 FR 49528), using the same cost report data in this study, we estimated a median overall CCR for the proposed calculation of 0.3081 (mean 0.3389) with a standard deviation of 0.1583. The similarity to the median and standard deviation of the ''traditional'' overall CCR calculation noted above (median 0.3040 and standard deviation of 0.1318) masks some sizeable changes in overall CCR calculations for specific hospitals due largely to the inclusion of Medicare Part B weighting.

In order to isolate the overall impact of adopting this methodology on APC medians, we used the first 9 months of CY 2005 claims data to estimate APC median costs varying only the two methods of determining overall CCR. As stated in the CY 2007 OPPS proposed rule (71 FR 49528), we expected the impact to be limited because the majority of costs are estimated using a cost center-specific CCR and not the overall. As predicted, we observed minor changes in APC median costs from the adoption of the proposed overall CCR calculation. We largely observed differences of no more than 5 percent in either direction. The median overall percent change in APC cost estimates was −0.3 percent. We typically observe comparable changes in APC medians when we update our cost report data. Using updated cost report data for the calculations in this final rule with comment period, we estimate a median overall CCR across all hospitals of 0.3015 using the new overall CCR calculation.

We believe that a single overall CCR calculation should be used for all components of the OPPS for both modeling and payment. Therefore, we proposed to use the modified overall CCR calculation as discussed above when the hospital-specific overall CCR is used for any of the following calculations: in the CMS calculation of median costs for OPPS ratesetting, in the CMS calculation of the outlier threshold, in the fiscal intermediary calculation of outlier payments, in the CMS calculation of statewide CCRs, in the fiscal intermediary calculation of pass-through payments for devices, and for any other fiscal intermediary payment calculation in which the current hospital-specific overall CCR may be used now or in the future.

Comment: Several commenters supported the proposed change to the calculation of the overall CCR to be weighted by Part B charges and to exclude the costs of nursing and allied health professional education programs. One commenter asked that CMS provide examples at the line level of how the revenue code to cost center crosswalk is applied to sample claims to illustrate to hospitals how selection of the revenue code for any particular item or service controls the resulting cost that is used in median calculation. The commenter also asked that CMS instruct fiscal intermediaries to allow hospitals to reclassify expense and revenue whenever the hospital believes it is appropriate, to ensure that the charges on the claim result in appropriate costs for median setting and order the fiscal intermediaries not to reverse reclassification of costs in audit adjustments. The commenter also suggested that CMS should have fiscal intermediaries conduct a survey of their audit staff with regard to the validity of the revenue code to cost center crosswalk.

Response: We continue to believe that the proposed change to the CCR calculation is appropriate, and we have used the revised formula to calculate the

overall CCRs used to set the medians on which the CY 2007 payment rates are based.

With respect to the request for detailed examples to illustrate how selection of a revenue code will control the cost that is used in the median calculation, we believe that hospitals, like any business, are responsible for performing their own analysis regarding issues that affect their revenue stream. We have gone to great lengths in the preamble of our proposed and final rules to discuss how we derive costs from charges and how we crosswalk the charge from the revenue code reported for the charge to the cost center on the cost report. Moreover, the revenue code to cost center crosswalk has been on the CMS Web site for several years, open continuously to public comment. We do not believe it is necessary to create and publish examples at the claim-line level to further elaborate on how we convert charges to costs for purposes of establishing median costs. Hospitals that are interested should have sufficient information available already on this topic. Moreover, Medicare auditing rules have been well-established and standardized over many years, and we rely on our contractors to enforce them appropriately.

Comment: One commenter suggested that CMS study the crosswalk that is used in the completion of the Provider Statistical and Reimbursement Report (PS&R) to determine whether changes to the CMS crosswalk of revenue codes to cost centers might be appropriate. Specifically, the commenter suggested the following revisions: Revenue code 0413 (hyperbaric oxygen therapy) should be crosswalked to the hospital overall CCR; Revenue code 026X (IV therapy) could have cost center 5600 (Drugs charges to patients) as the secondary default CCR before defaulting to the overall CCR; Revenue code 046X (Pulmondary therapy) should have cost center 4600 (respiratory therapy) as secondary and cost center 3160 as tertiary; and Revenue code 074X (EEG) should have cost center 5400 (EEG) as primary and cost center 3280 (EKG and EEG) as secondary.

Response: We have not made any changes in response to the commenter's suggestions for CY 2007. However, we will carefully examine the commenter's suggestions with regard to the calculation of CCRs for the CY 2008 OPPS.

After carefully considering all the public comments received, we are adopting our proposal for CY 2007 without modification. As stated in the CY 2007 proposed rule (71 FR 49529), we will issue a Medicare program instruction to fiscal intermediaries that will instruct them to recalculate and use the hospital-specific overall CCR as we have finalized for the above stated purposes.

2. Calculation of Median Costs for CY 2007

In this section of the preamble, we discuss the use of claims to calculate the proposed OPPS payment rates for CY 2007. The hospital outpatient prospective payment 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: *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 2007 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.''

As proposed, we used the following methodology to establish the relative weights to be used in calculating the OPPS payment rates for CY 2007 shown in Addenda A and B to this final rule with comment period. This methodology is as follows:

We used outpatient claims for the full CY 2005, processed before June 30, 2006, to set the relative weights for CY 2007. To begin the calculation of the relative weights for CY 2007, we pulled all claims for outpatient services furnished in CY 2005 from the national claims history file. This is not the population of claims paid under the OPPS, but all outpatient claims (including, for example, CAH claims, and hospital claims for clinical laboratory services for persons who are neither inpatients nor outpatients of the hospital).

We then excluded claims with condition codes 04, 20, 21, and 77. These are claims that providers submitted to Medicare knowing that no payment will be made. For example, providers submit claims with a condition code 21 to elicit an official denial notice from Medicare and document that a service is not covered. We then excluded claims for services furnished in Maryland, Guam, and the U.S. Virgin Islands, American Samoa, and the Northern Marianas 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 110 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 2006 (70 FR 68537), with a change to the development of the overall CCR as discussed above. That is, we first limited the population of cost reports to only those for hospitals that filed outpatient claims in CY 2005 before determining whether the CCRs for such hospitals were valid.

We then calculated the CCRs at a cost center level and overall 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 2004. As proposed, for this final rule with comment period, we used the most recently submitted cost report to calculate the CCRs to be used to calculate median costs for the CY 2007 OPPS. 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 II.A.1.c. of this preamble for all purposes that require use of an overall CCR.

We then flagged CAH claims, which are not paid under the OPPS, and claims from hospitals with invalid CCRs. The latter included claims from hospitals without a CCR; those from hospitals paid an all-inclusive rate; those from

hospitals with obviously erroneous CCRs (greater than 90 or less than .0001); and those from hospitals with 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 level by removing the CCRs for each cost center as outliers if they exceeded ±3 standard deviations from the geometric mean. This is the same methodology that we used in developing the final CY 2006 CCRs. For CY 2007, we proposed to trim at the departmental CCR level to eliminate aberrant CCRs that, if found in high volume hospitals, could skew the medians. 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 departmental 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 at 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 2 of the proposed rule (71 FR 49532) contained a list of the allowed revenue codes. Revenue codes not included in Table 2 are those not allowed under the OPPS because their services cannot be paid under the OPPS (for example, inpatient room and board charges) and thus, charges with those revenue codes were not packaged for creation of the OPPS median costs. One exception is the calculation of median blood costs, as discussed in section X. of this preamble.

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, and the U.S. Virgin Islands, American Samoa, and the Northern Marianas 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 also moved claims for observation services to another file. We moved to another file claims that contained nothing but influenza and pneumococcal pneumonia (''PPV'') vaccine. Influenza and PPV vaccines are paid at reasonable cost and, therefore, these claims are not used to set OPPS rates. We note that the two above mentioned separate files containing partial hospitalization claims and observation services claims are included in the files that are available for purchase as discussed above.

We next copied line-item costs for drugs, blood, and devices (the lines stay on the claim, but are copied off onto another file) to a separate file. No claims were deleted when we copied these lines onto another file. These line-items are used to calculate a per unit mean and median and a per day mean and median for drugs, radiopharmaceutical agents, blood and blood products, and devices, including but not limited to brachytherapy sources, as well as other information used to set payment rates, including a unit to day ratio for drugs.

We then divided the remaining claims into the following five groups:

1. *Single Major Claims:* Claims with a single separately payable procedure (that is, status indicator S, T, V, or X), all of which would be used in median setting.

2. *Multiple Major Claims:* Claims with more than one separately payable procedure (that is, status indicator S, T, V, or X), or multiple units for one payable procedure. As discussed below, some of these can be used in median setting.

3. *Single Minor Claims:* Claims with a single HCPCS code that is packaged (that is, status indicator N) and not separately payable.

4. *Multiple Minor Claims:* Claims with multiple HCPCS codes that are packaged (that is, status indicator N) and not separately payable.

5. *Non-OPPS Claims:* Claims that contain no services payable under the OPPS (that is, all status indicators other than S, T, V, X, or N). These claims are excluded from the files used for the OPPS. Non-OPPS claims have codes paid under other fee schedules, for example, durable medical equipment or clinical laboratory, and do not contain either a code for a separately paid service or a code for a packaged service.

In previous years, we made a determination of whether each HCPCS code was a major code, or a minor code, or a code other than a major or minor code. We used those code-specific determinations to sort claims into these five identified groups. For the CY 2007 OPPS, we proposed to use status indicators, as described above, to sort the claims into these groups. We believed that using status indicators 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 and become a more informed commenter on the proposed rule.

We note that the claims listed in numbers 1, 2, 3, and 4 above are included in the data files that can be purchased as described above.

We set aside the single minor, multiple minor claims and the non-OPPS claims (numbers 3, 4, and 5 above) because we did not use these claims in calculating median costs. We then examined the multiple major claims for date of service to determine if we could break them into single procedure claims using the dates of service on all lines on the claim. If we could create claims with single major procedures by using date of service, we created a single procedure claim record for each separately paid procedure on a different date of service (that is, a ''pseudo'' single).

We then used the ''bypass codes'' listed in Table 1 of the proposed rule (71 FR 49517) and discussed in section II.A.1.b. of this preamble to remove separately payable procedures that we determined contain limited costs or no packaged costs, or were otherwise suitable for inclusion on the bypass list, from a multiple procedure bill. When one of the two separately payable procedures on a multiple procedure claim was on the bypass code list, we split the claim into two single procedure claims records. The single procedure claim record that contained the bypass code did not retain packaged services. The single procedure claim record that contained the other separately payable procedure (but no bypass code) retained the packaged revenue code charges and the packaged HCPCS charges.

We also removed lines that contained multiple units of codes on the bypass list and treated them as ''pseudo'' single claims by dividing the cost for the multiple units by the number of units on the line. Where one unit of a single separately paid procedure code remained on the claim after removal of the multiple units of the bypass code, we created a ''pseudo'' single claim

from that residual claim record, which retained the costs of packaged revenue codes and packaged HCPCS codes. This enabled us to use claims that would otherwise be multiple procedure claims and could not be used. We excluded those claims that we were not able to convert to singles even after applying all of the techniques for creation of ''pseudo'' singles.

We then packaged the costs of packaged HCPCS codes (codes with status indicator ''N'' listed in Addendum B to this proposed rule) and packaged revenue codes into the cost of the single major procedure remaining on the claim. The list of packaged revenue codes was shown in Table 2 of the CY 2007 OPPS proposed rule (71 FR 49532) and below.

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, 58.4 million claims were left. Of these 58.4 million claims, we were able to use some portion of 54.1 million whole claims (92.6 percent of the 58.4 million potentially usable claims) to create the 98.5 million single and ''pseudo'' single claims for use in the CY 2007 median development and for ratesetting.

We also excluded (1) claims that had zero costs after summing all costs on the claim and (2) claims containing packaging flag 3. Effective for services furnished on or after July 1, 2004, the Outpatient Code Editor (OCE) assigns 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 OPPS) for which the fiscal intermediary is required to allocate the sum of charges for services with a status indicator equaling ''S'' or ''T'' based on the weight for the APC to which each code is assigned. We do not believe that these charges, which were token charges as submitted by the hospital, are valid reflections of hospital resources. Therefore, we deleted these claims. In the proposed rule, we deleted claims with payment flag 3 (not packaging flag 3) because we believed that payment flag 3 identified claims for which the charges were not as submitted by the provider as described above. As we were processing claims for this final rule with comment period, we realized that this was not the case and corrected the process to eliminate claims which, as described above, have charges that are not as submitted by the provider. See the CY 2007 final rule claims accounting under supporting documentation posted on our Web site, *http://www.cms.hhs.gov/HospitalOutpatientPPS*, for this final rule with comment period for further explanation. We note that in this final rule with comment period, as stated in both the proposed rule and here, we have excluded those claims that we believed were not valid reflections of hospital resources.

We also deleted claims for which the charges equal the revenue center payment (that is, the Medicare payment) on the assumption that where the charge equals the payment, to apply a CCR to the charge would not yield a valid estimate of relative provider cost.

For the remaining claims, we then standardized 60 percent of the costs of the claim (which we have previously determined to be the labor-related portion) for geographic differences in labor input costs. We made this adjustment by determining the wage index that applied to the hospital that furnished the service and dividing the cost for the separately paid HCPCS code furnished by the hospital by that wage index. As has been our policy since the inception of the OPPS, we proposed to use the pre-reclassified wage indices for standardization because we believed that they better reflect the true costs of items and services in the area in which the hospital is located than the post-reclassification wage indices, and would result in the most accurate adjusted median costs.

We also excluded claims that were outside 3 standard deviations from the geometric mean of units for each HCPCS code on the bypass list (because, as discussed above, we used claims that contain multiple units of the bypass codes). We then deleted 438,440 single bills reported with modifier 50 that were assigned to APCs that contained HCPCS codes that are considered to be conditional or independent bilateral procedures under the OPPS and that are subject to special payment provisions implemented through the OCE. Modifier 50 signifies that the procedure was performed bilaterally. Although these are apparently single claims for a separately payable service and although there is only one unit of the code reported on the claim, the presence of modifier 50 signifies that two services were furnished. Therefore, costs reported on these claims are for two procedures and not for a single procedure. Hence, we deleted these multiple procedure records, which we would have treated as single procedure claims in prior OPPS updates.

We used the remaining claims to calculate 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. As stated previously, 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 as deemed appropriate. Section III.B. of this preamble includes a discussion of the 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.

A detailed discussion of the medians for blood and blood products is included in section X. of this preamble. A discussion of the medians for APCs that require one or more devices when the service is performed is included in section IV.A. of this preamble. A discussion of the median for observation services is included in section XI. of this preamble, and a discussion of the median for partial hospitalization is included below in section II.B. of this preamble.

We specifically invited public comment on the relative benefits of deleting claims reported with modifier 50 signifying two procedures were performed versus dividing the costs for the two procedures by two to create two ''pseudo'' single claims. We received one comment on this issue.

Comment: One commenter supported deletion of the conditional or independent bilateral service claims because the commenter believes that the total cost of a bilateral procedure (including packaged costs) is generally less than 2 times the total cost of a unilateral procedure, and such cost savings are already reflected in each hospital's CCR. The commenter stated that to divide the cost of the bilateral procedure by two would result in ''pseudo'' singles that would underrepresent the full cost of a single procedure.

Response: We have excluded claims for conditional and independent bilateral procedures from the claims we used to calculate the median costs for the CY 2007 OPPS. We will carefully consider how to treat these claims for future years.

For the final CY 2007 OPPS ratesetting process, we deleted these claims, as we did for the proposed rule.

We received many comments on our proposed CY OPPS data process. A summary of the comments and our responses follows:

Comment: The commenters objected to what they view as wide fluctuations in the APC payment rates from CY 2006 to CY 2007, because such variability makes it difficult to plan and budget for the services that the hospital will provide in the upcoming year. The commenters objected to changes in proposed OPPS rates that are greater than 5 percent from the prior year's rates and urged CMS to adjust rates so that no payment rate in CY 2007 declined by more than 5 percent compared to its payment in CY 2006. The commenters stated that more than 250 APC rates declined compared to their CY 2006 rates, some by 10 to 20 percent or more. In contrast, they noted that over 300 APC rates increased, many substantially and by up to 30 percent compared to their CY 2006 rates. The commenters stated that they did not believe that the changes in the median costs were reflective of changes in hospital costs, because hospital costs do not vary so widely from year to year. The commenters indicated that they expected that after more than 5 years of experience, the rates would no longer show such significant volatility and urged CMS to use more multiple claims data to set the median costs.

Response: There are a number of factors pertinent to the OPPS that cause median costs to change from one year to the next. These include reassignment of HCPCS codes to APCs to rectify 2 times violations and to respond to public comments; the need to split costs derived from claims data among the many different HCPCS codes, which results in very few usable claims for some services; and annual changes in reported hospital charges and costs that provide the source of the cost data on which the system is based.

Although the APC number and title may remain the same from year to year, we routinely reassign HCPCS codes to different APCs to resolve violations of the 2 times rule as required by law or reconfigure APCs to create more levels in a series. We also reassign codes in response to public comments when we believe that the requested reassignment will result in improved clinical homogeneity and more similar resource use for a particular service or group of services. To the extent that there has been a reassignment either into or out of an APC or a reconfiguration of an APC into multiple levels, a comparison of the APC median from 1 year to the next is often not a valid comparison of the costs for the same services. In addition, every year new HCPCS codes that were initially assigned to clinical APCs for payment purposes may begin to contribute claims data to those APC median costs, also leading to ill-founded comparisons across years.

Moreover, many of the claims we receive for OPPS services are multiple procedure claims that must be fragmented for use in establishing the median costs for single procedures. Unlike other prospective payment systems in which the costs of multiple services are aggregated into a single payment for a defined encounter (for example, inpatient stay and home health episode of care), under the OPPS the costs that reflect the charges on Medicare claims that contain more than a single service on the same date must be fragmented into pieces to provide costs at a unit level, rather than being aggregated to provide the total cost for a set of services furnished in a single encounter. The more the costs on claims are split to accommodate payment for individual items and services described by HCPCS codes, and the fewer single bills that are available for ratesetting because the costs cannot be fragmented into unique services, the more variability is introduced into the cost. Because of the difficulty in assigning the revenue code charge data that hospitals submit on multiple procedure claims to the separately payable HCPCS codes that form the basis of payment in the OPPS, we must often use small numbers of claims to set the median costs for some services. We believe that the small numbers of single claims are the source of much of the volatility in the payment system. When we examine claims data for APCs like the Visit APCs, for which we have large and stable numbers of services, we do not see the median cost fluctuations that typically occur in those APCs for which we regularly have small numbers of single bills.

However, we are rarely asked for larger APCs that contain more codes or for more packaging of payment for HCPCS codes into the APC rates, both of which would enable us to use more claims and, we believe, provide more stable payment rates. Indeed, payment in the OPPS has become more specific each year, largely in response to our willingness to accommodate the requests of stakeholders when we believe they are justified and supported by the data. Each year, we are asked for increasingly more APCs that contain fewer HCPCS codes, as well as more precise costing of particular services. Generally, the comments received in response to our proposed rule asked for more separate payment, less packaging, and greater service-specific precision in the calculation of median costs for specifically identified services in the OPPS. We are also often asked to specifically recalculate median costs by using subsets of claims that meet specific criteria or by applying alternative methodologies for identified services. While these special approaches are generally intended to increase payments for their particular services of interest, they likely contribute to less stability in the system in general. Inevitably, such specificity would lead to more, not less, volatility as it would reduce the number of claims that can be used to set median costs.

Lastly, hospital charges and costs are the foundation of the payment weights, but hospitals change the mix of services they furnish and thereby also change their cost structure to some extent each year. Moreover, hospitals increase, sometimes decrease, or hold steady their charges each year based on a variety of business reasons, but these changes to charges often vary across the different services they furnish. Thus, hospital decisions to change their mix of services or to change their charges for some services differentially also contribute to the volatility in payment rates.

We recognize that it could be desirable for a payment system's rates to not vary by a certain percentage from the prior year's payment rates, but there is no reason to believe that limiting the changes in payment rates to prevent a decline by any percentage each year would be accurately reflective of changes in relative costs. Although the commenters asked that no payment for any service decline by more than 5 percent, none addressed a limitation for a payment increase. We do not believe that it is appropriate to artificially impose limits on a payment rate's increase or decrease from one year to the next, because, as noted above, comparisons between APC payment rates from year to year have little meaning for the many APCs that have experienced HCPCS migration. Moreover, to limit the increases or decreases in payment to a set amount for all services would conflict with the statutory requirement that at least annually we revise APCs and other components of the OPPS using new cost data and other relevant information. Therefore, we are not adjusting the rates as requested to account for a decline of more than 5 percent from CY 2006 in the final CY 2007 OPPS payment rates. We will continue to explore ways to use the data from multiple procedure claims because we agree that a high level of

volatility is not desirable in the OPPS, and we also believe that the most viable long term solution to instability is the use of all the claims data. However, we also believe that changes in median costs from one year to the next are unavoidable in a relative weight payment system which also depends on hospital charges and costs and in which reassignment of HCPCS codes from one APC to another is required by law in cases of 2 times violations. As the commenters noted, some CY 2007 APC payment rates decrease but others increase in comparison with the CY 2006 rates, consistent with expectations for a budget neutral payment system like the OPPS.

Comment: One commenter objected to the inclusion of charges from the following revenue codes as packaged services under the OPPS: (1) Revenue code 274 (Prosthetic/orthotic devices) on the basis that the revenue code is for nonimplanted devices that require a HCPCS code, are paid under the MPFS, and have a status indicator of ''A'' under the OPPS; (2) Revenue code 280 (Oncology) on the basis that there is no oncology service that would not be coded by a HCPCS code, and, therefore, any charge without a HCPCS code should not be packaged; (3) Revenue code 290 (Durable Medical Equipment (DME)) on the basis that DME is for use in the home and not in the outpatient setting; (4) Revenue codes 343 and 344 (Diagnostic radiopharmaceuticals and therapeutic radiopharmaceuticals) on the basis that they are required to be billed with a HCPCS code, and, therefore, charges without a HCPCS code should not be packaged; and (5) Revenue code 560 (Medical Social Services) on the basis that they are separately billable only by home health agencies and are, therefore, suspect and should not be packaged.

Response: With a few limited exceptions, CMS does not specify the revenue codes hospitals must use to report their charges. Therefore, we selected a generous set of revenue codes to maximize the likelihood that we would capture all of the costs of a particular service for purposes of calculating the median costs on which the OPPS payment rates are based. To cease packaging costs under these revenue codes where there is no HCPCS code reported on the line may result in erroneous reductions in median costs and, therefore, in the related OPPS payment rates. With regard to the specific concerns of the commenter, our responses regarding the rationale for packaging the revenue code charges for each revenue code of interest follow: (1) Revenue code 274 is one of the revenue codes we previously instructed hospitals to use to report devices that had been paid as pass-through devices; (2) Revenue code 280 is packaged because we believe that it is possible that a hospital could have costs related to packaged OPPS services for which it would choose not to bill a HCPCS code, and we want to ensure that those costs are not lost in median calculation; (3) Revenue code 290 (DME) is governed by the statute which explicitly states that implantable DME provided in hospitals is paid under the OPPS, and we believe that it is possible that hospitals may charge for implantable DME but not bill a HCPCS code for the items; (4) Revenue codes 343 and 344 (diagnostic and therapeutic radiopharmaceuticals) are included as hospitals may charge for these items without placing a HCPCS code on the line; (5) Revenue code 560 (Medical Social Services) is included because hospitals may charge without billing a HCPCS code for the services of a medical social worker that are related to a visit service and thus would otherwise not be packaged into the median cost for the visit. We note that National Uniform Billing Committee guidelines on use of revenue code 560 recognize that it may be reported by hospitals in some circumstances.

Comment: One commenter asked that CMS implement an indirect medical education adjustment under the CY 2007 OPPS to address what the commenter states is a 23-percent shortfall to the market basket for OPPS services. The commenter indicated that this adjustment was needed to reimburse hospitals for the higher costs incurred by major teaching hospitals to provide outpatient care to Medicare beneficiaries.

Response: 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. Moreover, in this final rule with comment period, we have developed payment weights that we believe resolve many of the public concerns regarding appropriate payments for new technology services and device-dependent procedures that we believe are furnished largely by teaching hospitals. We believe this and other payment changes should help ensure adequate and appropriate payment for teaching hospitals.

Comment: One commenter supported CMS' proposal to discard claims that contain token charges for packaged devices but opposed discarding claims when there is only one separately paid procedure on the claim, although there are other packaged services billed with token charges on other lines of the claim.

Response: We have not discarded claims that contain token charges where there is only one separately paid procedure on the claim if there are other packaged services billed with token charges on other lines of the claim. We discarded claims with token charges only when such claims included token charges for devices with procedure codes that are assigned to device-dependent APCs, because we instructed hospitals to bill token charges for devices that were replaced without cost to the provider due for example, to warranty, field action or recall. We also discarded claims that, as submitted, contained token charges for separately paid (not packaged) procedure codes, which during claims processing were converted to imputed charges for purposes of applying the outlier policy and which came to us through the national claims history with the imputed charges. These claims are identified with a packaging flag 3 and are excluded because the charges shown on the claim we receive were not the charges submitted by the provider. We discuss this in more detail in the CY 2007 final rule claims accounting on the CMS OPPS Web page at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

After carefully considering all public comments received, we are finalizing the list of packaged services by revenue code shown in Table 2 and our data process for calculating the median costs for OPPS services furnished on or after January 1, 2007, without modification. Table 2 below contains the list of packaged services by revenue code that we used in developing the APC relative weights listed in Addenda A and B of this final rule with comment period.

TABLE 2.—CY 2007 PACKAGED SERVICES BY REVENUE CODE

Revenue code	Description
250	PHARMACY.

TABLE 2.—CY 2007 PACKAGED SERVICES BY REVENUE CODE—Continued

Revenue code	Description
251	GENERIC.
252	NONGENERIC.
254	PHARMACY INCIDENT TO OTHER DIAGNOSTIC.
255	PHARMACY INCIDENT TO RADIOLOGY.
257	NONPRESCRIPTION DRUGS.
258	IV SOLUTIONS.
259	OTHER PHARMACY.
260	IV THERAPY, GENERAL CLASS.
262	IV THERAPY/PHARMACY SERVICES.
263	SUPPLY/DELIVERY.
264	IV THERAPY/SUPPLIES.
269	OTHER IV THERAPY.
270	M&S SUPPLIES.
271	NONSTERILE SUPPLIES.
272	STERILE SUPPLIES.
274	PROSTHETIC/ORTHOTIC DEVICES.
275	PACEMAKER DRUG.
276	INTRAOCULAR LENS SOURCE DRUG.
278	OTHER IMPLANTS.
279	OTHER M&S SUPPLIES.
280	ONCOLOGY.
289	OTHER ONCOLOGY.
290	DURABLE MEDICAL EQUIPMENT.
343	DIAGNOSTIC RADIOPHARMS.
344	THERAPEUTIC RADIOPHARMS.
370	ANESTHESIA.
371	ANESTHESIA INCIDENT TO RADIOLOGY.
372	ANESTHESIA INCIDENT TO OTHER DIAGNOSTIC.
379	OTHER ANESTHESIA.
390	BLOOD STORAGE AND PROCESSING.
399	OTHER BLOOD STORAGE AND PROCESSING.
560	MEDICAL SOCIAL SERVICES.
569	OTHER MEDICAL SOCIAL SERVICES.
621	SUPPLIES INCIDENT TO RADIOLOGY.
622	SUPPLIES INCIDENT TO OTHER DIAGNOSTIC.
624	INVESTIGATIONAL DEVICE (IDE).
630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS.
631	SINGLE SOURCE.
632	MULTIPLE.
633	RESTRICTIVE PRESCRIPTION.
681	TRAUMA RESPONSE, LEVEL I.
682	TRAUMA RESPONSE, LEVEL II.
683	TRAUMA RESPONSE, LEVEL III.
684	TRAUMA RESPONSE, LEVEL IV.
689	TRAUMA RESPONSE, OTHER.
700	CAST ROOM.
709	OTHER CAST ROOM.
710	RECOVERY ROOM.
719	OTHER RECOVERY ROOM.
720	LABOR ROOM.
721	LABOR.
762	OBSERVATION ROOM.
810	ORGAN ACQUISITION.
819	OTHER ORGAN ACQUISITION.
942	EDUCATION/TRAINING.

3. Calculation of Scaled OPPS Payment Weights

Using the median APC costs discussed previously, we calculated the final relative payment weights for each APC for CY 2007 shown in Addenda A and B of this final rule with comment period. In prior years, we scaled all the relative payment weights to APC 0601 (Mid Level Clinic Visit) because it is one of the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC.

As proposed, for the CY 2007 OPPS, we scaled 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 scaling base because under our proposal to reconfigure the APCs where clinic visits are assigned for CY 2007, APC 0606 is the middle level clinic visit APC (that is, Level 3 of five levels). We have historically used the median cost of the middle level clinic visit APC (that is APC 0601 through CY 2006) to calculate unscaled weights because mid-level clinic visits are among the most frequently performed services in the hospital outpatient setting. Therefore, to maintain consistency in using a median

for calculating unscaled weights representing the median cost of some of the most frequently provided services, we proposed to continue to use the median cost of the middle level clinic APC, proposed APC 0606, to calculate unscaled weights. Following our standard methodology, but using the CY 2007 median for APC 0606, we assigned APC 0606 a relative payment weight of 1.00 and divided the median cost of each APC by the median cost for APC 0606 to derive the unscaled relative payment weight for each APC. The choice of the APC on which to base the relative weights for all other APCs does not affect the payments made under the OPPS because we scale the weights for budget neutrality.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes, wage index changes, and other adjustments be made in a manner that assures that aggregate payments under the OPPS for CY 2007 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 2006 relative weights to aggregate payments using the CY 2007 final relative payment weights. Based on this comparison, we adjusted the relative weights for purposes of budget neutrality. The unscaled relative payment weights were adjusted by 1.364598352 for budget neutrality. We recognize the scaler, or weight scaling factor, for budget neutrality that we proposed for CY 2007 is higher than any previous OPPS weight scaler as a result of our proposal to use APC 0606 as the base for calculation of relative weights. Our use of the median cost for APC 0606 of $83.39 based on final rule with comment period data causes the unscaled weights to be lower than they would have been if we had chosen APC 0605 (Level 2 Clinic Visits; median $60.13 as the scaling base. The CY 2007 median cost of APC 0606 is significantly higher than the CY 2006 median cost of APC 0601 for mid-level clinic visits, which was used in CY 2006 and earlier years to calculate unscaled weights. Historically, the median cost for APC 0601 has been similar to the CY 2007 proposed median cost for APC 0605. In order to appropriately scale the total weight estimated for OPPS in CY 2007 to be similar to the total weight in OPPS for CY 2006, we calculated a scaler of 1.364598352 for this final rule with comment period, which is higher using APC 0606 as the base than it would be if we used APC 0605 as the base. In addition to adjusting for increases and decreases in weight due the recalibration of APC medians, the scaler also accounts for any change in the base.

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

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 preamble) is now included in the budget neutrality calculations for CY 2007 OPPS.

Under section 1833(t)(16)(C) of the Act, as added by section 621(b)(1) of Pub. L. 108–173, payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) is to be made at charges adjusted to cost for services furnished on or after January 1, 2004, and before January 1, 2007. As we stated in our January 6, 2004 interim final rule, charges for the brachytherapy sources were not used in determining outlier payments, and payments for these items were excluded from budget neutrality calculations for the CY 2006 OPPS. We excluded these payments from budget neutrality calculations, in part, because of the challenge posed by estimating hospital-specific cost payment. As proposed, for CY 2007, we calculated specific payment rates for brachytherapy sources, which were subjected to scaling for budget neutrality. (We provide a discussion of brachytherapy payment issues, including their CY 2007 treatment with respect to outlier payments, under section VII. of this preamble.) Therefore, the costs of brachytherapy sources are accounted for in the scaler of 1.364598352.

4. Changes to Packaged Services

Payments for packaged services under the OPPS are bundled into the payments providers receive for separately payable services provided on the same day. Packaged services are identified by the status indicator ''N.'' Hospitals include charges for packaged services on their claims, and the costs associated with these packaged services are then bundled into the costs for separately payable procedures on those same claims in establishing payment rates for the separately payable services. This is consistent with the principles of a prospective payment system based upon groupings of services and in contrast to a fee schedule that provides individual payment for each service billed. Hospitals may use CPT codes to report any packaged services that were performed, consistent with CPT coding guidelines.

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.'' Providers have often suggested that many 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 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.

The Packaging Subcommittee identified areas for change for some 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 2007, the Packaging Subcommittee reviewed the packaging status of numerous HCPCS codes and reported its findings to the APC Panel at its March 2006 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—

- CMS pay separately for HCPCS code 0069T (Acoustic heart sound recording and computer analysis; acoustic heart sound and computer analysis only).
- CMS maintain the packaged status of HCPCS code 0152T (Computer aided detection with further physician review for interpretation, with or without digitization of films radiographic images; chest radiograph(s)).

• CMS maintain the packaged status of CPT code 36500 (Venous catheterization for selective blood organ sampling).

• CMS pay separately for CPT code 36540 (Collection of blood specimen from a completely implantable venous access device) if there are no separately payable OPPS services on the claim.

• CMS pay separately for CPT code 36600 (Arterial puncture; withdrawal of blood for diagnosis) if there are no separately payable OPPS services on the claim.

• CMS pay separately for CPT code 38792 (Injection procedure for identification of sentinel node) if there are no separately payable OPPS services on the claim.

• CMS maintain the packaged status of CPT codes 74328 (Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation), 74329 (Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation), and 74330 (Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation).

• CMS pay separately for CPT code 75893 (Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, rennin), radiological supervision and interpretation) if there are no separately payable OPPS services on the claim.

• CMS continue to separately pay for CPT code 76000 (Fluoroscopy (separate procedures), up to one hour physician time, other than 71023 or 71024 (eg, cardiac fluoroscopy)).

• CMS maintain the packaged status of CPT codes 76001 (Fluoroscopy, physician time more than one hour, assisting a non-radiologic physician (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)), 76003 (Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)), and 76005 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral fact joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction).

• CMS maintain the packaged status of CPT codes 76937 (Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting) and 75998 (Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position)).

• CMS provide separate payment for CPT codes 94760 (Noninvasive ear or pulse oximetry for oxygen saturation; single determination), 94761 (Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations), and 94762 (Noninvasive ear or pulse oximetry for oxygen saturation by continuous overnight monitoring) if there are no separately payable OPPS services on the claim.

• CMS pay separately for CPT code 96523 (Irrigation of implanted venous access device for drug delivery systems) if there are no separately payable OPPS services on the claim.

• CMS maintain the packaged status of HCPCS code G0269 (Placement of occlusive device into either a venous or arterial access site).

• CMS pay separately for HCPCS code P9612 (Catheterization for collection of specimen, single patient) if there are no separately payable OPPS services on the claim.

• CMS bring data to the next APC Panel meeting that show the following: (a) how the costs of packaged items and services are incorporated into the median costs of APCs and (b) how the costs of these packaged items and services influence payments for associated procedures.

• The Packaging Subcommittee continue until the next APC Panel meeting.

At its August 2006 meeting, the Packaging Subcommittee further discussed the packaging status of several of the HCPCS codes described above and reported its findings to the APC Panel. The APC Panel accepted the report of the Packaging Subcommittee, heard one presentation, reviewed one written comment, and discussed the deliberations of the Packaging Subcommittee. The APC Panel made the following recommendations for CY 2007:

+ That CMS package new 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 (List separately in addition to code for primary procedure), and 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).

+ That CMS continue to package revised CPT code 0069T (Acoustic heart sound recording and computer analysis; acoustic heart sound recording and computer analysis only).

+ That CMS assign CPT code 96523 (Irrigation of implanted venous access device for drug delivery systems) status indicator ''Q'' as a ''special'' packaged code.

For CY 2007, we proposed to maintain CPT code 0069T as a packaged service and not adopt the APC Panel's March 2006 recommendation to pay separately for this code. The 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 and assigned a new interim status indicator of ''N'' in the CY 2005 OPPS final rule with comment period. The APC Panel recommended packaging CPT code 0069T for CY 2006, and we accepted that recommendation when we finalized the status indicator ''N'' assignment to 0069T for CY 2006. CPT code 0069T is an add-on code to an electrocardiography (ECG) service for CYs 2005 and 2006. However on July 1, 2006, the AMA released to the public a code descriptor change to remove the add-on code designation for CPT code 0069T. The effective date of this change is January 1, 2007, at which point the descriptor will be ''Acoustic heart sound recording and computer analysis; acoustic heart sound recording and computer analysis only.'' We do not include Category III CPT codes that are released in July of a given year in the OPPS proposed rule for the following calendar year because of timing restraints. We include these codes in the OPPS final rule where they are assigned interim comment indicator ''NI'' to denote that they are open for public comment.

In its March 2006 presentation to the APC Panel, a manufacturer 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 manufacturer 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.

During the August 2006 meeting, the Packaging Subcommittee further discussed CMS's proposal to package CPT 0069T for CY 2007 and the CY 2007 code descriptor change, and ultimately recommended to the APC Panel that CMS continue to package this code for CY 2007. The APC Panel accepted this recommendation.

Comment: One commenter requested that CMS pay separately for CPT code 0069T for CY 2007, mapping the code to an APC paying between $63 and $97. The commenter clarified that this service is sometimes provided with an ECG and sometimes provided without an ECG, according to its revised descriptor for CY 2007. The commenter could not explain the low median cost that was calculated from the claims data, but suggested that the nine claims used to calculate the median were miscoded. The commenter estimated the cost of the service to be approximately $80 per procedure, significantly higher than the median cost for APC 0099 (Electrocardiograms), which was $23.60 based on the CY 2005 data that were used to calculate the CY 2007 proposed median costs. Though the commenter agreed that it would be rare for the acoustic heart sound procedure to be performed alone without any other OPPS services, the commenter disagreed that the procedure would be ''associated'' with other services. Instead, the commenter clarified that it could be provided with a broad range of services, such as an emergency department visit, clinic visit, chest x-ray, or ECG. In addition, the commenter did not expect this service to have a meaningful impact on the median costs of those services because acoustic heart services are expected to be provided infrequently, compared to the total number of emergency department and clinic visits, chest x-rays, and ECGs.

Response: Despite the change in add-on status for CPT code 0069T for CY 2007, based on the clinical uses that were described during the March 2006 APC Panel meeting and in the public comments, we believe that it is highly unlikely that CPT code 0069T would be performed in the hospital outpatient department as a sole service without other separately payable OPPS services. Payment for CPT code 0069T could always be packaged into payments for those other services. Therefore, we believe that CPT code 0069T is appropriately packaged because it would usually be closely linked to the performance of an ECG, and would rarely, if ever, be the only OPPS service provided to a patient. We understand that the commenter is clarifying that this service is not required to be provided in conjunction with an ECG. However, we continue to believe that it is likely that an ECG or other separately payable service would be performed on the patient in conjunction with the acoustic heart sound service. Therefore, we believe that it is appropriate to continue packaging CPT code 0069T for CY 2007. In addition, this service is estimated to require only minimal hospital resources. Using CY 2005 claims that have been updated with more recent CCRs, we had only nine single claims for CPT code 0069T, with a median line-item cost of $2.45, consistent with its low expected cost. Packaging payment for CPT code 0069T is consistent with the principles of a prospective payment system that provides payments for groups of services. To the extent that the acoustic heart sounding recording service may be more frequently provided in the future in association with ECGs or other OPPS services as its clinical indications evolve, we expect that its cost would also be increasingly reflected in the median costs for those other services, particularly ECG procedures.

After carefully considering all comments received, we are adopting the APC Panel's August 2006 recommendation to continue to package this code for CY 2007. Therefore we are finalizing our proposal without modification to maintain CPT code 0069T as a packaged service for CY 2007.

For CY 2007, we proposed to accept the APC Panel's recommendation to maintain the packaged status of CPT code 0152T. The service involves 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. This code was a new Category III CPT code implemented in the CY 2006 OPPS and assigned a new interim status indicator of ''NI'' in the CY 2006 OPPS final rule with comment period. For CY 2006, the code is indicated as an add-on code to chest x-ray CPT codes, according to the AMA's CY 2006 CPT book. However, on July 1, 2006, the AMA released to the public an update that deletes code 0152T for CY 2007 and replaces it with two new Category III CPT codes, 0174T and 0175T. Effective January 1, 2007, the descriptor for CPT code 0174T will be ''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 (List separately in addition to code for primary procedure) and the descriptor for 0175T will be ''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.''

As indicated above, we do not include Category III CPT codes that are released in July of a given year in the OPPS proposed rule for the following calendar year because of timing restraints. We include these codes in the OPPS final rule, where they are assigned new interim comment indicator ''NI'' to denote that they are open to comment.

In its March 2006 presentation to the APC Panel, before the AMA had released the CY 2007 changes to this code, the manufacturer 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 manufacturer requested that we assign both of these 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 is was unclear as to whether ''remote'' referred to time, geography, or a specific provider. They thought 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 deliberation, the Panel recommended that we package both of the new CPT codes, 0174T and 0175T, for CY 2007.

Comment: One commenter requested that CMS pay separately for CPT codes 0174T and 0175T, mapping them to New Technology APC 1492, with a payment rate of $15. The commenter indicated that there is no basis for believing that chest x-ray computer-aided detection (CAD) will increase the number of chest x-rays performed in the outpatient setting, because chest x-ray CAD is not a screening tool and should only be applied to chest x-rays that are suspicious for lung cancer. The commenter also indicated that separate resources are required for chest x-ray CAD that are not required for a standard chest x-ray. In addition, the commenter stated that chest x-ray CAD can be performed at a different time or location or by a different provider than the chest x-ray. In these cases, the commenter believed that separate payment would be appropriate. The commenter was concerned that if hospitals are not paid separately for this technology, they will not be able to provide it, thereby limiting beneficiary access to chest x-ray CAD.

Response: We agree with the APC Panel that packaged payment for chest x-ray CAD under a prospective payment methodology for outpatient hospital services is appropriate because of the close relationship of chest x-ray CAD to chest x-ray services and its projected modest cost. We do not believe that CPT code 0174T would ever be performed as a sole service without other separately payable OPPS services, based on the code definition as an add-on service performed concurrent with the primary interpretation of a chest x-ray. We believe that payment for CPT code 0174T is appropriately packaged into payment for the chest x-ray services it accompanies. Payment for chest x-rays is provided through APC 0260 (Level I Plain Film Except Teeth), with a CY 2007 median cost of $43.35. The median costs for the individual x-ray services that can be reported with the CAD technology range from $36.00 to $56.11, easily overlapping the modest additional costs of providing chest x-ray CAD services. Although CPT code 0175T applies to chest x-ray CAD that is ''remote'' from the primary interpretation, the definition of ''remote'' as used in the code descriptor is vague, with respect to time, geography, or a specific provider, so the circumstances in which it would be the only service provided by a hospital are also unclear. As discussed by the APC Panel if an x-ray were sent to another hospital for performance of the CAD, the CAD service would likely be provided under arrangement, in which case the hospital that performed the x-ray would bill for both the x-ray and the CAD service. It is unnecessary to treat CPT code 0175T as a ''special'' packaged code because generally the payment for the x-ray CAD would be bundled into the payment for the chest x-ray. While we have no costs from claims data because 0152T was a new CPT code for CY 2006, and 0174T and 0175T are new codes for CY 2007, we estimate that the CAD service requires only modest resources. We expect that a hospital's cost per chest x-ray CAD service would largely depend on the volume of CAD services provided. To the extent that CAD may be more frequently provided in the future to aid in the review of diagnostic chest x-rays as its clinical indications evolve, we expect that its cost would also be increasingly reflected in the median costs for chest x-ray procedures.

After carefully considering all public comments received on this proposal, we are accepting the APC Panel's August 2006 recommendation to package new CPT codes 0174T and 0175T for CY 2007 on an interim final basis.

For CY 2007, we proposed to accept the recommendation of the APC Panel and maintain the packaged status of CPT code 36500. As noted in the CY 2007 OPPS proposed rule (71 FR 49535) we have heard that CPT code 36500 is sometimes billed only with its corresponding radiological supervision and interpretation code, 75893, but with no other separately payable OPPS services. In those cases, the provider would not receive any payment. For CY 2006, we accepted the APC Panel's recommendation to package both CPT codes 36500 and 75893 and to examine claims data. Our initial review of several clinical scenarios submitted by the public seemed to suggest that other separately payable procedures, such as venography, would likely be billed on the same claim. Our claims data indicate that there are usually separately payable codes that are billed on claims with CPT codes 36500 and 75893. However, we acknowledge that these two codes may occasionally be provided without any separately payable procedures. In these uncommon instances, the provider historically has not received any payment under the OPPS. We also understand that there is a cost associated with registering a patient and providing these services. Using CY 2005 claims, we have approximately 200 single claims for CPT code 75893, with a median cost of $269.13. As proposed for CY 2007 and described below for ''special'' packaged codes, when CPT codes 36500 and 75893 are billed on a claim with no separately payable OPPS services, CPT code 75893 would become separately payable and would receive payment for APC 0668. In this circumstance, payment for CPT code 36500 would be packaged into the separate payment for CPT code 75893.

We received no public comments on our proposal. Therefore, we are finalizing our proposal to accept the APC Panel's recommendation to maintain the packaged status of CPT code 36500 without modification.

For CY 2007, we proposed to accept the APC Panel's recommendation and pay separately for CPT codes 36540, 36600, 38792, 75893, 94762, and 96523 when any of these codes appear on a claim with no separately payable OPPS services also reported for the same date of service. We will refer to this subset of codes as ''special'' packaged codes. We acknowledge that there is a cost to the hospital associated with registering and treating a patient, regardless of whether the specific service provided requires minimal or significant hospital resources. While we continue to believe that these ''special'' packaged codes are almost always provided along with a separately payable service, our claims analyses indicate that there are rare instances when one of these services is provided without another separately payable OPPS service on the claim for the same date of service. In these instances, providers do not currently receive any payment. Therefore, we proposed to provide payment for the ''special'' packaged codes listed above when they are billed on a claim without another separately payable OPPS service on the same date. When any of the ''special'' packaged codes are billed with other codes that are separately payable under the OPPS on the same date of service, the ''special'' packaged code would be treated as a packaged code, and the cost of the packaged code would be bundled into the costs of the other separately payable services on the claim. The payments that the provider receives for the separately payable services would include the bundled payment for the packaged code(s).

During the August 2006 APC Panel meeting, the APC Panel reviewed a request from the public to assign payment to CPT code 96523 when it appears on a claim with no separately payable OPPS services also reported for the same date of service. The Panel

recommended that we treat CPT code 96523 as a ''special'' packaged code for CY 2007.

We have heard concerns from the public stating that they are unable to submit claims to CMS that report only packaged codes. We note that although these claims are processed by the OCE and are ultimately rejected for payment, they are received by CMS, and we have cost data for packaged services based upon these claims. However, we recognize that the data used in our analyses to assess the frequencies with which packaged services are provided alone and their median costs are somewhat limited. It is possible that an unknown number of hospitals chose not to submit claims to CMS when a packaged code(s) was provided without other separately payable services on their claims, realizing that they would not receive payment for those claims. While we have been told that some hospitals may bill for a low-level visit if a packaged service only is provided so that they receive some payment for the encounter, we note that providers should bill a low-level visit code in such circumstances only if the hospital provides a significant, separately identifiable low-level visit in association with the packaged service.

Through OCE logic, the PRICER would automatically assign payment for a ''special'' packaged service reported on a claim if there are no other services separately payable under the OPPS on the claim for the same date of service. In all other circumstances, the ''special'' packaged codes would be treated as packaged services. We assign status indicator ''Q'' to these ''special'' packaged codes to indicate that they are usually packaged, except for special circumstances when they are separately payable. Through OCE logic, the status indicator of a ''special'' packaged code would be changed either to ''N'' or to the status indicator of the APC to which the code is assigned for separate payment, depending upon the presence or absence of other OPPS services also reported on the claim for the same date. Table 3 included in the CY 2007 OPPS proposed rule (71 FR 49536) and shown below listed the proposed status indicators and APC assignments for these ''special'' packaged codes when they are separately payable. We note that the payment for these ''special'' packaged codes is intended to make payment for all of the hospital costs, which may include patient registration and establishment of a medical record, in an outpatient hospital setting even when no separately payable services are provided to the patient on that day.

In the case of a claim with two or more ''special'' packaged codes only reported on a single date of service, the PRICER would assign separate payment only to the ''special'' packaged code that would receive the highest payment. The other ''special'' codes would remain packaged and would not receive separate payment.

Comment: Many commenters complimented the Packaging Subcommittee for their efforts to improve payment under the OPPS. In addition, the commenters further commended the Packaging Subcommittee and CMS for proposing to provide payment for ''special'' packaged codes under certain circumstances. One commenter stated that ''special'' packaged codes further complicate an already complicated system and requested that CMS consistently either package a code or pay separately for a code, but not both.

Response: We appreciate the commenters' support and plan to continue working with the Packaging Subcommittee to review other packaged codes that are brought to our attention by the public. While we acknowledge that ''special'' packaged codes add a layer of complexity to a complicated payment system, we continue to believe that it is appropriate to assign payment to ''special'' codes under certain circumstances. We note the ''special'' packaged code policy should impose no additional reporting burden on hospital billing staff because the OCE is automatically programmed to assign payment when appropriate.

Comment: One commenter appreciated that CMS clarified that a hospital cannot bill a CPT E/M code simply because the hospital would like to receive payment for the packaged service that was provided. The commenter asked that CMS also clarify whether this applies only to packaged services, or if it also applies to a service for which there is no applicable HCPCS code. Another commenter noted that CMS is now contradicting Transmittal A–02–129, which states that hospitals can bill a low level clinic visit with CPT code 97602 (Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session) to receive payment.

Response: Providers should bill a low-level visit code only if the hospital provides a significant, separately identifiable visit from any other service provided. This general rule applies to any service provided by a hospital. As discussed below in section IX.A, we would expect that the hospital resources associated with a visit would be reflected in the hospital's internal guidelines used to select the level of reporting for the visit. The hospital should bill the clinic visit code that most appropriately describes the service provided. We acknowledge that Transmittal A–02–129 is based upon our past policy that a hospital could bill a low level visit code in addition to CPT code 97602, which was then packaged in CY 2003, at the time of the instruction. However, beginning in CY 2006 we have provided separate payment for CPT 97602 when it is performed as a nontherapy service in the hospital outpatient setting. Therefore, the instruction is no longer relevant and will be revised, because hospitals are now able to report and be paid for this wound care service with the most specific CPT code available. This OPPS payment policy for nontherapy, nonselective wound care services will continue for CY 2007. In circumstances where there is no applicable HCPCS code to describe a distinct service, hospitals should continue to report the most appropriate unlisted procedure or unlisted services CPT code. In summary, with respect to the billing of low level visit CPT codes, as described above, our current policy dictates that hospitals may only bill a low-level visit code if the hospital provides a significant, separately identifiable visit from any other service provided.

Comment: One commenter thanked CMS for clarifying that CMS receives claims with only packaged codes that may be used for data analysis. The commenter also stated that it hoped that the ''special'' packaged codes policy would convince its hospital billing department to submit claims with only packaged services on them, so that CMS would have cost data for these codes. Other commenters asked that CMS clarify that it receives claims with only packaged codes and no separately payable codes.

Response: We will clarify again that claims with only packaged codes are received and processed by the OCE. We can access cost data for all of the packaged codes on the claim. We encourage hospitals to continue to submit claims to CMS with only packaged codes because these submissions will allow us to continue to gather cost data for these codes, and help us determine whether it would be appropriate to add additional packaged codes to the ''special'' packaged codes list.

After carefully considering the public comments received, we are adopting without modification, our proposal to accept the APC Panel's March 2006 recommendation to treat CPT codes 36540, 36600, 38792, 75893, 94762, and 96523 as ''special'' packaged codes. We note that we also are adopting the APC Panel's August 2006 recommendation to treat CPT code 96523 as a ''special'' packaged code. The APC assignments for these codes are shown in Table 3 below. These codes are assigned status indicator ''Q'' in Addendum B to this final rule with comment period.

TABLE 3.—STATUS INDICATORS AND APC ASSIGNMENTS FOR ''SPECIAL'' PACKAGED CPT CODES

CPT code	Descriptor	CY 2007 APC	Status indicator	CY 2007 APC median
36540	Collect blood, venous access device	0624	S	$31.44
36600	Arterial puncture; withdrawal of blood for diagnosis	0035	T	12.22
38792	Sentinel node identification	0389	S	84.05
75893	Venous sampling through catheter, with or without angiography, radiological supervision and interpretation.	0668	S	381.71
94762	Noninvasive ear or pulse oximetry for oxygen saturation by continuous overnight monitoring.	0443	X	63.61
96523	Irrigation of implanted venous access device	0624	S	31.44

We will monitor and analyze the claims frequency and claims detail for situations in which these codes are billed alone and then separately paid. This will allow us to determine both which providers are billing these codes most often and under what circumstances these codes are billed and separately paid. We expect that hospitals scheduling and providing services efficiently to Medicare beneficiaries will continue to generally provide these minor services in conjunction with other medically necessary services.

For CY 2007, we proposed to accept the APC Panel's recommendation and maintain the packaged status of CPT codes 74328, 74329, and 74330. The AMA notes that these radiological supervision and interpretation codes should be reported with procedure CPT codes 43260–43272. In fact, our data indicate that these supervision and interpretation codes are billed with 43260–43272 more than 90 percent of the time, indicating their routine use. We believe that some providers may be concerned that although the payment for the endoscopic procedure includes the bundled payment for the supervision and interpretation performed by the radiology department, the payment for the comprehensive service may be directed to the hospital department that performed the endoscopic procedure, rather than to the radiology department. While we understand this concern, the OPPS pays hospital for services provided, and we believe that hospitals are responsible for attributing payments to hospital departments as they believe appropriate. We do not believe that packaging these radiological supervision and interpretation codes leads to inaccurate payments for the full hospital resources associated with endoscopic retrograde cholangiopancreatography procedures.

We received no public comments on our proposal. Therefore, we are adopting our proposal to accept the APC Panel's recommendation and maintain the packaged status of CPT codes 74328, 74329, and 74330 for CY 2007.

For CY 2007, we proposed to accept the APC Panel's recommendation to continue to package CPT codes 76001, 76003, and 76005 and to continue to pay separately for CPT code 76000. As noted in the CY 2007 proposed rule (71 FR 49536), we received a comment which stated that it was inconsistent to pay separately for CPT code 76000 but to package CPT code 76001, when CPT code 76001 appears to be a similar code, except that it is for a longer period of physician time. The Packaging Subcommittee believed that many of the claims that listed CPT code 76001 were erroneously billed, as many of the procedure codes that were billed with CPT code 76001 included fluoroscopy as an integral part of the procedure. In other cases, the Packaging Subcommittee noted that a procedure-specific fluoroscopy code should probably have been billed, instead of CPT code 76001. The Packaging Subcommittee believed that CPT code 76000 could often be provided as a sole service, with no other separately payable procedures. The Packaging Subcommittee recommended that CMS continue to pay separately for CPT code 76000, consistent with the AMA's definition of this code, which specifies that it is a separate procedure, and to continue to package CPT codes 76001, 76003, and 76005.

We received no public comments that objected to our proposal. Therefore, we are adopting our proposal, without modification, to accept the APC Panel's recommendation to continue to package CPT codes 76001, 76003, and 76005 and to continue to pay separately for CPT code 76000 for OPPS services furnished on or after January 1, 2007.

For CY 2007, we proposed to accept the APC Panel's recommendation to continue to package CPT codes 76937 and 75998. In the CY 2006 OPPS final rule with comment period (70 FR 68544 and 68545), we reviewed in detail the data related to these two codes and promised to share CY 2004 and early CY 2005 data with the Packaging Subcommittee. We reviewed current data with the Packaging Subcommittee, and it recommended that we continue to package these codes. In summary, we believe that these services would always be provided with another separately payable procedure, so their costs would be appropriately bundled with the definitive vascular access device procedures. We found that the costs for these guidance procedures are relatively low compared to the CY 2007 proposed payment rates for the separately payable services they most frequently accompany. If we were to unpackage CPT codes 76937 and 75998, the single bills available to develop median costs for vascular access device insertion services would be significantly reduced. Therefore, we proposed to continue to package both CPT codes 76937 and 75998 for CY 2007.

CPT code 75998 will be replaced with CPT code 77001, effective January 1, 2007. The code descriptor will remain the same.

Comment: Several commenters requested that CMS pay separately for CPT code 76937 because they believe that packaged payment creates a disincentive for use of this technology. Three commenters cited a June 2001 report published by the Agency for Healthcare Research and Quality that claims that use of ultrasound guidance reduced the relative risk for complications during a central venous

catheter insertion. In addition, two commenters submitted claims data analyses that suggested that for those vascular access procedures that CPT code 76937 could be reported with, CPT code 76937 was reported, on average, only 14 percent of the time, with the greatest utilization rate no more than 25 percent. The commenters stated that these analyses confirmed that ultrasound guidance is not standard practice while performing vascular access procedures.

Response: We appreciate the data analyses submitted by the commenters. In fact, we published the results of our similar analysis in the CY 2006 final rule with comment period (70 FR 68544). To summarize our previous analysis, using CY 2004 single claims data, we determined that for the four most commonly billed venous access device insertion codes (CPT codes 36556, 36558, 36561, and 36569), one or more forms of guidance (fluoroscopic and/or ultrasound) were reported on 41 to 64 percent of the single claims utilized for ratesetting. Specifically, ultrasound guidance was reported from 16 to 34 percent of the time and fluoroscopic guidance was billed from 29 to 52 percent of the time. Thus, overall for these vascular access device insertion services, guidance was used in at least 41 percent of the single claim cases, a very significant portion of the time. We note that all of the commenters are specifically concerned about unpackaging CPT code 76937 and do not appear to be concerned with the packaged status of CPT 75998. In fact, the commenters' analyses only included ultrasound guidance and did not specify the number of venous access device insertions that involved fluoroscopic guidance. We believe that hospital staff choose 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. We also note that the two commenters studied the frequency of CPT code 76937 when billed with CPT codes 36555–36585, which includes central venous access device insertions, repairs, and replacements. In fact, the study that the commenters reference indicates that ultrasound guidance is appropriate for central venous access device insertions. Interestingly, the data now show that 16 percent of all central venous access device insertions are billed with ultrasound guidance while only 2 percent of repairs and replacements are billed with ultrasound guidance. We believe that this indicates that it may be less useful to use ultrasound guidance in conjunction with central venous access device repairs and replacements. Our hospital claims data demonstrate that in CY 2004 guidance services were used frequently for the insertion of vascular access devices, and we have no evidence that patients lacked appropriate access to guidance services necessary for the safe insertion of vascular access devices in the hospital outpatient setting. To the extent that ultrasound guidance may be more frequently provided in the future in association with the insertions of venous access devices or other OPPS services, we expect that its cost would also be increasingly reflected in the median costs for those services.

Also in the CY 2006 final rule (FR 70 68544), we reported our analysis of claims data related to ultrasound guidance for vascular access device insertion procedures from another perspective. Rather than determining how often central venous access device insertions were billed with ultrasound guidance, we determined how often ultrasound guidance was billed with central venous access device insertions. The OPPS hospital claims data reviewed at that time revealed that out of the total instances of CPT code 76937 appearing on the claims used for setting payment rates for CY 2006, CPT code 76937 was billed with four separately payable codes for insertion of central venous access devices 84 percent of the time. This indicated, as might have been expected, that the costs for CPT code 76937 were typically packaged into payment for four CPT codes, 36566, 36558, 36561, and 36569, the most commonly billed codes under the OPPS for vascular access device insertion. Because we believe that ultrasound guidance would always be provided with another separately payable procedure, its costs would be appropriately bundled with the handful of vascular access device insertion procedures with which it is most commonly performed. In addition, packaging is also appropriate because the cost of ultrasound guidance is relatively low compared to the CY 2007 payment rates for the separately payable services it most frequently accompanies.

After carefully considering the public comments received, we are adopting our proposal without modification to accept the APC Panel's March 2006 recommendation to continue to package CPT codes 76937 and 77001, which replaces CPT code 75998.

For CY 2007, we proposed to accept the APC Panel's recommendation to continue to package HCPCS code G0269. This code should never be billed without another separately payable procedure. Recent data indicate that 94 percent of the time HCPCS code G0269 was billed with either CPT code 93510 (Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous) or 93526 (Combined right heart catheterization and retrograde left heart catheterization). In addition, the median cost of G0269 is low compared to the costs of the procedures with which it is typically associated.

We received no public comments on our proposal. Therefore, we are finalizing our proposal, without modification, to package HCPCS code G0269 for CY 2007.

For CY 2007, we proposed to continue packaging CPT codes 94760 and 94761 and not adopt the APC Panel's recommendation to provide separate payment for these services if there are no other separately payable OPPS services on the claim for the same date of service. Our data review revealed that these services are very frequently provided in the OPPS, with over 1.18 million claims in CY 2005 for the single pulse oximetry determination service and over 485,000 claims for the multiple determinations service. These high frequencies may actually be understated as both of these services are packaged codes, and we have been told that some hospitals may not report the HCPCS codes for services for which they receive no separate payments. Single and multiple pulse oximetry determinations are almost always provided in association with other services that are separately payable under the OPPS, into which their costs may be appropriately packaged. Specifically, OPPS hospital claims data revealed that out of the total instances of CPT code 94760 appearing on claims used for setting payment rates for this CY 2007 OPPS final rule with comment period, CPT code 94760 was billed only 4 percent of the time in association with no other separately payable OPPS services, with a median cost of $14. Using the same data, CPT code 94761 was billed only 7 percent of the time in association with no other separately payable OPPS services, with a median cost of $36. These pulse oximetry services have a relatively low cost compared with the OPPS services they frequently accompany. If we were to provide separate payment for these pulse oximetry determinations when performed as stand alone procedures by hospitals, we are concerned that hospitals would lose their incentive to provide these basic, low cost, and brief services as efficiently as possible, generally during the same encounters where they are providing other services to the same patients. We believe their

appropriate provision as single services should be very rare. Therefore, for CY 2007 we proposed not to include these codes on the list of ''special'' packaged codes, so their payment would remain packaged in all circumstances.

We received no public comments on our proposal. Therefore, we are adopting our proposal to continue packaging CPT codes 94760 and 94761 and are not adopting the APC Panel's March 2006 recommendation to provide separate payment for these services if there are no other separately payable OPPS services on the claim for the same date of service.

For CY 2007, we proposed to assign status indicator ''A'' to HCPCS code P9612 and reject the APC Panel's recommendation to pay separately under the OPPS for this code when it is billed without any separately payable OPPS services. This code is currently payable on the clinical lab fee schedule. Its status indicator of ''A'' would provide payment for the service whenever it is billed, regardless of the presence or absence of other reported services. In addition, for consistency we are proposing to assign status indicator ''A'' to HCPCS code P9615 as it is also payable on the clinical lab fee schedule. In general, when a code is payable on the clinical lab fee schedule, we defer to that fee schedule and do not assign payment under the OPPS.

We received no public comments on our proposal. Therefore, we are adopting our proposal without modification to assign status indicator ''A'' to HCPCS code P9612 and reject the APC Panel's recommendation to pay separately under the OPPS for this code when it is billed without any separately payable OPPS services.

For CY 2007, we proposed to assign status indicator ''N'' to CPT code 0126T (Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor). We received one public comment on this proposal.

Comment: One commenter disagreed with our status indicator assignment of ''N'' for CPT code 0126T and stated that CMS should pay separately for the common carotid IMT procedure because this is often the sole service that is performed in the hospital outpatient setting. As clarified by the commenter, common carotid IMT is a standardized ultrasound procedure that enables physicians to safely and accurately measure and monitor atherosclerosis, which is the underlying cause of heart attacks and stroke. The commenter reported that this code became effective on January 1, 2006. According to the commenter, unlike certain other ultrasound procedures that must be provided with other services, common carotid IMT is a stand-alone diagnostic test because it requires special imaging of the arterial wall and quantitative analysis. The commenter further added that based on the CPT code book instruction for other carotid procedures (that is, CPT codes 93880 and 93882), CPT coding does not permit bundling of 0126T with other procedure codes. The commenter urged CMS to pay separately for common carotid IMT and assign this code to New Technology APC 1504—Level IV ($200–$300), with a payment rate of $250.

Response: We continue to believe that it would be unlikely for this code to be provided without any other separately payable services on the same day. However, we also think that the commenter's suggestion bears closer examination. Therefore, we will review this code with the Packaging Subcommittee of the APC Panel, as is our standard procedure for codes that we are asked to review during the comment period, and as we have previously done for the other services discussed above. We will discuss with the Packaging Subcommittee, on an ongoing basis, packaged procedures for which status indicator changes have been suggested by the public.

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. Additional detailed suggestions for the Packaging Subcommittee should be submitted to *APCPanel@cms.hhs.gov*, with ''Packaging Subcommittee'' in the subject line.

B. Payment for Partial Hospitalization

1. Background

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for beneficiaries who have an acute mental illness. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified community mental health center (CMHC). Section 1833(t)(1)(B)(i) of the Act provides the Secretary with the authority to designate the hospital outpatient services to be covered under the OPPS. The Medicare regulations at 42 CFR 419.21(c) that implement this provision specify that payments under the OPPS will be made for partial hospitalization services furnished by CMHCs. Section 1883(t)(2)(C) of the Act requires that we establish relative payment weights based on median (or mean, at the election of the Secretary) hospital costs determined by 1996 claims data and data from the most recent available cost reports. Payment to providers under the OPPS for PHPs represents the provider's overhead costs associated with the program. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APC, effective for services furnished on or after August 1, 2000. For a detailed discussion, we refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18452).

Historically, the median per diem cost for CMHCs has greatly exceeded the median per diem cost for hospital-based PHPs and has fluctuated significantly from year to year while the median per diem cost for hospital-based PHPs has remained relatively constant ($200-$225). We believe that CMHCs may have increased and decreased their charges in response to Medicare payment policies. As discussed in more detail in section II.B.2. of the preamble of this final rule with comment period and in the CY 2004 OPPS final rule with comment period (68 FR 63470), we believe that some CMHCs manipulated their charges in order to inappropriately receive outlier payments.

In the CY 2003 OPPS update, the difference in median per diem cost for CMHCs and hospital-based PHPs was so great, $685 for CMHCs and $225 for hospital-based PHPs, that we applied an adjustment factor of .583 to CMHC costs to account for the difference between ''as submitted'' and ''final settled'' cost reports. By doing so, the CMHC median per diem cost was reduced to $384, resulting in a combined hospital-based and CMHC PHP median per diem cost of $273. As with all APCs in the OPPS, the median cost for each APC was scaled relative to the cost of a mid-level office visit and the conversion factor was applied. The resulting per diem rate for PHP for CY 2003 was $240.03.

In the CY 2004 OPPS update, the median per diem cost for CMHCs grew to $1,038, while the median per diem cost for hospital-based PHPs was again $225. After applying the .583 adjustment factor in the CY 2004 proposed rule to the median CMHC per diem cost, the median CMHC per diem cost was $605. Because the CMHC median per diem cost exceeded the

average per diem cost of inpatient psychiatric care, we proposed a per diem rate for CY 2004 based solely on hospital-based PHP data. The proposed PHP per diem for CY 2004, after scaling, was $208.95. However, by the time we published the OPPS final rule with comment period for CY 2004, we had received updated CCRs for CMHCs. Using the updated CCRs significantly lowered the CMHC median per diem cost to $440. As a result, we determined that the higher per diem cost for CMHCs was not due to the difference between ''as submitted'' and ''final settled'' cost reports, but was the result of excessive increases in charges which may have been done in order to receive higher outlier payments. Therefore, in calculating the PHP median per diem cost for CY 2004, we did not apply the .583 adjustment factor to CMHC costs to compute the PHP APC. Using the updated CCRs for CMHCs, the combined hospital-based and CMHC median per diem cost for PHP was $303. After scaling, we established the CY 2004 PHP APC of $286.82.

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 a Program Memorandum issued on January 17, 2003 (Transmittal A–03–004), we directed fiscal intermediaries to recalculate hospital and CMHC CCRs by April 30, 2003, using the most recently settled cost reports. Following the initial update of CCRs, fiscal intermediaries were further instructed to continue to update a provider's CCR and enter revised CCRs into the outpatient provider-specific file. Therefore, for CMHCs, we used CCRs from the outpatient provider-specific file.

In the CY 2005 OPPS update, the CMHC median per diem cost was $310 and the hospital-based PHP median per diem cost was $215. No adjustments were determined to be necessary and, after scaling, the combined median per diem cost of $289 was reduced to $281.33. We believed that the reduction in the CMHC median per diem cost indicated that the use of updated CCRs had accounted for the previous increase in CMHC charges, and represented a more accurate estimate of CMHC per diem costs for PHP.

For the CY 2006 OPPS final rule with comment period, we analyzed 12 months of the most current claims data available for hospital and CMHC PHP services furnished between January 1, 2004, and December 31, 2004. We also used the most currently available CCRs to estimate costs. The median per diem cost for CMHCs was $154, while the median per diem cost for hospital-based PHPs was $201. Based on the CY 2004 claims data, the average charge per day for CMHCs was $760, considerably greater than hospital-based per day costs but significantly lower than what it was in CY 2003 ($1,184). We believed that a combination of reduced charges and slightly lower CCRs for CMHCs resulted in a significant decline in the CMHC median per diem cost between CY 2003 and CY 2004.

Following the methodology used for the CY 2005 OPPS update, the CY 2006 OPPS update 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. We believed that this amount was too low to cover the cost for all PHPs.

Therefore, as stated in the CY 2006 OPPS final rule with comment period (70 FR 68548 and 68549), we considered the following three alternatives to our update methodology for the PHP APC for CY 2006 to mitigate this drastic reduction in payment for PHP services: (1) base the PHP APC on hospital-based PHP data alone; (2) apply a different trimming methodology to CMHC costs in an effort to eliminate the effect of data for those CMHCs that appeared to have excessively increased their charges in order to receive outlier payments; and (3) apply a 15-percent reduction to the combined hospital-based and CMHC median per diem cost that was used to establish the CY 2005 PHP APC. (We refer readers to the CY 2006 OPPS final rule with comment period for a full discussion of the three alternatives (70 FR 68548).) After carefully considering these three alternatives and all comments received on them, we adopted the third alternative for CY 2006. We adopted this alternative because we believed and continue to believe 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 believe that 15 percent is an appropriate reduction because it recognizes decreases in median per diem costs in both the hospital data and the CMHC data, and also reduces the risk of any adverse impact on access to these services that might result from a large single-year rate reduction. However, we adopted this policy as a transitional measure, and stated in the CY 2006 OPPS final rule with comment period that we would continue to monitor CMHC costs and charges for these services and work with CMHCs to improve their reporting so that payments can be calculated based on better empirical data, consistent with the approach we have used to calculate payments in other areas of the OPPS (70 FR 68548).

To apply this methodology for CY 2006, we reduced $289 (the CY 2005 combined unscaled hospital-based and CMHC median per diem cost) by 15 percent, resulting in a combined median per diem cost of $245.65 for CY 2006.

2. PHP APC Update for CY 2007

For CY 2007, we proposed to calculate the CY 2007 PHP per diem payment rate using the same update methodology that we adopted in CY 2006. That is, we proposed to apply an additional 15-percent reduction to the combined hospital-based and CMHC median per diem cost that was used to establish the CY 2006 per diem PHP payment.

As discussed in the CY 2007 OPPS proposed rule (71 FR 49538), we analyzed 12 months of data for hospital and CMHC PHP claims for services furnished between January 1, 2005, and December 31, 2005. We used the most currently available CCRs to estimate costs. Using these CY 2005 claims data, the median per diem cost for CMHCs was $165 and the median per diem cost for hospital-based PHPs was $209. Following the methodology used for the CY 2005 update, the CY 2007 combined hospital-based and CMHC median per diem cost is $172.

While the combined hospital-based and CMHC median per diem cost is about $10 higher using the CY 2005 data compared to the CY 2004 data ($172 compared to $161), we believe this amount is still too low to cover the cost for PHPs. As a result, we proposed the same policy we adopted for CY 2006—a 15-percent reduction applied to the current median cost. Therefore, to calculate the proposed PHP per diem rate for CY 2007, we applied an additional 15-percent reduction to the

combined hospital-based and CMHC median per diem cost.

To calculate the proposed 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 15 percent, which resulted in a proposed combined median per diem cost of $208.80.

We received numerous public comments in response to our proposal. A summary of the comments received and responses follow:

Comment: A number of commenters expressed concern about the magnitude of the reduction, particularly in light of last year's 15 percent reduction. The majority of commenters requested that CMS freeze the PHP rate at the CY 2006 level. Representatives of CMHCs argued that their costs are higher than those of hospitals, with most in the $300 to $400 range. Another commenter indicated that a per-day rate of $325 to $375 was more appropriate than the proposed amount. The commenters also suggested alternatives to calculating the PHP rate, such as including prior years' CMHC data trended forward based on medical inflation or market basket update. In addition, several patients were concerned that a 15-percent reduction in payment would negatively impact their ability to continue therapy.

Response: For this 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. These claims data are more current because the data include claims paid through June 30, 2006. We also used the most currently available CCRs to estimate costs. Using these updated data, we recreated the analysis performed for the CY 2007 proposed rule to determine if the significant factors we used in determining the proposed PHP rate had changed. The median per diem cost for CMHCs increased $8 to $173, while the median per diem cost for hospital-based PHPs decreased $19 to $190. The CY 2005 average charge per day for CMHCs was $675 similar to the figure noted in the CY 2007 proposed rule ($673) but still significantly lower than what is noted for CY 2003 ($1,184).

Following the 15-percent reduction methodology used for the CY 2005 update, the combined hospital-based and CMHC median per diem cost would be $175, only slightly more than the figure noted in the CY 2007 proposed rule ($172). We continue to believe this amount is too low to cover the cost of PHPs. However, we believe that freezing the current rate would not reflect the downward trend in data. Although the data continue to show a low per diem cost for PHP, we believe that a transition to the reduced amount may be more appropriate to ensure access for the vulnerable population served in PHPs. We recognize that many CMHCs are located in areas affected by Hurricanes Katrina and Rita where access to intensive mental health treatment is now limited. We note that the median per diem cost for hospital-based PHPs, which has been in the $200 to $225 range since the OPPS was implemented, went from $201 in CY 2004 to $190 in CY 2005, a decrease of 5 percent. We believe this percentage decrease provides a valid transitional percentage measure reflecting the downward trend in PHP cost.

Therefore, for CY 2007, we are making a 5-percent reduction to the CY 2006 median per diem rate. This amount accounts for the downward direction of the data and addresses concerns about the magnitude of a 15-percent reduction in 1 year. 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. If the PHP per diem cost continues to be low in CY 2008, we expect to continue the transition of decreasing the PHP median per diem cost to an amount that is reflective of the PHP data.

Comment: The commenters requested that CMS better define how it is monitoring and working with CMHCs to improve their reporting.

Response: CMS has provided guidance to all providers, through transmittals and manuals. In addition, when necessary, CMS has worked closely with fiscal intermediaries to provide guidance to targeted PHP providers to improve reporting.

Comment: Several commenters stated that CMS has applied its own assumptions and methodology on a different basis to compute the PHP rate each year from CY 2003 to CY 2006. The commenters also stated that the only years CMS used the same method was CY 2006 and CY 2007, when CMS made a simple 15-percent reduction from the previous year's rate.

Response: We do not agree with the commenters' assessment of our methodology for computing the PHP median per diem cost. Although a 0.583 adjustment factor was applied to CMHC costs in the CY 2003 update, all other aspects of the methodology that the commenter referenced have been the same each year until CY 2006. We have consistently calculated the PHP median per diem cost by using combined hospital-based and CMHC median cost data and scaled the figure relative to the cost of a mid-level office visit and then applied the conversion factor. However, in CY 2006, the combined hospital-based and CMHC median cost data produced an amount we believed was so low that it would result in too large of a single year rate reduction that we modified our methodology by limiting this decrease to 15 percent.

Comment: One commenter replicated the CMS methodology and computed rates very close to the CY 2007 proposed per diem rate, as well as the separate median per diem costs for CMHCs and hospital-based PHPs. The commenter also created a 3-year rolling median cost that also resulted in a rate similar to the proposed PHP rate. However, the commenter recommended that CMS use the hospital-specific cost center CCR for partial hospitalization instead of the overall outpatient CCR to calculate PHP median costs. The commenter believed that CMS has understated the PHP median costs by not using the hospital-specific CCRs for partial hospitalization.

Response: We note that most hospitals do not have a cost center for partial hospitalization; therefore, we have used the CCR as specific to PHP as possible. The following link contains the Revenue Cost to Cost Center Crosswalk: *http://www.cms.hhs.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage*.

This crosswalk indicates how (and if) 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 every revenue code that is used in the OPPS median calculations, starting with most specific, and ending with most general. CMS maps the revenue code to the most specific cost center with a provider-specific CCR. If the hospital does not have a CCR for any of the listed cost centers, the overall hospital CCR is the default. The PHP revenue centers are mapped to a Primary Cost Center 3550 ''Psychiatric/Psychological Services.'' If that cost center is not available, then the Secondary Cost Center is 6000 ''Clinic.'' We use the overall facility CCR 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 CCR from the outpatient provider-specific file.

Comment: One commenter stated that its internal computations reflect PHP per diem costs of $262.82 for its facility. The commenter urged CMS to increase the CY 2006 PHP rate of $245.65 by 6.8 percent so that the commenter's

program would break even. Another commenter questioned why CMS did not use actual cost report data to obtain true costs instead of estimating cost using CCRs applied to charges. A third commenter stated that CMS is required to include average costs for all providers and that CMS claims to utilize data representative of the mean of actual operating costs.

Response: We appreciate the commenter sharing its facility's per diem costs for its facility. However, PHP providers are paid under the OPPS. Under the OPPS, we generally determine rates based on median cost using charges from bill data and then estimate costs using CCRs. The OPPS is a PPS and will reflect generally the cost of providing services. A PPS may pay more or less than a provider's costs and is not a reasonable cost reimbursement system.

Comment: One commenter observed a decline of 19 percent in the number of hospital-based PHPs from CY 2003 to CY 2005 and a decline of 21 percent in the number of hospital-based PHP claims. The commenter expected further reductions in the number of hospital-based PHPs if CMS implements the proposed 15-percent rate cut in CY 2007.

Response: We do not believe this is an appropriate comparison because the commenter did not use the complete year of CY 2005 claims data. Rather, the commenter used CY 2005 claims processed through December 31, 2005. Using comparable CYs 2003 and 2005 data, (both CY 2003 and CY 2005 claims processed through June 30, 2004 and June 30, 2006, respectively), the declines are 11 percent and 5 percent, respectively. During the same time period, the number of CMHCs increased 13 percent and the number of CMHC PHP claims increased 36 percent. While there may have been fewer hospital-based PHPs, the number of CMHCs increased from 136 in CY 2003 to 179 in CY 2005. In CY 2005, CMHC and hospital-based PHPs combined provided 1.2 million days of PHP care, compared to approximately 0.8 million days of PHP care in CY 2003. We believe our payment rates continue to ensure adequate access to PHP care.

Comment: Several commenters suggested establishing a 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 commenters recommended that the new ratesetting task force be composed of CMS staff and a diverse group of stakeholders that include front-line providers of PHP services and representatives from national industry organizations.

Response: We agree that the payment rate for PHP needs to be accurate and appropriate to sustain access to care. As we consider changes to the current methodology, we believe 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 note that any significant change in payment methodology would require a statutory change.

Comment: A few commenters stated that wage index adjustment does not accurately reflect the cost of labor in areas affected by Hurricanes Katrina and Rita.

Response: The hospital wage data used to compute the FY 2007 hospital wage index is from the FY 2003 hospital cost reports for all hospitals. This is the standard lag timeframe in determining the hospital wage index. It will be another 2 years before the FY 2005 data will be reflected in the FY 2009 hospital wage index. The wage index is a relative measure of differences in area hourly wage levels. It compares a labor market's average hourly wage to the national average hourly wage. To the extent that post-hurricane hospital labor costs are higher relative to the national average, the wage index will reflect the higher relative labor cost beginning when the FY 2005 data will be used in the FY 2009 IPPS hospital wage index (which will be applied to the CY 2009 OPPS rate year). In addition, the statutory authority for the OPPS wage index policy in section 1833(t)(2)(D) of the Act requires that wage adjustments be made in a budget neutral manner. Therefore, we cannot raise one wage area and still maintain budget neutrality.

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: If a provider has charges on a bill for which they do 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 increased by $4.00. As such, we do not believe the calculations are adversely affected by the inclusion of these days.

Comment: A few commenters expressed concern that their financial status is affected where States limit payment of beneficiary coinsurance if the amount of Medicare payment made to a provider exceeds the State's payment rate for PHP.

Response: This is a Medicaid issue and beyond the scope of this final rule.

Comment: With respect to the methodology used to establish the PHP APC amount, commenters were concerned that data from settled cost reports fails to include costs reversed on appeal. The commenters stated that there are inherent problems in using claims data from a different time period than the CCRs from settled cost reports. The commenters indicated this would artificially lower the computed median costs, even though when cost reports are settled, generally 2 years or more after the actual year of services, as the providers have operated on actual revenues of 80 percent of the per diem.

Response: We use the best available data in computing the APCs. We issued a Program Memorandum on January 17, 2003 directing fiscal intermediaries to update the CCRs on an on-going basis whenever a more recent full year 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.

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 transportation to and from programs and does not cover meals. 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: 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 × $66.40=$265.60). Another commenter presented two different typical days using proposed CY 2007 rates. Typical Day 1 had three Group Therapy sessions (CPT code 90853, APC 0325, 3 × $66.40) and one Individual Psychotherapy session (CPT code 90818, APC 0325, $105.68). The commenter priced Typical Day 1 at $304.88. Typical Day 2 had one Group Therapy session (CPT code 90853, APC 0325, $66.40), one Individual Psychotherapy session (CPT code 90818, APC 0323, $105.68), and one Family Therapy session (CPT code 90847, APC 0324, $135.95). The commenter priced Typical Day 2 at $308.03. Based on the commenter's presented material, the commenter stated that the typical days yield an average componentized rate of $306. The commenters questioned how CMS can set rates for APCs 0322 through 0325, yet are unable to determine a payment rate for a day that is comprised of a minimum of three to four of those services. Another commenter stated that CMS requires a minimum of four treatments per day to qualify for a day of PHP and the proposed per diem rate of $208.27 for PHP that is less than what CMS would pay for four Group Therapy sessions (4 × $66.40=$265.60).

Response: We do not believe this is an appropriate comparison. The commenter does not use the PHP APC, APC 0033. 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 (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. We note that CMS does not require a minimum of four services.

Comment: One commenter requested that the same provisions given to rural hospital outpatient departments also be given to rural CMHCs.

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 CMHC providers. 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: Representatives of several CMHCs claimed that their costs 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 to share costs among its programs as needed. Further, we believe hospital costs in some areas, for example, capital and 24-hour maintenance costs, likely exceed CMHC costs.

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

Response: We believe that hospital-based programs may have benefited from the inclusion of CMHC data, as generally the median calculated from hospital outpatient department PHPs was consistently far less then the median amount that is computed for CMHCs. We have also taken steps to better educate the CMHCs in the cost reporting requirements.

Comment: One commenter asked why there are no CMHCs shown in the impact statement. 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 days of PHP provided by CMHCs stays the same as it was in CY 2005, the estimated impact on CMHCs as a result of the CY 2007 PHP payment rate compared to the CY 2006 PHP payment rate is a 5-percent decrease.

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, for CYs 2004, 2005, and 2006, 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. The CY 2006 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 2006 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 discussed in section II.B.2. of this preamble, we believe the CY 2005 CMHC data produce median per diem cost too low to use for the CY 2007 partial hospitalization payment rate. Due to the continued volatility of the CMHC charge data, we proposed to maintain the existing outlier threshold for CMHCs for CY 2007 at 3.40 times the APC payment amount and the CY 2007 outlier payment percentage applicable to costs in excess of the threshold at 50 percent.

As noted in section II.G. of this preamble, for CY 2007, 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 0.25 percent of outlier payments and 0.0025 percent of total OPPS payments would be allocated to CMHCs for PHP service outliers. As discussed in section II.G. of this preamble, 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 2007 at 3.40 percent times the APC payment amount and the CY 2007 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 preamble, using more recent data for this final rule with comment period, we set the target for hospital outpatient outlier payments at 1.0 of total OPPS payments. We allocate 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. For CY 2007, we set the outlier threshold for CMHCs for CY 2007 at 3.40 percent times the APC payment amount and the CY 2007 outlier percentage applicable to costs in excess of the threshold at 50 percent.

C. Conversion Factor Update for CY 2007

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 2007, 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 hospital market basket increase for FY 2007 published in the IPPS final rule on August 18, 2006 is 3.4 percent (71 FR 48146), the same as the forecast published in the FY 2007 IPPS proposed rule on April 25, 2006 (71 FR 24148). To set the OPPS proposed conversion factor for CY 2007, we increased the CY 2006 conversion factor of $59.511, as specified in the November 10, 2005 final rule with comment period (70 FR 68551), by 3.4 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for CY 2006 to ensure that the revisions we are making to our updates for a revised wage index and expanded rural adjustment are made on a budget neutral basis. We calculated a budget neutrality factor of 0.999331979 for wage index changes by comparing total payments from our simulation model using the FY 2007 IPPS final wage index values as finalized to those payments using the current (FY 2006) IPPS wage index values. To reflect the inclusion of essential access community hospitals (EACHs) as rural SCHs (discussed in section II.F. of this preamble), we calculated an additional budget neutrality factor of 0.999975941 for the rural adjustment, including EACHs. For CY 2007, we estimate that allowed pass-through spending would equal approximately $65.6 million, which represents 0.21 percent of total OPPS projected spending for CY 2007. The final conversion factor also is adjusted by the difference between the 0.17 percent pass-through dollars set-aside in CY 2006 and the 0.21 percent estimate for CY 2007 pass-through spending. Finally, payments for outliers remain at 1.0 percent of total payments for CY 2007.

The market basket increase update factor of 3.4 percent for CY 2007, the required wage index budget neutrality adjustment of approximately 0.999331979, the adjustment of 0.04 percent for the difference in the pass-through set-aside, and the adjustment for the rural payment adjustment for rural SCHs, including rural EACHs, of 0.999975941 result in a standard conversion factor for CY 2007 of $61.468.

We received many public comments on the calculation of the proposed conversion factor updates for CY 2007 with regard to the proposal to reduce the CY 2007 conversion factor for failure to report the IPPS RHQDAPU data. These comments are addressed in section XIX. of this preamble. We received no other comments on the proposed conversion factor update for CY 2007.

D. Wage Index Changes for CY 2007

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor and labor-related cost. Since the inception of the OPPS, CMS policy has been to wage adjust 60 percent of the OPPS payment, based on a regression analysis that determined that approximately 60 percent of the costs of services paid under OPPS were attributable to wage costs. We did not propose to revise this policy for CY 2007 OPPS. See 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 IPPS wage indices and 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 preamble, we standardize 60 percent of estimated costs (labor-related costs) for geographic area wage variation using the IPPS wage indices that are calculated prior to adjustments for reclassification to remove the effects of differences in area wage levels in determining the OPPS payment rate and the copayment standardized amount.

As published in the original OPPS April 7, 2000 final rule with comment period (65 FR 18545), OPPS has consistently adopted the final IPPS wage indices as the wage indices for adjusting the OPPS standard payment amounts for labor market differences. Thus, the wage index that applies to a particular hospital under the IPPS will also apply to that hospital under the OPPS. As initially explained in the September 8, 1998 OPPS proposed rule, we believed and continue to believe that

using the IPPS wage index as the source of an adjustment factor for OPPS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient within the hospital overall. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. In the CY 2007 OPPS proposed rule, in accordance with our established policy, we proposed to use the FY 2007 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 2007 which will include the finalized wage indices in effect through March 31, 2007, and those in effect on or after April 1, 2007, to accommodate the expiring reclassification provisions under section 508 of Pub. L. 108–173 to determine the wage adjustments for the OPPS payment rate and copayment standardized amount.

On May 17, 2006 (71 FR 28644), in response to a court order in *Bellevue Hosp. Ctr.* v. *Leavitt,* we published a second IPPS proposed rule that would revise the methodology for calculating the occupational mix adjustment for FY 2007. We proposed to replace in full the descriptions of the data and methodology that would be used in calculating the occupational mix adjustment discussed in the first FY 2007 IPPS proposed rule. The second proposed rule also states that, because of the collection of new occupational mix data, we would publish the FY 2007 occupational mix adjusted wage index tables and related impacts on the CMS Web site shortly after we published the FY 2007 IPPS final rule, and in advance of October 1, 2006. The weights and factors would also be published on the CMS Web site after the FY 2007 IPPS final rule, but in advance of October 1, 2006 (71 FR 28650). On October 11, 2006 (71 FR 59886), we published an IPPS notice in the **Federal Register** that, in part, finalized the adjusted occupational mix wage indices published in the FY 2007 IPPS final rule. Readers are directed to refer to the wage index tables that were published on the CMS Web site before October 1, 2006.

We note that the FY 2007 IPPS wage indices continue to reflect a number of changes implemented in FY 2005 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, and new wage adjustments provided for under Pub. L. 108–173. The following is a brief summary of the changes in the FY 2005 IPPS wage indices, continued for FY 2007, and any adjustments that we are applying to the OPPS for CY 2007. We refer the reader to the FY 2007 IPPS final rule (71 FR 48005 through 48028) for a detailed discussion of the changes to the wage indices. Readers should refer also to our IPPS notice published in the **Federal Register** on October 11, 2006, for finalized changes to the adjusted occupational mix wage indices and related issues (71 FR 59886). In this final rule with comment period, we are not reprinting the FY 2007 IPPS wage indices referenced in the discussion below, with the exception of the out-migration wage adjustment table (Addendum L of this final rule with comment period). We also refer readers to the CMS Web site for the OPPS at *http://www.cms.hhs.gov/providers/hopps.* At this Web site, the reader will find a link to the finalized FY 2007 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 2007 IPPS final rule, we again stated that hospitals located in MSAs will be urban and hospitals that are located in Micropolitan Areas or outside CBSAs will be rural. 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. To be consistent with the IPPS, we will continue the policy we began in CY 2005 of applying the same urban-to-rural transition to non-IPPS hospitals paid under the OPPS. That is, we would maintain the wage index of the MSA where the hospital was previously located for purposes of determining a wage index for CY 2007. Beginning in FY 2008, the 3-year transition will end and these hospitals will receive their statewide rural wage index. However, hospitals paid under the IPPS will be eligible to apply for reclassification.

For the occupational mix adjustment, we refer readers to the FY 2007 IPPS final rule and the October 11, 2006 IPPS notice discussed above. Under that final rule, the wage indices are adjusted 100 percent for occupational mix. In addition, as stated above, the finalized version of the FY 2007 IPPS wage index tables and other adjustment factors were published in the October 11, 2006 IPPS notice and are applicable to discharges occurring on or after October 1, 2006.

As noted above, for purposes of estimating an adjustment for the OPPS payment rates to accommodate geographic differences in labor costs in this final rule with comment period, we have used the finalized FY 2007 IPPS wage indices identified in the October 11, 2006 IPPS notice that are fully adjusted for differences in occupational mix using the new survey data, effective October 1, 2006. As proposed, in all cases, we are using the finalized FY 2007 IPPS wage indices, which include the wage indices to be in effect through March 31, 2007, and those to be in effect on or after April 1, 2007, with any subsequent corrections, for calculating OPPS payment in CY 2007.

2. *The reclassifications of hospitals to geographic areas for purposes of the wage index.* For purposes of the OPPS wage index, we proposed to adopt all of the IPPS reclassifications for FY 2007, including reclassifications that the Medicare Geographic Classification Review Board (MGCRB) approved under the one-time appeal process for hospitals under section 508 of Pub. L. 108–173. We note that section 508 reclassifications will terminate March 31, 2007, and that this expiration, along with the calendar year operating period of OPPS, impacts the calculation of the OPPS payment and the budget neutrality adjustment for the wage index. In the FY 2007 IPPS final rule (71 FR 48024 and 48025), we finalized the procedural rules for hospitals that wished to reclassify for the second half of FY 2007 (April 1, 2007, through September 30, 2007) under section 1886(d)(10) of the Act. These rules essentially provided procedures for some hospitals to retain section 508 reclassifications for the first half of FY 2007 and also be eligible to maintain an approved reclassification under section 1886(d)(10) for the second half of FY 2007. Rather than calculating one wage index that reflected all final reclassification adjustments, we will calculate two separate wage indices for FY 2007, one to be in effect October 1 through March 31, 2007, and one to be in effect April 1 through September 30, 2007.

These procedural rules also impact a hospital's eligibility to receive the out-migration wage adjustment, discussed

in greater detail in section III.I. of the FY 2007 IPPS final rule (71 FR 48026) and under section II.D.4. of this preamble. A hospital cannot receive an out-migration wage adjustment if it is reclassified under section 1886(d)(10) of the Act. Hospitals declining reclassification status for any part of the year become eligible to receive the out-migration wage adjustment if they are located in an adjustment county. We note that because the OPPS operates on a calendar year (January 1 through December 31) and not a fiscal year, the expiring reclassification status under section 508 of Pub. L. 108–173 results in different wage indices for OPPS for the first quarter of CY 2007 (January 1, 2007, through March 31, 2007) and the last three quarters of CY 2007 (April 1, 2007, through December 31, 2007).

3. *The out-migration wage adjustment to the wage index.* In FY 2007 IPPS final rule (71 FR 48026), we discussed the out-migration adjustment under section 505 of Pub. L. 109–173 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. (See the IPPS FY 2007 final rule for further information on out-migration.) For OPPS purposes, we proposed to continue our policy from CY 2006 to allow non-IPPS hospitals paid under the OPPS to qualify for 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. Tables identifying counties eligible for the out-migration adjustment were published after the FY 2007 IPPS final rule on October 11, 2006 (71 FR 59886). These tables reflect updated county listing to reflect changes to the occupation mix adjustment made in response to *Bellevue* court case discussed above. Because we proposed to adopt the final FY 2007 IPPS wage index, we are adopting any changes in a hospital's classification status that will make them either eligible or ineligible for the out-migration wage adjustment both through March 31, 2007, and on or after April 1, 2007.

With the exception of reclassifications resulting from the implementation of the one-time appeal process under section 508 of Pub. L. 108–173, all changes to the wage index resulting from geographic labor market area reclassifications or other adjustments must be incorporated in a budget neutral manner. Accordingly, in calculating the OPPS budget neutrality estimates for CY 2007, in this final rule with comment period, we have included the wage index changes that would result from MGCRB reclassifications, implementation of section 505 of Pub. L. 108–173, and other refinements made in the FY 2007 IPPS final rule, such as the hold harmless provision for hospitals changing status from urban to rural under the new CBSA geographic statistical area definitions. However, section 508 sets aside $900 million to implement the section 508 reclassifications. We considered the increased Medicare payments that the section 508 reclassifications would create in both the IPPS and OPPS when we determined the impact of the one-time appeal process. Because the increased OPPS payments already count against the $900 million limit, we did not consider these reclassifications when we calculated the OPPS budget neutrality adjustment.

Under the procedural rules described under section II.D.3. of this final rule with comment period and in section III.H.6. of the FY 2007 IPPS final rule (71 FR 48024) regarding expiring section 508 reclassifications, different wage indices may be in effect for the first quarter of the calendar year and the last three quarters of the calendar year. These rules have implications for budget neutrality adjustments. Any additional payment attributable to reclassifications due to section 508 between January 1 and April 1, 2007, must be excluded from a budget neutrality adjustment, and all other adjustments to the wage index are subject to budget neutrality. Rather than calculating two different conversion factors, with different budget neutrality adjustments, we proposed to calculate one budget neutrality adjustment that reflects the combined adjustments required for the first quarter and last three quarters of the calendar year, respectively. We followed the same approach in the FY 2007 IPPS final rule (71 FR 48026).

We received several comments on the proposed wage index policy for the CY 2007 OPPS.

Comment: One commenter urged CMS to use the IPPS labor-related adjustment to determine reimbursements for outpatient services. Specifically, the commenter requested that the labor-related percentage for the OPPS be revised from the 60 percent currently proposed to 69.7 percent, consistent with what is stated in the FY 2007 IPPS rule. The commenter further requested that, at a minimum, CMS update the OPPS labor-related share in effect for CY 2007 from 60 percent to 63 percent, the labor-related percentage referenced by CMS in the CY 2006 OPPS final rule.

Response: We did not propose a change to the labor share, but we do not believe that such a change is appropriate. The determination to wage adjust 60 percent of the payment of each APC was made based on a regression analysis at the beginning of the OPPS. We repeated this analysis as part of the rural adjustment study we performed for the CY 2006 OPPS based on CY 2004 claims data. This study examined the extent to which the body of costs for services furnished in the outpatient department was split between wage and nonwage costs and, based on our most recent findings, we believe that it remains appropriate to wage adjust 60 percent of the APC payment (70 FR 68533).

Comment: One commenter urged CMS to postpone the implementation of 100 percent of the occupational mix survey adjustment until the DRG severity refinements can be fully implemented and their possible unrecognized adverse effects on quality of care and outcomes can be resolved. Another commenter expressed concern about the application of the 100-percent occupational mix adjustment for CY 2007. The commenter encouraged CMS to approach Congress for authority to transition the occupational mix and to repeal the mandate that CMS apply an occupational mix adjustment to wage indices.

Response: We appreciate the comments concerning this issue and refer readers to the CMS final rule for the CY 2007 IPPS (71 FR 48006) for a discussion of the reasons that CMS adopted a 100 percent occupational mix adjusted wage index for hospitals receiving payments under the IPPS. As first published in the original OPPS final rule on April 7, 2000 (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. We 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. Therefore, given that a 100 percent occupational mix adjusted wage index was adopted in the IPPS, we will also adopt the same index for the OPPS.

After carefully considering all public comments received, we are finalizing our wage index adjustment policy for the CY 2007 OPPS as proposed without modification.

E. Statewide Average Default CCRs

CMS uses CCRs to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS. Some hospitals do not have a valid CCR. These hospitals include, but are not limited to, hospitals that are new and have not yet submitted a cost report, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds for a valid CCR, or hospitals that have recently given up their all-inclusive rate status. Last year, we updated the default urban and rural CCRs for CY 2006 in our final rule with comment period published on November 10, 2005 (70 FR 68553 through 68555). As we proposed, in this final rule with comment period, we have updated the default ratios for CY 2007 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. Refer to section II.A.1.c. of this preamble for a discussion of our revision to the overall CCR calculation. Table 4 published in the CY 2007 OPPS proposed rule listed the proposed CY 2007 default urban and rural CCRs by State and compared them to last year's default CCRs (71 FR 49542 through 49545). These CCRs are the ratio of total costs to total charges from each provider's most recently submitted cost report, for those cost centers relevant to outpatient services weighted by Medicare Part B charges. We also adjusted these ratios to reflect final settled status by applying the differential between settled to submitted costs and charges from the most recent pair of settled to submitted cost reports.

For the proposed rule, 81.79 percent of the submitted cost reports represented data for CY 2004. We have since updated the cost report data we use to calculate CCRs with additional submitted cost reports for CY 2005. For this final rule with comment period, 66.41 percent of the submitted cost reports utilized in the default ratio calculation were for CY 2004, whereas 34.95 percent were for CY 2005. We only used valid CCRs to calculate these default ratios. That is, we removed the CCRs for all-inclusive hospitals, CAHs, and hospitals in Guam and the U.S. Virgin Islands because these entities are not paid under the OPPS, or in the case of all-inclusive hospitals, because their CCRs are suspect. We further identified and removed any obvious error CCRs and trimmed any outliers. We limited the hospitals used in the calculation of the default CCRs to those hospitals that billed for services under the OPPS during CY 2004.

Finally, we calculated an overall average CCR, weighted by a measure of volume for CY 2004, 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. Very few providers in Maryland are eligible to receive payment under the OPPS, which limits the data available to calculate an accurate and representative CCR. The observed differences between last year's default statewide CCRs and the CY 2007 CCRs are a combination of the general decline in the ratio between costs and charges widely observed in the cost report data and the change in the proposed overall CCR calculation.

As stated above, CMS uses default statewide CCRs for several groups of hospitals, including, but not limited to, hospitals that are new and have not yet submitted a cost report, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds for a valid CCR, and hospitals that have recently given up their all-inclusive rate status. Current OPPS policy also requires hospitals that experience a change of ownership, but that do not accept assignment of the previous hospital's provider agreement, to use the previous provider's CCR.

For CY 2007, we proposed 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. We proposed that this policy be effective for hospitals experiencing a change of ownership on or after January 1, 2007. 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 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 the proposed statewide average default CCR. Therefore, we are finalizing the statewide average default CCRs shown in Table 4 below for OPPS services furnished on or after January 1, 2007 without modification.

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Table 4.--CY 2007 Statewide Average Cost-to-Charge Ratios (CCRs)

State	Urban/Rural	Default CCR (2007 Final rule)	Previous Default CCR (2006 OPPS final rule)
ALASKA	RURAL	0.5337	0.5461
ALASKA	URBAN	0.3830	0.3983
ALABAMA	RURAL	0.2321	0.2342
ALABAMA	URBAN	0.2228	0.2174
ARKANSAS	RURAL	0.2645	0.2911
ARKANSAS	URBAN	0.2749	0.2761
ARIZONA	RURAL	0.2823	0.3066
ARIZONA	URBAN	0.2323	0.2413
CALIFORNIA	RURAL	0.2463	0.2641
CALIFORNIA	URBAN	0.2324	0.2213
COLORADO	RURAL	0.3704	0.3922
COLORADO	URBAN	0.2672	0.2824
CONNETICUT	RURAL	0.3886	0.3808
CONNETICUT	URBAN	0.3491	0.3857
DISTRICT OF COLUMBIA	URBAN	0.3392	0.3487
DELAWARE	RURAL	0.3230	0.3536
DELAWARE	URBAN	0.3953	0.4244
FLORIDA	RURAL	0.2191	0.2218
FLORIDA	URBAN	0.1990	0.2100
GEORGIA	RURAL	0.2846	0.3093
GEORGIA	URBAN	0.2888	0.2920
HAWAII	RURAL	0.3574	0.3487
HAWAII	URBAN	0.3199	0.3264
IOWA	RURAL	0.3489	0.4038

State	Urban/Rural	Default CCR (2007 Final rule)	Previous Default CCR (2006 OPPS final rule)
IOWA	URBAN	0.3428	0.3465
IDAHO	RURAL	0.4360	0.4176
IDAHO	URBAN	0.4159	0.4627
ILLINOIS	RURAL	0.3082	0.3128
ILLINOIS	URBAN	0.2878	0.2747
INDIANA	RURAL	0.3160	0.3514
INDIANA	URBAN	0.3204	0.3498
KANSAS	RURAL	0.3200	0.3441
KANSAS	URBAN	0.2523	0.2646
KENTUCKY	RURAL	0.2508	0.2836
KENTUCKY	URBAN	0.2698	0.2912
LOUISIANA	RURAL	0.2808	0.2762
LOUISIANA	URBAN	0.2730	0.2574
MARYLAND	RURAL	0.3181	0.3362
MARYLAND	URBAN	0.2978	0.3024
MASSACHUSETTS	URBAN	0.3487	0.3432
MAINE	RURAL	0.4568	0.3850
MAINE	URBAN	0.4294	0.4384
MICHIGAN	RURAL	0.3461	0.3698
MICHIGAN	URBAN	0.3286	0.3332
MINNESOTA	RURAL	0.5085	0.4679
MINNESOTA	URBAN	0.3383	0.3430
MISSOURI	RURAL	0.2944	0.3082
MISSOURI	URBAN	0.3034	0.2907
MISSISSIPPI	RURAL	0.2841	0.2867
MISSISSIPPI	URBAN	0.2312	0.2533
MONTANA	RURAL	0.4392	0.4545
MONTANA	URBAN	0.4628	0.4128
NORTH CAROLINA	RURAL	0.3048	0.3202
NORTH CAROLINA	URBAN	0.3700	0.3568
NORTH DAKOTA	RURAL	0.3668	0.3743
NORTH DAKOTA	URBAN	0.3945	0.3695
NEBRASKA	RURAL	0.3756	0.3963
NEBRASKA	URBAN	0.2899	0.2902
NEW HAMPSHIRE	RURAL	0.3700	0.3755
NEW HAMPSHIRE	URBAN	0.3249	0.3228
NEW JERSEY	URBAN	0.2972	0.2823
NEW MEXICO	RURAL	0.2741	0.2984
NEW MEXICO	URBAN	0.3978	0.3708
NEVADA	RURAL	0.3348	0.4687
NEVADA	URBAN	0.2141	0.2120
NEW YORK	RURAL	0.4446	0.4302
NEW YORK	URBAN	0.4275	0.4118
OHIO	RURAL	0.3689	0.3835

State	Urban/Rural	Default CCR (2007 Final rule)	Previous Default CCR (2006 OPPS final rule)
OHIO	URBAN	0.2834	0.3054
OKLAHOMA	RURAL	0.2949	0.3129
OKLAHOMA	URBAN	0.2608	0.2711
OREGON	RURAL	0.3438	0.3871
OREGON	URBAN	0.4054	0.3986
PENNSYLVANIA	RURAL	0.3052	0.3275
PENNSYLVANIA	URBAN	0.2524	0.2596
PUERTO RICO	URBAN	0.4689	0.4250
RHODE ISLAND	URBAN	0.3087	0.3040
SOUTH CAROLINA	RURAL	0.2546	0.2573
SOUTH CAROLINA	URBAN	0.2479	0.2565
SOUTH DAKOTA	RURAL	0.3479	0.3769
SOUTH DAKOTA	URBAN	0.3035	0.3132
TENNESSEE	RURAL	0.2648	0.2834
TENNESSEE	URBAN	0.2491	0.2595
TEXAS	RURAL	0.2891	0.3077
TEXAS	URBAN	0.2580	0.2747
UTAH	RURAL	0.4410	0.4780
UTAH	URBAN	0.4161	0.4342
VIRGINIA	RURAL	0.2821	0.2904
VIRGINIA	URBAN	0.2805	0.2976
VERMONT	RURAL	0.4325	0.4443
VERMONT	URBAN	0.3376	0.3941
WASHINGTON	RURAL	0.3742	0.4057
WASHINGTON	URBAN	0.3717	0.3810
WISCONSIN	RURAL	0.3670	0.3914
WISCONSIN	URBAN	0.3638	0.3672
WEST VIRGINIA	RURAL	0.3162	0.3257
WEST VIRGINIA	URBAN	0.3691	0.3802
WYOMING	RURAL	0.4714	0.4687
WYOMING	URBAN	0.3520	0.3841

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F. OPPS Payments to Certain Rural Hospitals

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

When the OPPS was implemented, every provider was eligible to receive an additional payment adjustment (transitional corridor payment) if the payments it received for covered OPD services under the OPPS were less than the payments it would have received for the same services under the prior reasonable cost-based system. Section 1833(t)(7) of the Act provides that the transitional corridor payments are temporary payments for most providers, with two exceptions, to ease their transition from the prior reasonable cost-based payment system to the OPPS system. Cancer hospitals and children's hospitals receive the transitional corridor payments on a permanent basis. Section 1833(t)(7)(D)(i) of the Act originally provided for transitional corridor payments to rural hospitals with 100 or fewer beds for covered OPD services furnished before January 1, 2004. However, section 411 of Pub. L. 108–173 amended section 1833(t)(7)(D)(i) of the Act to extend these payments through December 31, 2005, for rural hospitals with 100 or fewer beds. Section 411 also extended the transitional corridor payments to sole community hospitals (SCHs) located in rural areas for services furnished during the period that begins with the provider's first cost reporting period beginning on or after January 1, 2004, and ends on December 31, 2005. Accordingly, the authority for making transitional corridor payments under section 1833(t)(7)(D)(i) of the Act, as amended by section 411 of Pub. L. 108–173, expired for rural hospitals having 100 or fewer beds and SCHs located in rural areas on December 31, 2005.

Section 5105 of Pub. L. 109–171 reinstituted the hold harmless transitional outpatient payments (TOPs) for covered OPD services furnished on or after January 1, 2006, and before January 1, 2009, for rural hospitals having 100 or fewer beds that are not SCHs. When the OPPS payment is less than the payment the provider would have received under the previous reasonable cost-based system, the amount of payment is increased by 95 percent of the amount of the difference

between those two payment systems for CY 2006, by 90 percent of the amount of that difference for CY 2007, and by 85 percent of the amount of that difference for CY 2008.

For CY 2006, we have implemented section 5105 of Pub. L. 109–171 through Transmittal 877, issued on February 24, 2006. We did not specifically address whether TOPs payments apply to essential access community hospitals (EACHs), which are considered to be SCHs under section 1886(d)(5)(D)(iii)(III) of the Act. Accordingly, under the statute, EACHs are treated as SCHs. Therefore, we believe that EACHs are not eligible for TOPs payment under Pub. L. 109–171. In the CY 2007 OPPS proposed rule, we proposed to update § 419.70(d) to reflect the requirements of Pub. L. 109–171.

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 only for rural SCHs and we implemented a payment adjustment for those hospitals beginning January 1, 2006.

As indicated in the CY 2007 OPPS proposed rule (71 FR 49547), we recently became aware that we did not specifically address whether the adjustment applies to EACHs, which are considered to be SCHs under section 1886(d)(5)(D)(iii)(III) of the Act. Thus, under the statute, EACHs are treated as SCHs. Currently, fewer than 10 hospitals are classified as EACHs. As of CY 1998, under section 4201(c) of Pub. L. 105–33, a hospital can no longer become newly classified as an EACH. Therefore, for purposes of receiving this rural adjustment, we are clarifying that EACHs are treated as SCHs for purposes of receiving this adjustment, assuming these entities otherwise meet the rural adjustment criteria.

This adjustment is budget neutral and applied before calculating outliers and coinsurance. We also stated that we would not reestablish the adjustment amount on an annual basis, but that we might review the adjustment in the future and, if appropriate, would revise the adjustment. For CY 2007, we proposed to continue our current policy of a budget neutral 7.1 percent payment increase for rural SCHs for specified services.

Comment: Many commenters expressed concern that small rural hospitals will suffer financially if TOPs payments continue to decrease each year, as specified in section 5105 of Pub. L. 109–171. The commenters noted that patient access to small rural hospitals could be at risk. One commenter supported permanent TOPs for rural SCHs, which currently do not receive any TOPs payments. Several commenters noted their support for a Senate bill, S.3606, which is known as the ''Save our Safety Net Act of 2005.''

Response: We share the concerns of rural hospitals and do not intend to limit access to health care for Medicare beneficiaries in rural areas. However, we note that the statute is very specific and does not provide TOPs payments for entities other than those listed in the statute. The statute also requires TOPs payments to gradually decrease through CY 2008.

Comment: Several commenters requested that CMS clarify that the 7.1 percent rural SCH adjustment applies to EACHs retroactive to January 1, 2006.

Response: As stated above, we are clarifying that EACHs are treated as SCHs for purposes of receiving this adjustment, assuming these entities otherwise meet the rural adjustment criteria. EACHs are eligible for this adjustment effective January 1, 2006, as are all rural SCHs. As stated above, we agree with the commenters and are revising § 419.43(g) to specifically reflect this clarification. In addition, we will ensure that a retroactive payment adjustment occurs.

Comment: Several commenters supported the 7.1 percent adjustment for rural SCHs for CY 2007, but requested that CMS rerun the analyses to possibly provide for an adjustment for other rural hospitals during CY 2008 and CY 2009, when TOPs payments will be further reduced.

Response: As stated above, while we will not reestablish the adjustment amount nor determine whether other rural hospitals are eligible for the adjustment on an annual basis, we may review the adjustment in the future and, if appropriate, would revise the adjustment.

After carefully considering the comments received, we are finalizing our policy by continuing a payment adjustment for rural SCHs, including EACHs, of 7.1 percent and finalizing the regulation text at § 419.70(d) without modification. We are also revising § 419.43(g) to clarify that EACHs are also eligible for the rural SCH OPPS adjustment.

G. CY 2007 Hospital Outpatient Outlier Payments

Currently, the OPPS pays outlier payments on a service-by-service basis. For CY 2006, 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 $1,250 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. For a discussion on CMHC outliers, see section II.B.3. of the preamble to this final rule with comment period.

As explained in the CY 2006 OPPS final rule with comment period (70 FR 68561), we set our projected target for aggregate outlier payments at 1.0 percent of aggregate total payments under the OPPS. The outlier thresholds were set so that estimated CY 2006 aggregate outlier payments would equal 1.0 percent of aggregate total payments under the OPPS. In the CY 2006 OPPS final rule with comment period (70 FR 68563), we also published total outlier payments as a percent of total expenditures for past years. However, when we published the CY 2007 OPPS proposed rule, we did not have a complete set of CY 2005 claims data to produce this number for CY 2005 and stated that we would report on CY 2005 outlier payments in this CY 2007 OPPS final rule with comment period. In the final set of CY 2005 OPPS claims, aggregated outlier payments were 2.39 percent of aggregated total OPPS payments. For CY 2005, the estimated outlier payments were set at 2 percent of the total aggregated OPPS payments. Therefore, for CY 2005, we paid 0.39 percent in excess of the CY 2005 outlier target of 2 percent of total aggregated OPPS payments.

1. CY 2007 Proposal

For CY 2007, we proposed to continue our policy of setting aside 1.0 percent of

aggregate total payments under the OPPS for outlier payments. We proposed that a portion of that 1.0 percent would be allocated to CMHCs for partial hospitalization program service outliers. We proposed that the portion allocated to CMHCs would be determined by the amount of estimated outlier payments resulting from the CMHC outlier threshold.

In order to ensure that estimated CY 2007 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPPS, we proposed that the outlier threshold be set so that outlier payments would be triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,825 fixed-dollar threshold.

We calculated the fixed-dollar threshold for the CY 2007 proposed rule using the same methodology as we did in CY 2006, except we used the revised overall CCR calculation discussed in section II.A.1.c. of this preamble. As discussed in section II.A.1.c. of this preamble, we discovered that the calculation of the overall CCR that the fiscal intermediaries are using to determine outlier payment and payment for services paid at charges reduced to cost differs from the overall CCR that we traditionally use to model the outlier thresholds. We discovered this during our calculations of the outlier threshold for the CY 2006 OPPS final rule with comment period, and we indicated in our preamble discussion for that rule, that we might revisit the threshold estimate methodology in light of identified differences in the overall CCR calculation. Because, on average, the overall CCR calculation used by the fiscal intermediaries results in higher CCRs than those estimated using our ''traditional'' CCR sets, the outlier threshold calculated for the CY 2006 OPPS final rule with comment period is too low. The OPPS impact table in section XXVII. of the CY 2007 proposed rule (Table 49; 71 FR 49687) demonstrated an estimated payment differential of 0.25 percent of total spending for hospital outlier payments in CY 2006 because of the differences in overall CCR calculations. The revised overall CCR calculation that we proposed for CY 2007 aligns the two CCR calculations 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'' calculation by total Medicare Part B charges. We expected this proposed change in the overall CCR calculation to raise the outlier threshold.

2. CY 2007 Final Rule Outlier Calculation

The claims that we use to model each OPPS update lag by 2 years. For this final rule with comment period, we used CY 2005 claims to model the CY 2007 OPPS. In order to estimate CY 2007 outlier payments for this final rule with comment period, we inflated the charges on the CY 2005 claims using the same inflation factor of 1.1642 that we used to estimate the IPPS fixed-dollar outlier threshold for the FY 2007 IPPS final rule. For 1 year, the inflation factor is 1.079. The methodology for determining this charge inflation factor was discussed in the FY 2007 IPPS final rule (71 FR 48150). As we stated in the CY 2005 OPPS final rule with comment period, we believe that the use of this charge inflation factor is appropriate for the OPPS because, with the exception of the routine service cost centers, hospitals use the same cost centers to capture costs and charges across inpatient and outpatient services (69 FR 65845). As also noted in the FY 2006 IPPS final rule, we believe that a charge inflation factor is more appropriate than an adjustment to costs because this methodology closely captures how actual outlier payments are made and calculated (70 FR 47495). We then applied the revised overall CCR that we calculated from each hospital's most recent cost report (CMS–2552–96) and, if the cost report was not settled, we adjusted it by a settled-to-submitted ratio. We simulated aggregated outlier payments using these costs for several different fixed-dollar thresholds holding the 1.75 multiple constant until the total outlier payments equaled 1.0 percent of aggregated total OPPS payments. We estimate that a threshold of $1,825 combined with the multiple threshold of 1.75 times the APC payment rate would allocate 1.0 percent of aggregated total OPPS payments to outlier payments.

For CMHCs, in CY 2007 we are projecting that the outlier threshold is met when the cost of furnishing a service or procedure by a CMHC exceeds 3.40 times the APC payment rate. If a CMHC provider meets this condition, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC payment rate. In the CY 2007 OPPS proposed rule, we proposed to continue the same threshold policy for CY 2007 as we have established for CY 2006. An explanation for this proposed policy is discussed in section II.B.3. of the preamble to this final rule with comment period.

We received many comments on our proposed outlier policy for CY 2007.

Comment: Some commenters were concerned that the outlier threshold that CMS proposed is set too high and will result in CMS not spending all of the money in the projected 1.0 percent outlier target. The commenters stated 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 OPPS rates or reduce the threshold for qualification so that the outlier expenditures are at a zero balance at the end of each year. One commenter 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 2007, that the CY 2006 threshold would be increased by only 3.4 percent.

Response: We believe that the threshold of $1,825 will result in paying 1.0 percent of the OPPS expenditures in outliers. As we indicated in the CY 2006 OPPS final rule, in the final set of CY 2004 OPPS claims, aggregated outlier payments were 2.5 percent of aggregated total OPPS payments. Similarly, using the final set of CY 2003 OPPS claims, aggregated outlier payments were 3.1 percent of total OPPS payments. As stated earlier, in the final set of CY 2005 claims, aggregated outlier payments were 2.39 percent of the aggregated total OPPS payments. For all three years, the estimated outlier payments were set at 2.0 percent of the total aggregated OPPS payments. Hence, our historic estimation of outlier payments has resulted in outlier payments that exceeded our target, and we believe that our proposed methodology will provide an outlier threshold that will result in more accurate aggregate program outlier payments.

As discussed above, for the proposed rule, we used a charge inflation factor of 1.1515 to inflate the charges for CY 2005 claims to CY 2007 dollars. We then applied the provider's overall CCR that we calculate as part of our APC median estimation process to those inflated charges to estimate costs. We compared these estimated costs to 1.75 times the proposed APC payment amount and to the APC payment amount plus a number of fixed-dollar thresholds until we identified a threshold that produced an estimate of total outlier payments equal to 1.0 percent of total aggregated OPPS payments.

We used the same estimation process for this final rule with comment period. We used a complete set of CY 2005 claims, and the updated charge inflation

estimate of 1.1642 percent from the FY 2007 IPPS final rule and each hospital's overall CCR, as calculated for our APC median setting process.

Using this methodology, the final fixed-dollar threshold for the CY 2007 OPPS is $1,825, and the final multiple threshold is 1.75 times the APC payment rate.

We did not increase the CY 2007 outlier threshold by the market basket update of 3.4 percent because our calculations are intended to best approximate the outlier target of 1.0 percent of CY 2007 OPPS expenditures. As we stated in the CY 2006 OPPS final rule, we established the projected target for aggregate outlier payments at 1.0 percent because we believed, consistent with MedPAC's recommendations, that the fairly narrow definitions of APC groups make outlier payment less necessary for the OPPS, that multiple service payments are common for any given claim, and that the susceptibility to ''gaming'' through charge inflation continues (70 FR 68563). Because OPPS outlier payments are targeted to services, rather than clinical cases, we believe it is unlikely that any specific service would be excessively costly, and reducing the outlier threshold to 1.0 percent of total OPPS payment effectively raises the payment for all other services. We continue to believe that an outlier target of 1.0 percent of total OPPS payment is appropriate for the OPPS.

Comment: One commenter asked that CMS modify the charge methodology used to set the OPPS outlier threshold to account for the change in CCRs over time in a manner similar to that used for the FY 2007 IPPS. The commenter believed that it is appropriate to apply an adjustment factor to the CCRs, so that the CCRs CMS would use in simulations of outlier payments would more closely reflect the CCRs that would be used in CY 2007.

Response: Given the potential difference in cost increases between inpatient and outpatient hospital departments, we do not believe it would be appropriate to apply the exact same CCR adjustment used under the IPPS without an OPPS-specific analysis. However, it is possible that a similar analysis specific to the OPPS could indicate that it would be appropriate to apply an OPPS CCR adjustment. We expect to study this issue further and would address any changes to the outlier methodology through future rulemaking.

Comment: Some commenters objected to the lack of analysis to support the statement that the proposed outlier threshold would result in full payment of the outlier pool and urged CMS to publish the estimated outlier payments in the proposed rule, based on available data, to permit the public to better comment on the proposed outlier policy.

Response: The proposed rule contained considerable discussion of the methodology we use to create the proposed outlier threshold, as well as the projected program expenditure amount that we use to determine the amount of the outlier set aside. Moreover, the claims we used for the simulation are available to the public. Indeed, the commenters perform many different types of analyses and often comment in extreme detail based on their analyses of the claims data and our description of the methodology we use to calculate the median costs on which the payment rates are based. Therefore, the public has every opportunity to perform a full and complete analysis of our outlier projections in preparation for commenting on the proposed outlier policy.

Comment: One commenter objected to the payment of 50 percent of the cost that exceeds the threshold and believed that CMS should pay 80 percent of the cost rather than 50 percent to ameliorate the level of losses that major teaching hospitals incur to provide complex outpatient services and to make outlier payment under the OPPS consistent with IPPS outlier payment.

Response: We disagree with the commenter that we should pay 80 percent of the cost that exceeds the threshold to ameliorate the level of losses that major teaching hospitals incur and to make outlier payment under the OPPS consistent with outlier payment under the IPPS. As we have explained, if we increase the percent of the excess over cost, in particular by 30 percent more than our proposed level of 50 percent, the threshold would need to be greatly increased to avoid paying more than the 1.0 percent we have allowed for outlier payments. Moreover, we do not believe that it is appropriate to have the same policy governing outlier payment under both the IPPS and the OPPS because of the inherent differences in the clinical cases and payment methodologies that characterize the two systems. The circumstances giving rise to outlier payments under each system are not found in the other system, and therefore applying the same outlier policies would likely be contrary to the reasons behind each policy.

After carefully considering the public comments received, we are finalizing our proposed policy for CY 2007 outlier payments. Recalculation of the fixed outlier threshold using this methodology results in a fixed-dollar outlier threshold of $1,825 and a multiple threshold of 1.75, based on an outlier estimate of 1.0 percent of payments projected to be made under the CY 2007 OPPS and outlier payments to be made at 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC rate. The following is an example of an outlier calculation for CY 2007 under our final policy with this modification. A hospital charges $26,000 for a procedure. The wage adjusted, and rural adjusted, if applicable, APC payment for the procedure is $3,000. The provider's overall CCR is 0.30. The estimated cost to the hospital is $7,800 (0.30 × $26,000). To determine whether this provider is eligible for outlier payments for this procedure, the provider must determine whether the cost for the service exceeds both the APC outlier cost threshold (1.75 × APC payment) and the fixed-dollar threshold ($1,825 + APC payment). In this example, the provider meets both criteria:

(1) $7,800 exceeds $5,250 (1.75 × $3,000).

(2) $7,800 exceeds $4,825 ($3,000 + $1,825).

To calculate the outlier payment, which is 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC rate, subtract $5,250 (1.75 × $3,000) from $7,800 (resulting in $2,550). The provider is eligible for 50 percent of the difference, in this case $1,275 ($2,550/2). The formula is (cost − (1.75 × APC payment rate))/2.

H. Calculation of the OPPS National Unadjusted Medicare Payment

The basic methodology for determining prospective payment rates for OPD services under the OPPS is set forth in existing regulations at § 419.31 and § 419.32. The payment rate for services and procedures for which payment is made under the OPPS is the product of the conversion factor calculated in accordance with section II.C. of this 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 payment under the OPPS has been assigned in Addendum B to this final rule with comment period (Addendum B is provided as a convenience for readers) was calculated by multiplying the final CY 2007 scaled

weight for the APC by the final CY 2007 conversion factor.

However, to determine the payment that will be made in a calendar year under the OPPS to a specific hospital for an APC for a service that has a status indicator of ''S,'' ''T,'' ''V,'' or ''X'' in a circumstance in which the multiple procedure discount does not apply, we take the following steps:

Step 1. Calculate 60 percent (the labor-related portion) of the national unadjusted payment rate. Since the initial implementation of the OPPS, we have used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. (Refer 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.)

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 2007 under the IPPS, reclassifications through the Medicare Classification Geographic Review Board, section 1866(d)(8)(B) ''Lugar'' hospitals, and section 401 of Pub. L. 108–173, and the reclassifications of hospitals under the one-time appeals process under section 508 of Pub. L. 108–173. 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 2007 IPPS payment rates and finalized in the IPPS notice published in the **Federal Register** on October 11, 2006 (71 FR 59886). These finalized FY 2007 IPPS wage indices, which are effective October 1, 2007, have been adjusted 100 percent for differences in occupational mix. As is our practice, we adopt changes made to the FY 2007 IPPS wage index values after they have been finalized.

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 contains the qualifying counties and the finalized wage index increase developed for the FY 2007 IPPS (71 FR 59886). This step is to be followed only if the hospital has chosen not to accept reclassification under Step 2 above.

Step 4. Multiply the applicable wage index determined under Steps 2 and 3 by the amount determined under Step 1 that represents the labor-related portion of the national unadjusted payment rate.

Step 5. Calculate 40 percent (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product of Step 4. The result is the wage index adjusted payment rate for the relevant wage index area.

Step 6. If a provider is a SCH, as defined in § 412.92, and located in a rural area, as defined in § 412.63(b), or is treated as being located in a rural area under § 412.103 of the Act, multiply the wage index adjusted payment rate by 1.071 to calculate the total payment.

We did not receive any public comments on our proposed methodology for calculating the national unadjusted Medicare payment amount for CY 2007. Therefore, we are finalizing our proposed methodology for CY 2007 without modification.

I. Beneficiary Copayments for CY 2007

1. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed specified percentages. For all services paid under the OPPS in CY 2007, and in calendar years thereafter, the specified percentage is 40 percent of the APC payment rate (section 1833(t)(8)(C)(ii)(V) of the Act). Section 1833(t)(3)(B)(ii) of the Act provides that, for a covered OPD service (or group of such services) furnished in a year, the national unadjusted coinsurance amount cannot be less than 20 percent of the OPD fee schedule amount.

Sections 1834(d) (2) and (d)(3) of the Act further require Medicare to pay the lesser of the ASC or OPPS payment rate for screening flexible sigmoidoscopies and screening colonoscopies, with coinsurance equal to 25 percent of the payment amount. We have applied the 25-percent coinsurance to all of these services since the beginning of the OPPS. Medicare does not make payment to ASCs for screening sigmoidoscopies so there is no payment comparison to be made for those services. However, 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 exceed the ASC payment of $446 for these procedures. Therefore, for CY 2007, the OPPS payment rates for HCPCS codes G0105 and G0121 that describe screening colonoscopies will be set to equal the CY 2007 ASC rate of $446 for these services.

2. Copayment for CY 2007

For CY 2007, we proposed to determine copayment amounts for new and revised APCs using the same methodology that we implemented for CY 2004. (Refer to the November 7, 2003 OPPS final rule with comment period, 68 FR 63458.) These unadjusted copayment amounts for services payable under the OPPS that will be effective January 1, 2007, are shown in Addendum A and Addendum B of this final rule with comment period.

3. Calculation of an Adjusted Copayment Amount for an APC Group for CY 2007

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 $30.21.

Step 2. Calculate the wage adjusted payment rate for the APC, for the provider in question, as indicated in section II.H. of this preamble. Calculate the rural adjustment for eligible providers as indicated in section I.H. of this preamble.

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 unadjusted copayments for services payable under the OPPS that will be effective January 1, 2007, are shown in Addendum A and Addendum B of this final rule with comment period.

We did not receive any public comments concerning our methodology for calculating the beneficiary unadjusted copayment amount. Therefore, we are finalizing our proposed methodology for CY 2007 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 Second and Third Quarterly OPPS Updates for CY 2006

During the second and third quarters of CY 2006, we created a total of four new Level II HCPCS codes, specifically C9227, C9228, C9229, and C9230 that were not addressed in the November 10, 2005 final rule with comment period that updated the CY 2006 OPPS. We designated the payment status of these codes and added them either through the April update (Transmittal 896, dated March 24, 2006) or the July update of the CY 2006 OPPS (Transmittal 970, dated May 30, 2006). In the CY 2007 OPPS proposed rule, we also solicited public comments on the status indicators and APC assignments of these codes, which were listed in Table 5 of that proposed rule (71 FR 49548), and now appear in Table 5 of this final rule with comment period. Because of the timing of the proposed rule, the codes implemented in the July 2006 OPPS update were not included in Addendum B of that proposed rule, while those codes based upon the April 2006 OPPS update were included in Addendum B. In the CY 2007 OPPS proposed rule, we proposed to assign the new HCPCS codes for CY 2007 to the appropriate APCs and incorporate them into our final rule with comment period for CY 2007, which is consistent with our annual APC updating policy.

We did not receive any public comments on the APC assignments and status indicators designated for C9227, C9228, C9229, or C9230 that were implemented in either April 2006 or July 2006. However, for CY 2007, the National HCPCS Panel created permanent J-codes for each of these drugs. Consistent with our general policy of using permanent HCPCS codes if appropriate rather than C-codes for the reporting of drugs under the OPPS in order to streamline coding, we are showing the J-codes in Table 5 that replaced the C-codes, effective January 1, 2007. C9227 is replaced with J2248 (Injection, micafungin sodium, 1 mg); C9228 with J3243 (Injection, tigecycline, 1 mg); C9229 with J1740 (Injection, ibandronate sodium, 1 mg); and C9230 with J0129 (Injection, abatacept, 10 mg). The J-codes describe the same drugs and the same dosages as the C-codes that will be deleted December 31, 2006. We note that C-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. Because the four new J-codes describe the same drugs and the same dosages that are currently designated by C9227, C9228, C9229, and C9230 and all four of these drugs will continue with pass-through status in CY 2007, we are assigning the J-codes to the same APCs and status indicators as their predecessor C-codes, as shown in Table 5. That is, J2248 will be assigned to the same APC and status indicator as C9227; J3243 to APC 9228; J1740 to APC 9229; and J0129 to APC 9230. Because we received no public comments on the APC and status indicator assignments for the new HCPCS codes that were implemented in April or July 2006, we are adopting as final without modification, our proposal to assign their replacement HCPCS J-codes to the appropriate APCs, as shown in Addendum B of this final rule with comment period.

TABLE 5.—NEW HCPCS CODES IMPLEMENTED IN APRIL OR JULY 2006

New HCPCS J-Code effective January 1, 2007	HCPCS C-Code	Description	Assigned status indicator	Assigned APC
J2248	C9227	Injection, micafungin sodium, per 1 mg	G	9227
J3243	C9228	Injection, tigecycline, per 1 mg	G	9228
J1740	C9229	Injection, ibandronate sodium, per 1 mg	G	9229
J0129	C9230	Injection, abatacept, per 10 mg	G	9230

2. Treatment of New CY 2007 Category I and III CPT Codes and Level II HCPCS Codes

As has been our practice in the past, we implement new Category I and III CPT codes and new Level II HCPCS codes, which are released in the summer through the fall of each year for annual updating, effective January 1, in the final rule updating the OPPS for the following calendar year. These codes are flagged with comment indicator ''NI'' in Addendum B of the OPPS final rule to indicate that we are assigning them an interim payment status which is subject to public comment following publication of the final rule that implements the annual OPPS update. (See the discussion immediately below concerning our modified policy for implementing new Category I and III mid-year CPT codes.) In our CY 2007 OPPS proposed rule, we proposed to continue this recognition and process for CY 2007. Therefore, new Category I and III CPT codes and new Level II HCPCS codes, effective January 1, 2007, are listed in Addendum B of 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'' are open to public comment. As indicated in the CY 2007 OPPS proposed rule, we will respond to all comments received concerning these codes in a subsequent final rule for the next calendar year's OPPS update.

We received some comments to the CY 2007 proposed rule regarding individual new HCPCS codes that commenters expected to be implemented for the first time in the CY 2007 OPPS. We could not discuss APC and/or status indictor assignments for new CY 2007 HCPCS codes in the proposed rule 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 2007 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, 2006, for implementation January 1, 2007, 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.

Two new G-codes for CY 2007 that are assigned comment indicator ''NI'' in this final rule with comment period were developed to enable clinicians and facilities to specifically report transluminal balloon angioplasty to existing arteriovenous fistulas or prosthetic grafts for hemodialysis access. Currently, there are no CPT or alphanumeric HCPCS codes on the ASC list that would provide payment to ASCs for providing this service to Medicare patients with failing or stenotic hemodialysis access fistulas or grafts. There are no CPT codes that are specific to this particular service. Therefore, we are creating two Level II HCPCS G-codes for implementation in CY 2007: (1) G0392 (Transluminal balloon angioplasty, percutaneous, hemodialysis access fistula or graft; arterial) and (2) G0393 (Transluminal balloon angioplasty, percutaneous, hemodialysis access fistula or graft; venous). We will provide payment for these G-codes at the same OPPS rates as for CPT codes 35475 (Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel) and 35476 (Transluminal balloon angioplasty, percutaneous; venous) through APC 0081 (Non-Coronary Angioplasty or Atherectomy), with a CY 2007 final median cost of $2,450.64. We will also assign both G-codes to payment group 9 for ASC payment in CY 2007. The G-codes will be used by hospital outpatient departments and ASCs to report transluminal balloon angioplasty of hemodialysis access fistulas or grafts in these settings.

Beginning in CY 2007, CPT codes 35475 and 35476 should not be reported for patients undergoing percutaneous transluminal balloon angioplasty of hemodialysis access fistulas or grafts. Both CPT codes will remain active to report all other clinical services that would be described by these codes.

We did not receive any public comments on our proposal to assign a comment indicator of ''NI'' in Addendum B of the OPPS final rule to the new codes that are open to public comment. Therefore, we are finalizing our proposed treatment of new CY 2007 Category I and III CPT codes, as well as the Level II HCPCS codes, without modification.

3. Treatment of New Mid-Year 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. (In addition, the AMA issues mid-year Category I CPT codes for vaccines for which FDA approval is imminent, to ensure timely availability of a code.) The AMA establishes these codes to allow collection of data specific to the service described by the code, as these services could otherwise only be reported using a Category I CPT unlisted code. The AMA releases Category III CPT codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January. Prior to CY 2006, we treated new Category III CPT codes implemented in July of the previous year or January of the OPPS update year in the same manner that new Category I CPT codes and new Level II HCPCS codes implemented in January of the OPPS update year are treated; that is, we provided APC or status indicator assignments or both in the final rule updating the OPPS for the following calendar year. New Category I and Category III CPT codes, as well as new Level II HCPCS codes, were flagged with comment indicator ''NI'' in Addendum B of the final rule to indicate that we assigned them an interim payment status which was subject to public comment following publication of the final rule that implemented the annual OPPS update.

As discussed in the CY 2006 OPPS final rule with comment period (70 FR 68567), we modified our process for implementing the Category III codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between Category III CPT codes and some of the C-codes that are payable under the OPPS and were created by us in response to applications for new technology services. Therefore, beginning on July 1, 2006, we implemented in the OPPS seven Category III CPT codes that the AMA released in January 2006 for implementation in July 2006. These codes were shown in Table 6 of the CY 2007 OPPS proposed rule (71 FR 49549). They were not included in Addendum B of that rule, which was based upon the April 2006 OPPS update. In the CY 2007 OPPS proposed rule, we solicited public comments on the status indicators and, if applicable, the APC assignments of these services. We proposed in the CY 2007 OPPS proposed rule to finalize the assignments of these Category III CPT codes implemented in July 2006 in this final rule with comment period.

As indicated in the CY 2007 OPPS proposed rule (71 FR 49549), some of the new Category III CPT codes describe services that we have determined to be similar in clinical characteristics and resource use to HCPCS codes in an existing APC. 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. We expect that we will have received applications for new technology status for some of the services described by new Category III CPT codes, which may assist us in determining appropriate APC assignments. If the AMA establishes a Category III CPT code for a service for which an application has been submitted to CMS for new technology status, CMS may not have to issue a temporary Level II HCPCS code to describe the service, as has often been the case in the past when Category III CPT codes were only recognized by the OPPS on an annual basis.

Therefore, for CY 2007, we proposed to include in Addendum B of this final rule with comment period, the new Category III CPT codes and the new Category I CPT codes for vaccines released in January 2006 for implementation on July 1, 2006 (through the OPPS quarterly update process) and the Category III and vaccine Category I CPT codes released in July 2006 for implementation on January 1, 2007. However, only those new Category III CPT codes and the new vaccine codes implemented effective January 1, 2007, are flagged with comment indicator ''NI'' in Addendum B of this final rule with comment period to indicate that we have assigned them an interim payment status which is subject to public comment. As discussed earlier, Category III CPT codes implemented in July 2006, which appear in Table 6, were subject to comment through the CY 2007 OPPS proposed rule and their statuses are finalized in this final rule with comment period.

TABLE 6.—CATEGORY III CPT CODES IMPLEMENTED IN JULY 2006

CPT code	Long descriptor	Proposed CY 2007 status indicator	Proposed CY 2007 APC	Final CY 2007 status indicator	Final CY 2007 APC
0155T	Laparoscopy, surgical, implantation or replacement of gastric stimulation electrodes, lesser curvature (ie, morbid obesity).	T	0130	T	0130
0156T	Laparoscopy, surgical, revision or removal of gastric stimulation electrodes, lesser curvature (ie, morbid obesity).	T	0130	T	0130
0157T	Laparotomy, implantation or replacement of gastric stimulation electrodes, lesser curvature (ie, morbid obesity).	C.			
0158T	Laparotomy, revision or removal of gastric stimulation electrodes, lesser curvature (ie, morbid obesity).	C.			
0159T	Computer-aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI.	N.			
0160T	Therapeutic repetitive transcranial magnetic stimulation treatment planning.	X	0340	S	0216
0161T	Therapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session.	X	0340	S	0216

We received several public comments on the proposed APC assignments for Category III CPT codes 0159T, 0160T, and 0161T. A summary of the comments and our responses follows:

Comment: One commenter requested that CMS assign CPT code 0159T to an APC that is separately payable under the OPPS because there are additional resources associated with performing a breast MRI with computer-aided detection (CAD), which is a significant advancement in early detection and treatment for possible breast cancers. The commenter indicated that the procedure described by CPT code 0159T is similar to the CAD procedures that are associated with mammography, which CMS previously recognized and allowed separate payment. The commenter urged CMS to pay separately for CPT code 0159T, if not through the hospital OPPS, then by a separate payment under the MFPS, similar to other hospital-based mammography services.

Response: The CAD procedures that the commenter makes reference to are described by CPT codes 77051 (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; diagnostic mammography) and 77052 (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; screening mammography). These are both paid off the MPFS, according to specific provisions in the law for screening and diagnostic mammography that specify that such services, when performed in the hospital outpatient setting, are paid according to the MPFS. Other hospital outpatient imaging services, such as CPT code 0159T, are paid under the OPPS. We have assigned this service packaged payment status under the OPPS for CY 2007, because we believe that it is a minor ancillary service that would always be provided in association with another separately payable service (mostly likely an MRI), into which its payment would be appropriately packaged. As a prospective payment system, the OPPS makes payment for groups of services that are clinically coherent with similar resource utilization and packages payment for many items, supplies, and minor associated services into the payment for the primary service. Our final CY 2007 treatment of CPT code 0159T is the same as our final CY 2007 packaged status for two chest x-ray CAD services, CPT code 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 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) that is discussed further in section II.A.4. of this final rule with comment period.

Comment: One commenter requested that CMS not map Category III CPT codes 0160T and 0161T to APC 0340 (Minor Ancillary Procedures) because the technology associated with these procedures is currently under review by the FDA and approval is not expected until January 2007. The commenter indicated that these codes describe therapeutic transcranial magnetic stimulation (TMS) therapy, which is used for the treatment of major depression. The commenter further indicated that TMS therapy represents a procedure that involves a complex brain mapping and stimulation treatment process and requires the use of specific equipment and a specialized operator skill set. As such, the commenter concluded that TMS therapy represents a procedure whose hospital resources are significantly greater than reflected by the proposed payment rate for APC 0340 of about $38. The commenter believed that mapping Category III CPT codes 0160T and 0161T to APC 0340, or to any other APCs, is inappropriate at this time because the costs of these services are currently not known. The commenter cautioned that assigning these codes to specific APCs would be arbitrary and could significantly overcompensate or undercompensate providers because there are no cost data available to appropriately map codes 0160T and 0161T at this time. The commenter acknowledged that not assigning the two codes to specific APCs may result in no payment for TMS therapy performed in hospital outpatient settings for CY 2007 and likely limit access for some patients. However, the commenter indicated that it plans to work with the APC Panel in CY 2007 to determine the appropriate mapping for the two codes to ensure access for appropriate patients.

Other commenters noted that there was a related Category III code, CPT code 0018T (Delivery of high power,

focal magnetic pulses for direct stimulation to cortical neurons) that was created prior to the full maturation of the therapeutic TMS procedure and related technology. The commenters noted differences between CPT code 0018T and the two new Category III CPT codes, including its lack of incorporation of the treatment planning function, its failure to specify repetitive in the descriptor, and its lack of description of therapeutic treatment delivery. They believed that the historical APC assignment of code 0018T to APC 0215 (Level I Nerve and Muscle Tests) was inappropriate, although one commenter stated that it was not involved in determining that mapping. The commenters pointed out that there are also two Category I CPT codes that incorporate TMS for diagnostic purposes, including CPT code 95928 (Central motor evoked potential study (transcranial motor stimulation); upper limbs) and CPT code 95929 (Central motor evoked potential study (transcranial motor simulation); lower limbs). The commenters added that both of these codes were proposed for assignment to APC 0218 (Level II Nerve and Muscle Tests) for CY 2007 with a payment rate of about $74.

Response: We appreciate the commenters' suggestion and background information. However, because the CPT code descriptors are general in nature and not specific to a particular product, our policy has been to assign an APC to each Category III CPT code if we believe that the procedure, if covered, would be appropriate for separate payment in the OPPS.

In addition, as indicated in the CY 2006 OPPS final rule (70 FR 68567), some of the new Category III CPT codes may describe services that our medical advisors determine to be similar in clinical characteristics and resource use to HCPCS codes in an existing APC. In such instances, we may assign the Category III CPT code to the appropriate clinical APC. Other Category III CPT codes may describe services that our medical advisors determine 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 the case of CPT codes 0160T and 0161T, we believe the services described by these active CPT codes would be appropriately separately paid under the OPPS if they are covered. We do not believe the technology used to provide these services is so new that their assignment to New Technology APCs would be appropriate. Although our final determination regarding these two codes is to provide assignments to specific APCs with payment rates for CY 2007 as described below, this decision does not represent a determination that the services described by Category III CPT codes 0160T and 0161T are reasonable and necessary. Medicare contractors determine whether the services described by all HCPCS codes with status indicators reflecting their potential for payment under the OPPS, including Category III CPT codes, meet all the program requirements for coverage in different clinical circumstances.

The Internet listing of Category III code changes on the AMA Web site includes a parenthetical note that CPT Code 0018T has been deleted as of July 1, 2006, the same date new CPT codes 0160T and 0161T were first implemented. The note also indicates that, to report the procedure previously described by 0018T, one should see CPT codes 0160T and 0161T. CPT Changes, an Insider's View for CY 2002 when 0018T was created, describes the use of CPT code 0018T for treatment of a patient with a long history of depression, incorporating planning and therapeutic treatment delivery in the description of the procedure. In general, that outline of the service described by CPT code 0018T closely parallels the clinical vignettes for CPT codes 0160T and 0161T that were provided to us in a public comment. Therefore, we do not agree with the commenters that our historical claims for 0018T must be instances of miscoding or the use of TMS for diagnostic purposes. While we had no claims for CPT code 0018T for CY 2005, we do have claims data for this service from CYs 2002 through 2004, although there were fewer than 15 total claims for each of those years. The procedure was assigned to APC 0215 (Level I Nerve and Muscle Tests) with a payment rate of about $35 throughout that time period, with no specific comments from the public on this assignment during the OPPS proposed updates for those years.

We understand that the hospital resource costs of specific technologies may change over time as those technologies evolve. In reviewing the clinical aspects of CPT codes 0160T and 0161T, in the context of related codes and our historical OPPS claims data for CPT code 0018T and other services, we agree with the commenter that APC 0340 is not the most appropriate assignment for CPT codes 0160T and 0161T for CY 2007. The commenter provided no specific suggestions regarding the APC assignments for these codes. As discussed earlier, CPT codes describe general services that are not specific to one product, and we believe it is most appropriate to provide APC assignments for all new HCPCS codes that would be appropriately separately paid under the OPPS if they were covered. This approach helps ensure access to services described by these codes for Medicare beneficiaries in the hospital outpatient department and allows us to initiate collection of hospital cost information as soon as possible. The commenter indicated that TMS may be safely performed in the hospital outpatient setting. We do not see any reason to provide the Category III CPT codes for TMS nonpayable status indicators in the OPPS for CY 2007, when the codes were implemented in July 2006 and there are no alternative HCPCS codes to describe the services. However, we believe that APC 0216 (Level III Nerve and Muscle Tests) best represents both the clinical and resource homogeneity of CPT codes 0160T and 0161T for CY 2007, considering all of the information available to us. We note that this APC has a status indicator of ''S,'' so that under the occasional circumstance of two treatments in one day for a single patient as described by a commenter, payment would not be reduced for the second service. We will reevaluate these assignments for future OPPS updates as additional information becomes available to us, including updated claims data.

After carefully considering the comments received, we are finalizing our general proposal for the treatment of new mid-year CPT codes, with modification only to the CY 2007 APC assignments for Category III CPT codes 0160T and 0161T as described above and indicated in Table 6.

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 the Ambulatory Payment Classification Groups (or 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 surgical, diagnostic, and partial hospitalization 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 each procedure or service within an APC group the costs associated with those items or services that are directly related and integral to performing a procedure or furnishing a service. 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 preamble); and (7) incidental services such as venipuncture. Our proposed packaging methodology is discussed in section II.A. of this preamble.

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the APC group to which the service 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 we are proposing it to be the middle level clinic visit APC (that is, where the Level III 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 outpatient hospital setting. See section II.A.3. of this preamble for a complete discussion of the reasons for choosing APC 0606 as the basis for scaling the APC relative weights.

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 CY 2007 OPPS and our responses to them are discussed in the relevant specific sections throughout this preamble).

Finally, as discussed earlier, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (referred to as the ''2 times rule''). We use the median cost of the item or service in implementing this provision. The statute authorizes the Secretary to make exceptions to the 2 times rule in unusual cases, such as low-volume items and services.

2. Application of the 2 Times Rule

In accordance with section 1833(t)(2) of the Act and § 419.31 of the regulations, we annually review the items and services within an APC group to determine, with respect to comparability of the use of resources, if the median of the highest cost item or service within an APC group is more than 2 times greater than the median of the lowest cost item or service within that same group (''2 times rule''). We make exceptions to this limit on the variation of costs within each APC group in unusual cases such as low-volume items and services.

During the APC Panel's March 2006 meeting, we presented median cost and utilization data for services furnished during the period of January 1, 2005, through September 30, 2005, 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 2007 are contained principally in sections III.C. and III.D. of this preamble.

In addition to the assignment of specific services to APCs which 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 of the CY 2007 proposed rule. In these cases, to eliminate a 2 times violation, we reassigned the codes to APCs that contained services that were similar with regard to both resource use and clinical homogeneity. 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 changed 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 our CY 2007 proposed policies.

Addendum B of the CY 2007 OPPS 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 2006 Addendum B update. Addendum B of this final rule with comment period identifies with the ''CH'' comment indicator the final CY 2007 changes compared to the codes'' status as reflected in the October 2006 Addendum B update.

We received many public comments regarding the proposed APC and status indicator assignments for CY 2007 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 2007 related to each HCPCS code is noted in those sections.

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. At the time of the proposed rule, taking into account the APC changes that we proposed for CY 2007 based on the APC Panel recommendations discussed mainly in sections III.C. and III.D. of the preamble, the proposed changes to status indicators and APC assignments as identified in Addendum B of the CY 2007 OPPS proposed rule, and the use of CY 2005 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, refer to the April 7, 2000 OPPS final rule with comment period (65 FR 18457).

Table 7 published in the CY 2007 OPPS proposed rule (71 FR 49551)

listed the APCs that we proposed to exempt from the 2 times rule 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 2007. The median costs for hospital outpatient services for these and all other APCs which were used in development of the proposed rule can be found on the CMS Web site: *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. We received a number of specific comments about some of the procedures assigned to APCs that we proposed to make exempt from the 2 times rule for CY 2007. Those discussions are elsewhere in the preamble, in sections related to the types of procedures that were the subjects of the comments.

For the proposed rule, the listed exceptions to the 2 times rule were based on data from January 1, 2005, through September 30, 2005. For this final rule with comment period, we used data from January 1, 2005 through December 1, 2005. Thus, after responding to all of the comments on the proposed rule and making changes to APC assignments based on those comments, we analyzed the full CY 2005 data to identify APCs with 2 times rule violations.

Based on those final data, we found that there were 37 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 2007. The final revised list of APCs that are exceptions to the 2 times rule for CY 2007 is displayed in Table 7 below. After careful review of all public comments on the proposed rule and the claims data for the full year, CY 2005, available to us for this final rule with comment period, we are finalizing the list of APCs exempted from the two times rule as displayed in Table 7 below.

TABLE 7.—APC EXCEPTIONS TO THE 2 TIMES RULE FOR CY 2007

APC	APC description
0007	Level II Incision & Drainage.
0010	Level I Destruction of Lesion.
0019	Level I Excision/ Biopsy.
0024	Level I Skin Repair.
0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.
0043	Closed Treatment Fracture Finger/Toe/Trunk.
0058	Level I Strapping and Cast Application.
0060	Manipulation Therapy.
0081	Non-Coronary Angioplasty or Atherectomy.
0093	Vascular Reconstruction/Fistula Repair without Device.
0105	Revision/Removal of Pacemakers, AICD, or Vascular.
0111	Blood Product Exchange.
0112	Apheresis, Photopheresis, and Plasmapheresis.
0203	Level IV Nerve Injections.
0204	Level I Nerve Injections.
0215	Level I Nerve and Muscle Tests.
0245	Level I Cataract Procedures without IOL Insert.
0251	Level I ENT Procedures.
0252	Level II ENT Procedures.
0274	Myelography.
0303	Treatment Device Construction.
0307	Myocardial Positron Emission Tomography (PET) Imaging.
0312	Radioelement Applications.
0323	Extended Individual Psychotherapy.
0330	Dental Procedures.
0340	Minor Ancillary Procedures.
0367	Level I Pulmonary Test.
0381	Single Allergy Tests.
0397	Vascular Imaging.
0409	Red Blood Cell Tests.
0418	Insertion of Left Ventricular Pacing Elect.
0432	Health and Behavior Services.
0437	Level II Drug Administration.
0604	Level I Clinic Visits.
0621	Level I Vascular Access Procedures.
0664	Level I Proton Beam Radiation Therapy.
0676	Thrombolysis and Thrombectomy.

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. More recently, at its August 2006 meeting the APC Panel recommended that when CMS assigns a new service to a New Technology APC, the service should remain there for at

least 2 years until sufficient claims data are collected. In general, services remain in New Technology APCs for at least 2 years consistent with the APC Panel's recommendation. However, we do not fully accept the APC Panel's recommendation. While we agree with the APC Panel that we need sufficient claims data to move services from New Technology APCs to clinical APCs, we also continue to believe that it occasionally may be appropriate to move a service from a New Technology APC to a clinical APC in less than 2 years if the data are robust and there is an appropriate clinical APC for its assignment.

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 intervals of $100, and from $2,000 through $6,000 in intervals of $500. These intervals, 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.

Every year we receive many requests for higher payment amounts for specific procedures under the OPPS because they require the use of expensive equipment. We are taking this opportunity to reiterate our response in general to the issue of hospitals' capital expenditures as they relate to the OPPS and Medicare.

Under the OPPS, one of our goals is to make payments that are appropriate for the services that are necessary for the treatment of Medicare beneficiaries. The OPPS, like other Medicare payment systems, is budget neutral and so, although we do not pay full hospital costs for procedures, we believe that our payment rates generally reflect the costs that are associated with providing care to Medicare beneficiaries in cost-efficient settings. Further, we believe that our rates are adequate to assure access to services for most beneficiaries.

For many emerging technologies there is a transitional period during which utilization may be low, often because providers are first learning about the techniques and their clinical utility. Quite often, the requests for higher payment amounts are for new procedures in that transitional phase. These requests, and their accompanying estimates for expected Medicare beneficiary or total patient utilization, often reflect very low rates of patient use, resulting in high per use costs for which requesters believe Medicare should make full payment. Medicare does not, and we believe should not, assume responsibility for more than its share of the costs of procedures based on Medicare beneficiary projected utilization and does not set its payment rates based on initial projections of low utilization for services that require expensive capital equipment. For the OPPS, we rely on hospitals to make informed business decisions regarding the acquisition of high cost 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.

We note that in a budget neutral environment, payments may not fully cover hospitals' costs, including those for the purchase and maintenance of capital equipment. We rely on providers to make their decisions regarding the acquisition of high cost equipment with the understanding that the Medicare program must be careful to establish its initial payment rates for new services that lack hospital claims data based on realistic utilization projections for all such services delivered in cost-efficient hospital outpatient settings. As the OPPS acquires claims data regarding hospital costs associated with new procedures, we will regularly examine the claims data and any available new information regarding the clinical aspects of new procedures to confirm that our OPPS payments remain appropriate for procedures as they transition into mainstream medical practice.

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 bands, reassign the procedure or service to a different New Technology APC that most appropriately reflects its cost.

The procedures presented below represent services assigned to New Technology APCs for CY 2006 for which at the time of developing the proposed rule we believed we had sufficient data to reassign them to clinically appropriate APCs for CY 2007.

a. Nonmyocardial Positron Emission Tomography (PET) Scans (APC 0308)

Positron emission tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the human body. PET serves an important role in the clinical care of many Medicare beneficiaries. We recognize that PET is a useful technology in many instances and want to ensure that the technology remains available to Medicare beneficiaries when medically necessary. Since August 2000, nonmyocardial PET procedures have been assigned to a New Technology APC in the OPPS. As a result of our collection of 5 full years of hospital claims data, in the CY 2007 proposed rule (71 FR 49566 through 49567) we indicated that we believed that we had sufficient data to assign nonmyocardial PET scans to a clinically appropriate APC for CY 2007. We assign a service to a New Technology APC only when we do not have adequate claims data upon which to determine the median cost of performing the procedure, and we expect that the service's clinical or resource characteristics will differ from all other procedures already assigned to clinical APCs. Each New Technology APC represents a particular cost band (for example, $1,400–1,500), and we assign procedures to these APCs based on our analysis of the costs of the procedures. Payment for items assigned to a New Technology APC is the midpoint of the band (for example, $1,450). We move a service from a New Technology APC to a clinical APC when we have adequate claims data upon which to base its future payment rate. As noted in the CY 2007 proposed rule, in the case of nonmyocardial PET services, we believed that we had sufficient data to assign them to a clinically appropriate APC.

For CY 2006, we maintained the APC payment methodologies from CY 2005 for nonmyocardial PET services. According to that methodology, payment was based on a 50/50 blend of their median cost based on CY 2003 claims data and the payment rate of the CY 2004 New Technology APC to which they were assigned. Therefore, nonmyocardial PET scans were assigned to New Technology APC 1513 (New Technology—Level XIII ($1100–$1200)) for a blended payment rate of $1,150.

For CY 2007, we proposed the assignment of nonmyocardial PET procedures to a clinically appropriate APC as we now have several years of robust and stable claims data upon which to determine the median cost of

performing these procedures. Based on analysis of the Medicare claims data, the median costs for nonmyocardial PET scans have ranged between approximately $852 and $924 for claims submitted from CY 2002 through CY 2005. However, our payment rates have been significantly higher than the median costs throughout this same time period. We have observed significant growth in the number of nonmyocardial PET scans performed on Medicare beneficiaries, from about 48,000 in CY 2002, to 68,000 in CY 2003, and to 121,000 in CY 2004, the year when we first reduced the OPPS nonmyocardial PET scan payment rates from $1,450 to $1,150. For the CY 2007 OPPS proposed rule, we had about 45,000 single PET claims from CY 2005, yielding a stable median cost for PET procedures of about $867. Although the CY 2005 claims data were not complete when we published the CY 2007 OPPS proposed rule, we noted that the apparent decline in numbers of claims for nonmyocardial PET scans alone in the CY 2005 claims data was likely related to the large number of claims for PET/CT scans observed in CY 2005, when codes for that combined service were first available for billing. In fact, the total number of PET scans provided to Medicare beneficiaries in CY 2005, defined as PET scans and PET/CT scans, continued to climb to almost 128,000 based upon the CY 2005 claims data available for the proposed rule, in comparison to final claims for CY 2004 of approximately 121,000 for PET scans.

Therefore, we proposed to assign nonmyocardial PET scans, in particular, CPT codes 78608, 78811, 78812, and 78813, to new APC 0308 (Nonmyocardial Positron Emission Tomography (PET) Imaging) with a median cost of $865.30 for CY 2007. We noted we were confident that in the face of our stable median costs for nonmyocardial PET scans over the past 4 years, their additional 2-year period of receiving New Technology APC payments at the blended rate of $1,150 for CY 2005 and CY 2006 as we transitioned the services to a clinical APC would ensure continued availability of this technology now that its services would be paid through a clinical APC in CY 2007, like most other OPPS services.

Comment: A few commenters representing rural providers stated that they would no longer be able to provide PET scans to their patients who are Medicare beneficiaries if Medicare lowered its payment for the services. They stated that, because they relied on more costly, mobile units, the proposed payment amount would not be adequate for them to be able to continue to provide the service in their communities. A number of other commenters opposed proposed payment reductions for PET imaging services that they believed were essential to ensuring appropriate treatment of patients with cancer and providing necessary patient access.

Response: We are sensitive to the obstacles that rural providers face in trying to provide some services to Medicare beneficiaries. However, we have years of stable and consistent data that indicate that Medicare will now be paying more accurately for the scans at the proposed clinical APC rate. We believe this rate will ensure the necessary patient access to PET services.

Comment: Several commenters requested that, instead of assigning CPT code 78608 (Brain imaging, positron emission tomography (PET); metabolic evaluation), to APC 0308 with the CPT codes for tumor PET scans, CMS should assign this single code to a separate clinical APC. The commenters had no objections to assignment of PET services to clinical APCs, with payment rates based on the APCs' median costs. The commenters believed that assignment of the CPT code for brain PET scans to its own APC would be more appropriate because the brain PET scans are not clinically homogenous with the other tumor PET scans assigned to APC 0308.

Response: The brain PET scan services have been assigned to the same New Technology APC with the same payment rate as the other nonmyocardial PET services for a number of years. The CY 2005 median cost for the brain PET CPT code of $886 is very similar to the median costs for the two tumor PET CPT codes of $873 and $762, indicating that all three of these related PET services require comparable hospital resources. 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 and two CPT codes in another APC. The OPPS is a prospective payment system that provides payment for groups of services that share clinical and resource use 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. Therefore, we are finalizing our proposal to assign CPT code 78608 to APC 0308, along with CPT codes 78811, 78812, and 78813.

After carefully considering the comments, we are adopting our proposal for CY 2007 without modification to provide payment for nonmyocardial PET scans through APC 0308.

b. PET/Computed Tomography (CT) Scans (APC 0308)

Since August 2000, we have 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 on the November 15, 2004 final rule with comment period (69 FR 65682) urged us to 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 that 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 CPT codes 78814, 78815, and 78816 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, we proposed the assignment of concurrent PET/CT scans, specifically CPT codes 78814, 78815, and 78816, to a clinically appropriate APC because we believed that we had adequate claims data from CY 2005 upon which to determine the median cost of performing these procedures. At the time of the proposed rule, based on our analysis of CY 2005 single claims, the median cost of PET/CT scans was $865 from almost 70,000 single claims. Comparison of the median cost of nonmyocardial PET procedures of $867 with the median cost of concurrent PET/CT scans demonstrated that the median costs of PET scans with or without

concurrent CT scans for attenuation correction and anatomical localization were about the same. This result was not unexpected because many newer PET scanners also had the capability of rapidly acquiring CT images for attenuation correction and anatomical localization, sometimes with simultaneous image acquisition.

To explore the possibility that the similarity in median costs for PET and PET/CT procedures could be related to different groups of hospitals billing the two types of PET services based on their available equipment, rather than the true comparability of hospital resources required for the two types of services, we analyzed claims from a subset of hospitals billing both PET and PET/CT scans in CY 2005. This analysis looked at 362 providers that billed a PET HCPCS code and a PET/CT CPT code at least one time each during CY 2005. The median cost from this subset of claims for nonmyocardial PET scans was $890, in comparison with $863 for the PET/CT scans. Thus, we observed the same close relationship between median costs of PET and PET/CT procedures from hospitals billing both sets of services as we did for all OPPS CY 2005 claims available for the proposed rule for these scans. We believed that our claims data accurately reflected the comparable hospital resources required to provide PET and PET/CT procedures, and the scans had obvious clinical similarity as well. Therefore, for CY 2007 we proposed to assign the CPT codes for PET/CT scans, along with the CPT codes for PET scans, to the same new APC 0308 (Nonmyocardial Positron Emission Tomography (PET) Imaging) with a proposed median cost of $865.30.

At its August 2006 meeting, the APC Panel recommended that CMS retain PET/CT scans in New Technology APC 1514 with a payment rate of $1,250 for CY 2007.

We note that we have been paying separately for fluorodeoxyglucose (FDG), the radiopharmaceutical described by HCPCS code A9552 (Fluorodeoxyglucose F–18 FDG, diagnostic, per study dose, up to 45 millicuries) that is commonly administered during nonmyocardial PET and PET/CT procedures. For CY 2007, we proposed to continue paying separately for FDG, according to the methodology described in section V. of the preamble of the CY 2007 proposed rule.

Comment: A number of commenters disagreed with the proposal to assign PET/CT services to APC 0308. Among the reasons provided by commenters that PET/CT services should not be assigned to APC 0308 were that: payment at the proposed level would not cover the costs of providing the services; the APC Panel recommended during its August 2006 meeting that CMS retain PET/CT services in New Technology APC 1514 for another year so that more CPT-coded claims upon which to base a decision about the appropriate APC assignment for the services would be available; PET/CT services are a clinically distinct technology from conventional PET procedures and should not be assigned to the same APC; PET/CT services are more costly to provide than are other nonmyocardial PET services and there must be a payment differential to recognize that; and a 30-percent payment decrease would result in decreased Medicare beneficiary access to the services. The commenters reported that the higher costs associated with PET/CT were due to requirements for specially-trained, licensed technicians, more costly capital equipment, and higher equipment maintenance costs.

Most commenters recommended that PET/CT should remain in its current New Technology APC 1514 with a payment rate of $1,250 for CY 2007. Some of the commenters believed that CMS' proposal to assign PET/CT scans to a clinical APC was premature because CMS did not have a full year of reliable cost data for PET/CT. They made that assertion because the CPT codes used to report the services were newly recognized by the OPPS in April 2005 and, therefore, only 9 months of claims data were available for the CY 2007 OPPS update. The commenters observed that if PET/CT scans were moved to a clinical APC for CY 2007, they would have been assigned to a New Technology APC for only 21 months, while the APC Panel recommended at its August 2006 meeting that services assigned to New Technology APCs should remain there for at least 2 years. Further, because hospitals often do not update their chargemasters more than once per year, the commenters believed that true hospital costs were not reflected in the CY 2005 data that CMS considered when developing its proposal for CY 2007.

One of the commenters provided limited hospital-level average cost data for PET and PET/CT scans, as well as a cost analysis model for PET/CT services. Those data covered the 6-month period of July through December and display average cost and charge data for two sets of hospitals, separated according to two different methods of reducing their charges to costs.

Response: We have carefully considered the APC Panel recommendation and all of the information provided in the comments received regarding the proposed APC assignment and payment amount for PET/CT scans for CY 2007. We remain confident that our CY 2005 data for conventional nonmyocardial PET services are accurate reflections of hospital costs for those services, in spite of the CY 2005 coding changes. Similarly, our review of the hospital data provided in one of the public comments shows that the average cost per hospital for PET/CT for one set of hospitals was $829 and for the other group was $912. We are encouraged that these mean costs are so similar to our median cost for the services, and these data serve to increase our confidence in the CY 2005 claims data.

However, we recognize that there are other factors to consider related to hospital charging practices for PET/CT services. For instance, prior to institution of the specific CPT codes for PET/CT scans, hospitals were reporting a diagnostic CT scan charge in addition to the appropriate G-code charge for the PET scan. Therefore, the transition to the new CPT codes was not a simple coding crosswalk for the PET/CT services because it required the hospital to change from reporting two charges for the service to only one charge that was to include the costs of the entire service. We are aware that making that adjustment may have been difficult for some hospitals.

After considering the information and opinions provided to us in the comments, particularly with respect to our data that are limited to 9 months of claims (although there are over 76,000 single claims from that time period), we are persuaded that there are valid reasons to assign PET/CT services to a different APC than the conventional PET services for CY 2007. We are convinced that, in this instance, we should 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 is warranted for CY 2007.

For these reasons, we are assigning PET/CT to a different APC than conventional PET services for CY 2007, based on our continued expectation of the appropriate relative cost difference between the two types of services. When we first recognized PET/CT CPT codes for payment in CY 2005, we established their payment rate at $100 more than the payment rate for PET scans. Although the commenters to the CY 2007 proposed rule did not provide specific information regarding an appropriate differential between

payments for PET and PET/CT scans, the commenters generally did not oppose our proposed payment for PET scans through a clinical APC with a payment rate of about $850. Historically, when both PET and PET/CT scans were assigned to New Technology APCs with a $100 payment difference for CYs 2005 and 2006, we received few public comments indicating that payment difference was inappropriate. Therefore, we are assigning PET/CT scans to New Technology APC 1511 (New Technology—Level XI ($900–$1,000)) with a payment of $950 for CY 2007 to maintain the approximately $100 difference between payments these services and nonmyocardial PET scans, which will be assigned to APC 0308 with a median cost of about $850 for CY 2007. In this way, the differential payment between conventional PET and PET/CT scans will be preserved at an appropriate level, the payment decrease for PET/CT procedures will be moderated as the services transition to payment based on their costs in a clinical APC, and CMS will be able to consider a full 12 months of CPT-coded claims prior to making the assignment of PET/CT scans to a clinical APC.

c. Stereotactic Radiosurgery (SRS) Treatment Delivery Services (APCs 0065, 0066, and 0067)

For the past several years, we have collected hospital costs associated with the planning and delivery of stereotactic radiosurgery services (hereafter referred to as SRS). As new technology emerged in the field of SRS, public commenters urged us 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. For CY 2004, based on comments received regarding the G-codes used for SRS, we made some modifications to the coding (68 FR 63431 and 63432). First, we received comments regarding the descriptors for HCPCS codes G0173 and G0251, indicating that these codes did not 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 created two new G-codes (G0339 and G0340) to describe complete and fractionated image-guided robotic linear accelerator-based SRS treatment. We placed HCPCS code G0339 in APC 1528 at a payment rate of $5,250, and HCPCS code G0340 in APC 1525 at a payment rate of $3,750. Second, we received comments on HCPCS code G0242 which requested that we modify the code descriptor to avoid confusion and misuse of the code, and also to appropriately describe treatment planning for both linear accelerator-based and Cobalt 60-based SRS treatments. In response, for CY 2004, we created HCPCS code G0338 to distinguish linear accelerator-based SRS treatment planning from Cobalt 60-based SRS treatment planning. We placed HCPCS code G0338 in APC 1516 at a payment rate of $1,450.

In CY 2005, there were no changes to the coding or New Technology APC payment rates for the SRS planning or treatment delivery codes from CY 2004. We stated in the CY 2005 OPPS final rule with comment period (69 FR 65711) that any SRS code changes would be premature without cost data to support a code restructuring. Therefore, we maintained HCPCS codes G0173, G0242, G0243, G0251, G0338, G0339, and G0340 in their respective New Technology APCs for CY 2005. We further stated that until we had completed an analysis of claims for these procedure codes, we would continue to maintain HCPCS codes G0173, G0242, G0243, G0251, G0338, G0339, and G0340 in their respective New Technology APCs for CY 2005 as we considered the adoption of CPT codes to describe all SRS procedures for CY 2006.

At its February 2005 meeting, the APC Panel discussed the clinical and resource cost similarities between planning for Cobalt 60-based and linear accelerator-based SRS. The APC Panel also discussed the use of CPT codes instead of specific G-codes to describe the services involved in SRS planning, noting the clinical similarities in radiation treatment planning regardless of the mode of treatment delivery. Given the APC Panel's deliberations about the possible need for CMS to separately track planning for SRS, the APC Panel eventually recommended that CMS create a single HCPCS code to encompass both Cobalt 60-based and linear accelerator-based SRS planning. Because we had no programmatic need to separately track SRS planning services, in the CY 2006 OPPS final rule with comment period (70 FR 68585), we discontinued HCPCS codes G0242 and G0338 for the reporting of charges for SRS planning and instructed hospitals to bill charges for SRS planning, regardless of the mode of treatment delivery, using all of the available CPT codes that most accurately reflect the services provided.

Furthermore, the APC Panel recommended that CMS make no changes to the coding or APC placement of SRS treatment delivery HCPCS codes G0173, G0243, G0251, G0339, and G0340 for CY 2006. In addition, presenters to the APC Panel described ongoing deliberations among interested professional societies around the descriptions and coding for SRS. The APC Panel and presenters suggested that CMS wait for the outcome of these deliberations before making any significant changes to SRS delivery coding or payment rates. As indicated in the CY 2007 OPPS proposed rule, we did not receive a report from participating professional societies as to the outcome of such deliberations prior to publishing that rule (71 FR 49554).

In response to comments for CY 2006 regarding the mature technology and stable median costs associated with Cobalt 60-based SRS treatment delivery described by HCPCS code G0243, we reassigned G0243 from a New Technology APC to new clinical APC 0127 (Stereotactic Radiosurgery), with a payment rate of $7,305 established based on the CY 2004 median cost of G0243. We made no changes for CY 2006 to the New Technology APC assignments of the other four SRS treatment codes, specifically, G0173, G0251, G0339, and G0340.

Since we first established the full group of SRS treatment delivery codes in CY 2004, we now have 2 years of hospital claims data reflecting the costs of each of these services. Based on our proposed rule analysis of our claims data from CY 2004 and CY 2005, the median costs for linear accelerator-based SRS treatment delivery procedures as described by HCPCS codes G0173, G0251, G0339, and G0340 have been stable and generally lower than our New Technology APC payment rates in effect from CY 2004 through CY 2006. Specifically, the payment rate for HCPCS code G0173, a complete course of non-image guided, non-robotic linear accelerator-based SRS treatment, has been set at $5,250, yet our claims data indicate a median cost of $2,802 from CY 2004 claims and $3,665 from our proposed rule CY 2005 claims, based upon hundreds of single claims from each year. For HCPCS code G0251, fractionated non-image guided, non-robotic linear accelerator-based SRS treatment, the corresponding median costs have been $1,028 and $1,386 based upon over 1,000 single claims from each year, and relatively consistent with the procedure's New Technology APC payment of $1,150. With respect to the complete course of therapy in one session or first fraction of image-guided, robotic linear accelerator-based SRS, described by HCPCS code G0339, its

median costs have been $4,917 and $4,809 for CY 2004 and CY 2005 respectively, based upon over 500 single bills in each year, in comparison with the procedure's payment rate of $5,250 for those years. Lastly, the median costs of HCPCS code G0340, the second through fifth sessions of image-guided, robotic linear accelerator-based SRS treatment, have been $2,502 for CY 2004 and $2,917 for CY 2005 as determined by over 1,000 single bills during each year, significantly lower than its payment rate of $3,750. Unquestionably, the claims data from CY 2004 and CY 2005 for linear accelerator-based SRS treatment delivery services revealed highly stable median costs from year to year based on significant claims volume.

Based on the above findings, in the CY 2007 proposed rule we indicated that we believed that we had adequate claims data to assign the SRS treatment delivery procedures to clinically appropriate APCs, and we believed that such movement was appropriate. For CY 2007, we proposed to create several new SRS clinical APCs of different levels to assign the HCPCS codes describing linear accelerator-based SRS treatment, G0173, G0251, G0339, and G0340, based on their clinical and hospital resource similarities and differences. In particular, we proposed to assign HCPCS codes G0339 and G0173 to the same Level III SRS APC, because we believed that these codes that describe the complete or first fraction of all types of linear accelerator-based SRS treatments had substantial hospital resource and clinical similarity, as observed in their median costs and recognized previously in their equivalent New Technology APC payments. The codes describing subsequent fractions of image-guided, robotic and non-image guided, non-robotic linear accelerator-based SRS treatments were each assigned to their own clinical APCs in our proposal, as they demonstrated significant differences in resource utilization as reflected in their median costs. Their previous assignments to different New Technology APCs anticipated these resource distinctions. We proposed to continue our assignment of HCPCS code G0243 for Cobalt 60-based SRS treatment delivery to clinical APC 0127, renamed Level IV Stereotactic Radiosurgery. Our proposed reassignments of SRS services from New Technology APCs to clinical APCs were listed in Table 8 of the CY 2007 OPPS proposed rule (71 FR 49554), which has been reproduced as Table 8 below, amended with the final status indicators, APC assignments, and median costs for these services.

We received many comments on our proposal from hospitals, health professionals, and various healthcare associations. A summary of the comments and our responses follow:

Comment: Several commenters objected to our use of the CY 2005 claims data in setting the CY 2007 payment rates, specifically with regards to the image-guided robotic SRS services, as described by HCPCS codes G0339 and G0340. They indicated that the claims data used to set the proposed payment rates for HCPCS codes G0339 and G0340 were based on a flawed methodology because several centers providing these services submitted claims to CMS for less than a full year during CY 2004 and CY 2005. Because centers that provided image-guided SRS grew in number significantly over the past 2 years, the commenters believed that CMS did not have meaningful data over 2 years from a large number of institutions providing the services upon which to base the proposed changes. They believed that new technology services should have a minimum of 2 years of claims data before moving them to clinical APCs. These commenters urged CMS to maintain HCPCS code G0339 in its current New Technology APC 1528 with a payment rate of $5,250, and to also maintain HCPCS G0340 in its current New Technology APC 1525 with a payment rate of $3,750.

Response: 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 noted that we would retain services within New Technology APC groups until we gathered sufficient claims data to enable us to assign the service to a clinically appropriate APC. There is no requirement for a minimum number of claims or years of claims data before services may be moved from New Technology APCs to clinical APCs.

In the case of the image-guided robotic SRS services, specifically G0339 and G0340, we continue to believe that we have adequate claims data from CY 2005 upon which to base our payments for CY 2007. Both HCPCS codes G0339 and G0340 were effective for reporting beginning January 1, 2004, under the OPPS, and consequently, we have 2 full years worth of hospital claims data for these services. As we noted earlier, the median costs for both procedures have been reasonably stable over the past 2 years based upon substantial numbers of single claims, and there was similar growth in both services from CY 2004 to CY 2005. The fact that image-guided robotic SRS centers have grown in number and service volume over the most recent 2 years of claims submissions is expected for new technology and other OPPS services. Many OPPS services are only provided in a small subset of hospitals paid under the OPPS, and we routinely establish APC median costs based on Medicare OPPS claims from the hospitals that were providing the services 2 years prior to the OPPS update year. We recognize that our claims data evolve over time, in part because the pool of hospitals providing certain procedures may change significantly.

The information provided in the comments did not convince us that the proposed payment rates for HCPCS code G0339 and G0340 were based on inadequate claims data that did not represent the costs of the procedures for the hospitals providing the services in CY 2005. Based on our final CY 2005 claims data, we found 1,535 single (of 1,655 total) claims for HCPCS code G0339 and 2,716 single (of 2,798 total) claims for HCPCS code G0340. We believe that the single claims data for both procedures are sufficiently robust for ratesetting purposes.

Comment: Several commenters agreed with CMS that the hospital claims data from the past 2 years for the SRS services have been relatively stable and based on at least several hundreds of claims both years. However, these commenters expressed concern about our proposal to assign HCPCS codes G0173 and G0339 to the same APC, specifically APC 0067 (Level III Stereotactic Radiosurgery). The commenters opposed assignment of the two procedures to the same APC because they believed that our claims data clearly showed that the median cost of G0339 has been significantly higher than the median cost of G0173 for both CY 2004 and CY 2005.

Response: Both services have been assigned to the same New Technology APC 1528 for the past 3 years because of our initial expectation that the costs of the first or complete session of linear accelerator-based SRS would be similar, regardless of whether or not the SRS procedure was an image-guided robotic service. While we have observed that their costs are somewhat different, we believe that they are sufficiently comparable to warrant placement of the SRS services in the same clinical APC, given the comparable clinical characteristics of the services. The OPPS provides payments based on APC groups of services that share clinical and resource characteristics, and the median of the highest cost service

within an APC group should not be more than 2 times greater than the median cost of the lowest cost service within that same group. The final CY 2005 median cost of G0173 is $3,407.53, and the final CY 2005 median cost of G0339 is $4,126.46. These median costs are quite comparable, and APC 0067, configured as proposed, does not violate the 2 times limit on the variation of costs within the APC.

Therefore, for CY 2007, both HCPCS codes G0339 and G0173 are reassigned to clinical APC 0067 with a median cost of $3,872.87, and HCPCS code G0340 is reassigned to clinical APC 0066, with a median cost of $2,629.53.

Comment: Several organizations supported our proposed clinical APC assignments but were concerned by the extent of the payment reductions for certain services. The commenters expressed concern regarding the 23-percent reduction in payment for HCPCS codes G0173 and G0339. They urged CMS to review the cost calculations for all SRS services and use the most current claims data available for the CY 2007 OPPS final rule.

Response: We thank the commenters for their suggestion. The payment rates reflected in Table 8 are based on the latest and most complete CY 2005 claims data, with CY 2007 payment rates based upon APC median costs calculated according to the standard OPPS methodology. Almost all of the claims are single claims; therefore, we are confident that the observed costs in the claims data are representative of the costs of the SRS services provided in CY 2005.

Comment: Several commenters requested that CMS modify the descriptors for HCPCS codes G0339 and G0340 to be more precise and reflect the technology accurately. The commenters provided their proposed language, and indicated that not refining the descriptors would make it virtually impossible to determine appropriate APC payment rates for image-guided robotic SRS services in the future. They also urged CMS to work with the centers providing these specialized services to establish accurate and appropriate payments for image-guided robotic SRS.

Response: The recommended language provided by the commenters is very specific and may cause more confusion for hospitals and coders. Long descriptors of HCPCS codes that describe services and procedures are usually more general and not specific to a particular specialty or product. We do not establish HCPCS codes that are specific to certain technologies. Instead, we rely on hospitals to select the most specific HCPCS codes that accurately describe the services they provide. We believe that the current HCPCS code descriptors adequately distinguish image-guided robotic linear accelerator-based SRS from other types of SRS. We observe significant difference in the costs of G0251 and G0340 that describe the later fractions of non-image-guided and image-guided SRS respectively, so that they require assignment to two separate clinical APCs. We have no evidence that hospitals are not accurately reporting these services based on the technology utilized to provide SRS in their institutions.

For CY 2007, the CPT Editorial Panel created four new SRS Category I CPT codes in the Radiation Therapy 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). For CY 2007, we will continue our recent practice of not recognizing established CPT code 61793 (Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions) under the OPPS because the OPPS will utilize more specific SRS codes to provide appropriate payment for the facility resources associated with specific types of SRS treatment delivery. Below is our discussion of the new SRS CPT codes, and our assignments for the codes under the OPPS.

- CPT code 77371 describes a cobalt-based SRS procedure for a single, complete treatment session of one or more cerebral lesions. Under the OPPS, this procedure has been separately payable under HCPCS code G0243 (Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions) since January 1, 2002. We believe this single CPT code may be appropriately reported in all clinical situations of cobalt-based SRS treatment. For CY 2007, HCPCS G0243 will no longer be reportable under the hospital OPPS because the code will be deleted and replaced with CPT code 77371, effective January 1, 2007. CPT code 77371 is assigned to the same APC and status indicator as its predecessor code (G0243). That is, for CY 2007, CPT code 77371 is assigned to APC 0127 (Level IV Stereotactic Radiosurgery) with a status indicator of ''S''.
- CPT code 77372 describes a single session, complete course of treatment, linear accelerator-based procedure. During CY 2006, this procedure was reported under one of two HCPCS codes, depending on the technology used, specifically, G0173 (Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session) and G0339 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment). Because HCPCS codes G0173 and G0339 are more specific in their descriptors than CPT code 77372, we have decided to continue using G0173 and G0339 under the OPPS for CY 2007. Therefore, for CY 2007, we have assigned CPT code 77372 to status indicator ''B'' under the OPPS.
- CPT code 77373 describes a fractionated session linear accelerator-based procedure. During CY 2006, CPT code 77373 was reported under one of three HCPCS codes depending on the circumstances and technology used, specifically, G0251 (Linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment), G0339 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment), and G0340 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment). Because HCPCS codes G0251, G0339, and G0340 are more specific in their descriptors than CPT code 77373 and these HCPCS codes are assigned to different clinical APCs for CY 2007, we have decided to continue using G0251, G0339, and G0340 under the OPPS for CY 2007. Therefore, for CY 2007, we have assigned CPT code 77373 to status indicator ''B'' the hospital OPPS.
- CPT code 77435 also describes treatment management for a full treatment course of linear accelerator-based SRS. During CY 2006, 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 has decided to delete CPT code 0083T on December 31, 2006, and replaced it with CPT code 77435. Because the costs of SRS treatment management are already packaged into the OPPS payment rates for SRS treatment delivery, for CY2007 we have assigned CPT code 77435 to status indicator ''N'', which is the same status indicator that was assigned to its predecessor Category III CPT code.

After carefully considering all the comments and concerns raised by the commenters, we are finalizing our proposal as shown in Table 8 without modification. Given the ample cost information reflected in the CY 2005 claims data for the SRS services and given the fact that these services have been in New Technology APCs for 3 full years, since they were first assigned to New Technology APCs beginning January 1, 2004, we believe our claims data are sufficient for us to move these services to clinical APCs. Therefore, for CY 2007, HCPCS codes G0173 and G0339 are assigned to clinical APC 0067, with a median cost of $3,872.87, HCPCS code G0251 to clinical APC 0065, with a median cost of $1,241.89, and HCPCS code G0340 to clinical APC 0066 with a median cost of $2,629.53. As described above, despite new CPT codes for SRS treatment delivery in CY 2007, coding for linear accelerator-based SRS treatment delivery services will not change in the CY 2007 OPPS.

TABLE 8.—FINAL APC ASSIGNMENTS FOR SRS TREATMENT DELIVERY SERVICES FOR CY 2007

HCPCS code	Short descriptor	CY 2006 SI	CY 2006 APC	CY 2006 payment rate	Final CY 2007 SI	Final CY 2007 APC	Final CY 2007 APC median cost
G0173	Linear acc stereo radsur com	S	1528	$5,250.00	S	0067	$3,872.87
G0251	Linear acc based stero radio	S	1513	1,150.00	S	0065	1,241.89
G0339	Robot lin-radsurg com, first	S	1528	5,250.00	S	0067	3,872.87
G0340	Robt lin-radsurg fractx 2–5	S	1525	3,750.00	S	0066	2,629.53

d. Magnetoencephalography (MEG) Services (APCs 0038 and 0209)

Magnetoencephalography (MEG) is a noninvasive diagnostic tool that assists surgeons in the presurgical period by measuring and mapping brain activity. It may be used for epilepsy and brain tumor patients. Since CY 2002, the MEG procedures described by CPT codes 95965 (Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)), 95966 (Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization)), and 95967 (Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (e.g., sensory, motor, language, or visual cortex localization)) have been assigned to New Technology APCs. In the CY 2006 proposed rule (70 FR 42709), we proposed to reassign MEG procedures to clinical APC 0430 using CY 2004 claims data to establish median costs on which the CY 2006 payment rates would be based. This proposal involved the reassignment of the three MEG procedures, specifically CPT codes 95965, 95966, and 95967, from three separate New Technology APCs into one new clinical APC with a status indicator of ''T.'' The commenters on the CY 2006 proposal believed that their assignment to clinical APC 0430 would be inappropriate because the proposed payment level of $674 was inadequate to cover the costs of the procedures, and because the procedures should not be assigned to only one level as their required hospital resources differ significantly. They further stated that our data did not represent the true costs of the procedures because MEG procedures are performed on very few Medicare patients.

Analysis of our hospital data for claims submitted from CY 2002 through CY 2005 indicated that these procedures are rarely performed on Medicare beneficiaries. For claims submitted from CY 2002 through CY 2005, our single claims data showed that there were annually only between 2 and 23 claims submitted for CPT code 95965, between 3 and 7 claims for CPT code 95966, and only 1 claim for CPT code 95967. In addition, the hospital claims median costs for these codes have varied widely, perhaps due to our small volume of claims. The median cost for CPT code 95965 has ranged from $332 using CY 2002 claims to $3,166 based upon CY 2005 claims. The median cost for CPT code 95966 has varied widely from CY 2002 to CY 2005. For single claims submitted during CY 2002, the median cost was $1,949, while it was $507 for CY 2003, $1,435 for CY 2004, and $701 from 3 single claims for CY 2005. The median cost for CPT code 95967 based upon 1 single claim from CY 2005 claims was $217. As noted in our CY 2007 OPPS proposed rule (71 FR 49555), we had no hospital median cost data for CPT code 95967 prior to CY 2005.

In the November 10, 2005 final rule with comment period (70 FR 68579), we stated that we carefully considered our claims data, information provided by the commenters, and the APC Panel recommendation for CY 2006 that we retain the MEG procedures in New Technology APCs. As a result of this analysis, we determined that using a 50/50 blend of the code-specific median costs from our most recent CY 2004 hospital claims data and the CY 2005 New Technology APC code-specific payment amounts as the basis for assignment of the procedures for CY 2006 would be an appropriate way to recognize both the current payment rates for the procedures, which were originally based on the theoretical costs to hospitals of providing MEG services, and the median costs based upon our hospital claims data regarding actual MEG services provided to Medicare beneficiaries by hospitals. Therefore, CPT codes 95965, 95966, and 95967 were assigned to different New Technology APCs for CY 2006 based on this blended methodology, with payment rates of $2,750, $1,250, and $850 respectively.

At the March 2006 APC Panel meeting, the Panel recommended that CMS move CPT codes 95965 (MEG, spontaneous), 95966 (MEG, evoked, single), and 95967 (MEG, evoked, each additional) from their CY 2006 New Technology APCs which were assigned based on the blended methodology described above to clinical APC(s) for CY 2007. Following that meeting, interested parties provided us with CY 2005 charge and cost information from six hospitals that provided MEG services. These external data showed wide variation in hospitals' costs and charges for MEG procedures, with

generally higher values for CPT code 95965 and lower values for CPT codes 95966 and 95967 but no consistent proportionate relationship among those costs and charges. In some cases, the charges and costs for CPT codes 95966 and 95967 were quite similar for the two related services, one of which describes MEG for a single modality of evoked magnetic fields and the other that describes MEG for each additional modality of evoked magnetic fields. The individual hospital cost and charge data for specific services demonstrated significant variations of up to six fold across the hospitals, with an apparent inverse relationship between the numbers of services provided and the costs of the procedures. This finding was not unexpected, given the dependence of MEG procedures on the use of expensive capital equipment. As we have previously stated, our OPPS payment rates generally reflect the costs that are associated with providing care to Medicare beneficiaries in cost-efficient settings. For emerging technologies, we establish payment rates for new services that lack hospital claims data based on realistic utilization projections for all such services delivered in cost-efficient hospital outpatient settings. In the CY 2007 OPPS proposed rule, we indicated that since we now had 4 years of hospital claims data for MEG procedures and because MEG was no longer a new technology, we did not believe these external data from six hospitals that performed MEG services in CY 2005 provided a better estimate of the hospital resources used in MEG procedures during the care of Medicare beneficiaries than our standard OPPS historical claims methodology.

We agreed with the APC Panel and proposed to accept their recommendation to move the MEG CPT codes into clinical APCs for CY 2007. While the volumes for the MEG procedures are low, almost all procedures, including those with very low Medicare volume, are assigned to clinical APCs under the OPPS, with their payment rates based on the median costs of their assigned APCs. Therefore, we proposed to assign CPT code 95965 to new clinical APC 0038 (Spontaneous MEG), with a proposed median cost of $3,166.30, and to assign both CPT codes 95966 and 95967 to APC 0209 (Level II MEG, Extended EEG Studies, and Sleep Studies), with a proposed median cost of $709.36. We believed that the assignment of CPT codes 95966 and 95967 to APC 0209 was appropriate because MEG studies were similar to EEGs and sleep studies in measuring activity of the brain over a significant time period, and our hospital claims data showed that their hospital resources were also relatively comparable. MEG procedures and their CY 2007 proposed APC assignments were displayed in Table 9 published in the CY 2007 OPPS proposed rule (71 FR 49556), which has been reproduced in Table 9 of this final rule with comment period and updated to include the final status indicators, APC assignments, and APC median costs for CY 2007.

Comment: Most of the commenters agreed with the APC assignments for both CPT codes 95965 and 95967 but requested that CMS reconsider the APC assignment for CPT code 95966. The commenters supported the establishment of a separate APC for CPT code 95965 and its proposed payment rate. They also agreed that CPT code 95967 is an add-on code that is always used in conjunction with CPT codes 95965 or 95966 and is less costly to perform. They generally agreed with the proposed APC assignment and payment rate for CPT code 95967, despite the very low volume of OPPS claims for the procedure. The commenters disagreed with the proposed APC and payment rate for CPT code 95966. They indicated that MEG is a highly specialized service performed in a limited number of hospitals in the U.S. Because the service is not commonly performed, the commenters acknowledged that Medicare beneficiaries represent only a small number of patients who receive MEG services because epilepsy surgery is rarely performed on elderly patients, which further explains the very low volume of these services in the Medicare claims data. While the commenters agreed with the proposed APC assignments for CPT codes 95965 and 95967, they believed that the resources required to perform 95966 were significantly higher than the payment rate reflected in APC 0209, its proposed assignment for CY 2007. The commenters indicated that the costs of MEG services were substantially higher than the EEG or sleep study services that are also assigned to APC 0209. As such, the commenters believed that CPT code 95966 should be assigned to its own APC at a rate equal to 50 percent of the payment rate for CPT code 95965, or approximately $1,550. They believed that this payment rate was supported by the hospital cost data for the six hospitals providing a high volume of MEG services, which were provided to CMS and discussed in the CY 2007 OPPS proposed rule.

Response: We appreciate the commenters' input and suggestions. However, given that we have 4 years of hospital claims data for MEG procedures and because MEG is no longer a new technology, we believe that the proposed APC assignment for CPT code 95966 is appropriate. If we were to assign CPT code 95966 to its own clinical APC, the median cost of that APC would be the median cost of CPT code 95966 of $709 from CY 2005 claims data, quite consistent with the median cost of APC 0209. We do not assign payment rates for clinical APCs based upon speculative relationships of the costs of its services to payments for other services. Instead, the standard OPPS methodology to develop the median cost of a clinical APC upon which a specific procedure's payment is based is to establish the APC median from claims data for all of the services assigned to the APC. As we have indicated above, while the volumes of MEG procedures are low, almost all procedures, including those with very low Medicare volume, are assigned to clinical APCs under the OPPS, with their payment rates based on the median costs of their assigned APCs. Taking into consideration our hospital claims data for CPT code 95966 from the last several years, we continue to believe that its assignment to APC 0209 is appropriate, and that the service is sufficiently similar to other diagnostic procedures also residing in the APC. Therefore, for CY 2007, we are assigning CPT code 95965 to APC 0038, with a final CY 2007 median cost of $3,270, and CPT codes 95966 and 95967 to APC 0209, with a final CY 2007 median cost of $687.

Comment: One commenter indicated that the claims data cited in the CY 2007 OPPS proposed rule for CPT codes 95965, 95966, and 95967 were based both on incomplete and inaccurate claims data. The commenter submitted copies of paid Medicare claims from CY 2005 for CPT code 95965, which included nine claims that reflected 5 months of data, each representing total charges greater than the CY 2007 proposed payment rate for CPT code 95965. The commenter requested that CMS consider these claims in determining the appropriate APC assignments for the MEG services.

Response: We confirmed that the claims data submitted to us are accurately reflected in the CY 2005 claims data used for the CY 2007 OPPS update. Consequently, we believe that our claims data adequately reflect the costs associated with providing the MEG service identified by CPT code 95965. In determining a hospital's cost for a service, we take the individual hospital's departmental CCR and multiply this by the total charge on a

single claim for that service. In the event there is no applicable departmental CCR, we use the overall hospital-specific CCR. For this CY 2007 OPPS update, the average overall hospital CCR is 0.30142. Multiplying this average CCR by the typical MEG procedure charge of about $10,500 on the claims provided to us yields a cost for CPT code 95965 of about $3,165, consistent with the final CY 2007 median cost of APC 0038 of about $3,270. This median cost provides the basis for establishing the procedure's payment rate. Overall, we believe the claims provided by the commenter help to validate our final CY 2007 APC 0038 assignment of CPT code 95965, with its payment rate calculated according to our standard OPPS methodology.

After carefully reviewing the data and considering the public comments received, we are finalizing our proposal for APC assignment for MEG as shown in Table 9 without modification.

TABLE 9.—CY 2007 APC ASSIGNMENT FOR MEG

HCPCS code	Short descriptor	CY 2006 SI	CY 2006 APC	CY 2006 payment rate	CY 2007 SI	Final CY 2007 APC	Final CY 2007 APC median cost
95965	Meg, spontaneous	S	1523	$2,750.00	S	0038	$3,270.35
95966	Meg, evoked, single	S	1514	1,250.00	S	0209	687.26
95967	Meg, evoked, each additional	S	1510	850.00	S	0209	687.26

e. Other Services in New Technology APCs

Other than the PET, PET/CT, SRS, and MEG new technology services discussed in section III.C.2.a. through d. of this preamble, there are 23 procedures currently assigned to New Technology APCs for CY 2007 for which we believed we also had data that were adequate to support their assignment to clinical APCs. For CY 2007, we proposed to reassign these procedures to clinically appropriate APCs, applying their CY 2005 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 10 of the CY 2007 OPPS proposed rule. This table has been reproduced as Table 10 at the end of this section and updated with the final status indicators, APC assignments, and median costs.

We received many comments concerning the proposed reassignment of other new technology procedures listed in Table 10 to clinical APCs for CY 2007. A summary of the comments and our responses follow:

(1) Breast Brachytherapy (APCs 0029 and 0030)

For CY 2007, we proposed to reassign CPT code 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) from New Technology APC 1524 (New Technology Level XIV—($3000-$3500)) to clinical APC 0030 (Level III Breast Surgery) with a proposed median cost of $2,516.94. We also proposed to reassign CPT code 19297 (Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy) from New Technology APC 1523 (New Technology Level XXIII—($2500–$3000)) to clinical APC 0029 (Level II Breast Surgery), with a proposed median cost of $1,738.75.

Comment: Numerous commenters requested that CMS maintain CPT code 19296 and CPT code 19297 in New Technology APCs 1524 and 1523, respectively, for another year so that more claims data could be collected for both services. They were concerned about the proposed significant payment decreases for CPT codes 19296 and 19297 that ranged from -23 percent to -37 percent. The commenters also indicated that the number of hospital outpatient claims for both codes were low and thus inadequate to support their assignment to appropriate clinical APCs. The commenters indicated that in developing the proposed rule, CPT code 19296 had a total of 491 single claims for CY 2005, and only 36 single claims were available for CPT code 19297. One commenter was surprised that CMS would consider moving CPT code 19297 to a clinical APC with only 36 single claims, while CPT code 19298 (Place breast rad tube/caths), with 49 single claims for CY 2005, would continue to be assigned to New Technology APC 1524.

The commenters generally urged CMS to reevaluate the proposed clinical APCs for these procedures, and, if necessary, place them in more appropriate APCs that accurately reflected the costs and clinical characteristics of these services. Many commenters requested that CMS either continue to assign CPT codes 19296 and 19297 to their current CY 2006 New Technology APCs for CY 2007, or place them in APC 0648, retitled ''Level IV Breast Surgery,'' which had a proposed median cost of $3,012.92 and a CY 2006 title of ''Breast Reconstruction with Prosthesis.'' As to our proposed CY 2007 APC assignments, for these codes, the commenters indicated that the other procedures in APCs 0030 and 0029 did not use high cost devices, and the median costs of the various procedures assigned to these APCs violated the 2 times rule when the device-dependent median costs of CPT codes 19296 and 19297 were considered. The commenters further added that the procedures within these APCs were not clinically homogeneous and recommended that we reassign CPT codes 19296 and 19297 to APC 0648 (Breast Reconstruction with Prosthesis), which contained procedures that were more similar to the brachytherapy catheter insertion procedures in terms of their clinical characteristics and use of costly devices.

Response: As we have stated previously, we retain services within New Technology APC groups until we gather sufficient claims data to enable us to assign the services to clinically appropriate APCs. This policy allows us to move services from New Technology APCs in less than 2 years if sufficient data are available. It also permits us to retain services in New Technology APCs for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected. In the case of CPT codes 19296 and 19297, the predecessor codes for these services were created in April 2004. CPT code 19296 was previously described by HCPCS code C9715 (Placement of balloon catheter into the breast for interstitial radiation therapy following a partial mastectomy; delayed), and CPT code 19297 was described by HCPCS code C9714 (Placement of balloon catheter into the breast for interstitial

radiation therapy following a partial mastectomy; concurrent/immediate). Both predecessor codes were assigned to New Technology APCs when the codes were announced in the April update of the CY 2004 OPPS (Transmittal 132, dated March 30, 2004). Specifically, HCPCS code C9715 was assigned to New Technology APC 1524 and HCPCS code C9714 was assigned to New Technology APC 1523. Consequently, we believe we have sufficient data from almost 3 years of hospital claims to assign both CPT codes 19296 and 19297 to clinically appropriate APCs. We recognize that, in the case of CPT code 19297 which is an add-on code to a partial mastectomy service, single bills would likely always be miscoded and available in only small numbers, because the correctly coded claims would be multiple procedure claims that we could not use for ratesetting.

However, in light of the comments received and our review of all the information provided by the commenters, we reconsidered the proposed APC assignments for CPT codes 19296 and 19297. We agree with the commenters that the clinical APC assignments for CPT codes 19296 and 19297 should accurately reflect the costs of the procedures, as well as their clinical features. We note that the final CY 2005 median cost for CPT code 19296 is $3,041.58 based on 537 (of 860 total) single claims, and the final CY 2005 median cost for CPT code 19297 is $1,322.03 based on 36 single claims (of 443 total claims). As noted previously, we do not believe the median cost of CPT code 19297 is calculated based upon correctly coded claims. Therefore, after full consideration of the public comments received, we believe it is appropriate for CY 2007 to assign both services to clinical APC 0648 with an APC title of ''Level IV Breast Surgery'' and a final median cost of $3,130.45. We believe this is the most appropriate assignment for both procedures, when we consider their clinical and resource characteristics in the context of other procedures also assigned to APC 0648.

APC 0648 is assigned status indicator ''T,'' which means that when a service assigned to it is reported with a lower priced service (for example, a mastectomy procedure) that is also assigned status indicator ''T,'' payment for the lower priced service would be reduced by 50 percent. This reduction in payment reflects the efficiencies that occur when a lower paid service is performed during the same operative session as a higher paid surgical procedure. We believe this reduction is appropriate due to efficiencies that may be gained when both services are performed in a single session. As for CPT code 19298, because there was no predecessor code to describe this procedure, which was new in CY 2005, we only have 1 year of claims data. Therefore, we are continuing to assign this code to New Technology APC 1524 for CY 2007 to enable us to collect additional data for appropriate ratesetting in the future.

Comment: Several commenters indicated that the procedure associated with CPT codes 19296 and 19297 requires the use of a specialized catheter that has a list price of $2,750, which is more costly than the proposed payment rate for APC 0030 or APC 0029. One commenter added that hospitals do not receive discounts or rebates on the unique catheters, and that regardless of whether the procedure is performed at the time of lumpectomy or during future surgery, the cost of the catheter is still the same in both cases.

Response: As noted above, after carefully considering all the public comments received, we have reassigned CPT codes 19296 and 19297 to APC 0648, a device-dependent APC, for CY 2007. The final median cost for this device-dependent APC was calculated using only claims that contained appropriate device HCPCS codes for all the procedures assigned to it with nontoken charges for the devices as discussed in section IV.A.2 of this preamble. The median cost from the subset of claims reporting a device HCPCS code for the brachytherapy catheter was $3,469.85 for CPT code 19296 and $3,379.97 for CPT code 19297. We believe that payment for APC 0648 accurately reflects the resources and costs associated with performing these device-dependent brachytherapy catheter insertion procedures. To ensure that their future claims include charges for the necessary devices to assist in ratesetting, we will implement procedure-to-device edits for both of these services in CY 2007. In order to receive payment for the two procedures to insert brachytherapy balloon catheters, hospitals will be required to report the appropriate device HCPCS code or their claims will be returned to them for correction.

Comment: Several commenters were concerned about the proposed assignment of status indicator ''T'' to both CPT codes 19296 and 19297. They observed that the indicator would always reduce the payment for CPT code 19297 by 50 percent.

Response: Based on the final CY 2007 assignment of CPT code 19297 to APC 0648, we believe this reduction is appropriate due to efficiencies that may be gained when both the partial mastectomy and placement of brachytherapy catheter procedures are performed in a single operative session. According to the CPT manual, CPT code 19297 would be reported with CPT code 19160 (Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)) or 19162 (Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy). These codes are assigned to APCs 0028 (Level I Breast Surgery), with a final CY 2007 median cost of $1,178.12, and 0693 (Breast Reconstruction), with a final CY 2007 median cost of $2,260.98, respectively. In cases where the partial mastectomy is performed with concurrent placement of a brachytherapy balloon catheter into the breast, payment for the nondevice-dependent partial mastectomy procedure would be appropriately reduced by 50 percent, while full payment would be provided for the device-dependent procedure described by CPT code 19297, consistent with the expected resource efficiencies when these procedures are performed in a single session.

After carefully considering all public comments received, we are finalizing our CY 2007 proposal with modification to reassign CPT codes 19296 and 19297 from New Technology APCs to clinical APC 0648, retitled ''Level IV Breast Procedures,'' with a final CY 2007 median cost of $3,130.45. We also are implementing appropriate procedure-to-device edits for both of these procedures.

(2) Radiofrequency Ablation (APCs 0050 and 0423)

For CY 2007, we proposed to reassign CPT code 20982 (Ablation, bone tumor(s) (e.g., osteoid osteoma, metastasis), radiofrequency, percutaneous, included computed tomographic guidance) from New Technology APC 1557 (New Technology—Level XX ($1800–$1900)) to APC 0050 (Level II Musculoskeletal Procedures Except Hand and Foot), with a proposed median cost of $1,535.66.

We also proposed that CPT code 50592 (Ablation, one or more renal tumor(s), percutaneous, unilateral radiofrequency), which was a new CPT code for CY 2006, and CPT code 47382 (Ablation, one or more liver tumor(s), percutaneous, radiofrequency) continue to be assigned to APC 0423 (Level II Percutaneous Abdominal and Biliary Procedures), with a proposed median cost of $2,410.33.

Comment: One commenter objected to the proposed payment for APC 0423 and

the placement of CPT codes 47382 and 50592 in APC 0423 because the commenter believed that the proposed payment was too low to adequately compensate hospitals for the required radiofrequency electrode and the necessary services. One commenter also asked that CPT code 20982 be reassigned to APC 0051 (Level III Musculoskeletal Procedures Except Hand and Foot) to pay a more appropriate amount. The commenter provided a comparison to the MPFS practice expense inputs that showed that the supply, clinical time, and capital expense for performing CPT code 20982 was about $2,100. Moreover, the commenter asked that CMS ensure that a forthcoming CPT code for ablation of a lung tumor be assigned to an APC that would make appropriate payment for both the electrode and the services. The commenter stated that the electrodes used in these services typically cost from $900 to $2,500, with an approximate average of $1,500. The commenter asked that CMS grant its pass-through device category application, establish a new device category code for radiofrequency electrodes for pass-through payment, and designate APCs 0423, 0132 (Level III Laparoscopy), and 0050 as device-dependent APCs and implement appropriate procedure-to-device edits.

Response: The MPFS is a different payment system that establishes payment rates based on a methodology that is wholly unrelated to the OPPS setting of relative weights, so its practice expense costs are not applicable to the OPPS. However, in this final rule with comment period, we are reassigning CPT code 20982 to APC 0051 for CY 2007 because we agree, based on review of our historical claims data and final CY 2005 claims, that CPT code 20982 is more appropriately assigned to APC 0051 than to APC 0050 from hospital resource and clinical perspectives. However, we are retaining CPT codes 47382 and 50592 in APC 0423, with a median cost established based upon our standard OPPS methodology, because we believe that we have sufficient claims data for CPT code 47382, which was created in CY 2002. We have 4 years of claims data for this procedure, with hundreds of single claims from CY 2005 that reflect a stable code-specific median cost in comparison with CY 2004 claims. For CY 2007, CPT code 47382 is the only code assigned to APC 0423 that contributes claims data to the median cost calculation for the APC. We also believe that CPT code 50592, which has no CY 2005 claims data because it was new for CY 2006, is similar to CPT code 47382 based on clinical and resource considerations. Therefore, it is most appropriately assigned to the same clinical APC. Moreover, because CPT code 47382 uses devices that never had pass-through status, we have not placed any of the CPT codes for radiofrequency ablation procedures in specialized APCs, nor do we consider their APCs to be device-dependent. Because the device is well-established in its use for radiofrequency ablation of liver tumors, we believe that hospital charges for the procedure contain the charges the hospital considers are appropriate for the electrode and other required supplies. This is similar to our treatment of CPT code 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)). This is a well-established service that predates the OPPS and that uses a device that was never a pass-through device. We also do not consider its APC to be device-dependent.

We also are assigning new CPT code 32998 (Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral) to APC 0423 because we have no reason to believe that the resources required for the newly coded service differ in any substantive way from the resources required for longstanding CPT code 49382. This new CPT code's assignment is open to comment in this final rule with comment period. We do not make pass-through device category determinations through rulemaking, nor do we create new device category codes outside of the pass-through process. Because there is no specific device code to describe the radiofrequency ablation electrode, we are unable to implement procedure-to-device edits for any of these procedures.

After carefully considering the public comments received, we are finalizing our proposal with modification. CPT code 20982 is reassigned to APC 0051 for CY 2007, with a median cost of $2,510.95. CPT codes 47382 and 50592 continue to be assigned to APC 0423 for CY 2007, with a median cost of $2,283.08. New CPT code 32998 is also assigned to APC 0423 for CY 2007, and this assignment is open to comment in this final rule with comment period.

(3) Extracorporeal Shock Wave Treatment (APC 0050)

For CY 2007, we proposed to reassign CPT code 28890 (Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia) and CPT code 0102T (Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, involving lateral humeral epicondyle) from New Technology APC 1547 (New Technology—Level X ($800–$900)) to clinical APC 0050 (Level II Musculoskeletal Procedures Except Hand and Foot), which had a proposed payment rate of $1,542.47.

Comment: One commenter on our CY 2006 final rule with comment period was concerned that our assignment of new CPT code 28890 to APC 1547 may be insufficient to appropriately pay for the costs associated with its performance and facility costs in the outpatient setting. The commenter admitted that it did not have actual cost data for supplies and equipment used in the hospital outpatient setting. Nevertheless the commenter was concerned that the $850 payment rate for services assigned to APC 1547 may be insufficient for this service the OPD. The commenters on our CY 2007 OPPS proposed rule believed that our proposed reassignment of CPT codes 28890 and 0102T to APC 0050 was appropriate for CY 2007 until the Medicare hospital claims data become more robust. Several commenters supported our proposal to reassign CPT code 28890 and CPT code 0102T from New Technology APC 1547 to clinical APC 0050. The commenters believed that APC 0050 appropriately reflects the true costs and clinical resources associated with CPT code 0102T. One commenter indicated that the costs of the procedures currently classified under clinical APC 0050 are not dissimilar to the median cost of its predecessor code, specifically, HCPCS code C9720 (High-energy (greater than 0.22mj/mm2) extracorporeal shock wave (ESW) treatment for chronic lateral epicondylitis (tennis elbow)), and therefore, agreed with our proposed assignment. However, one commenter believed that the true resource costs of CPT codes 28890 and 0102T are not fully reflected in the CY 2005 claims data upon which CY 2007 payment rates are based. Therefore, the commenter recommended that CMS adopt the proposed assignments of these CPT codes to APC 0050, but that CMS continue to track and evaluate its claims data as additional claims data become available.

However, the commenter questioned our assignment of CPT code 0101T (Extracorporeal shock wave involving musculoskeletal system, not otherwise

specified, high energy) to APC 0050, stating that this code describes a variety of unspecified procedures for which we have no CY 2005 claims data. The commenter recommended that we not assign CPT code 0101T to APC 0050 or to any inappropriately low-priced New Technology APC.

Response: Concerning the comment to our CY 2006 assignment of CPT code 28890, we note that the OPPS payment is for the technical or facility portion of the payment only. The physician performing the procedure would also bill CMS for the professional services in providing the procedure. Therefore, the CY 2006 OPPS payment for APC 1547 was not for both the performance and facility fee as suggested by the commenter. Nevertheless, in our proposed rule for CY 2007, we proposed reassigning CPT code 28890 to APC 0050, Level II Musculoskeletal Procedures Except Hand and Foot, with a proposed payment rate of $1,542.47. Prior to the introduction of this CPT code in CY 2006, hospitals reported HPCPS code C9721 (High-energy (greater than 0.22mj/mm^2) extracorporeal shock wave (ESW) treatment for chronic plantar fasciitis), to describe the service. This C-code had a median cost of about $1,794 based on CY 2005 claims, consistent with the proposed payment rate for APC 0050.

We appreciate the support for our proposed reassignment of ESWT CPT codes 28890 and 0102T to APC 0050 for CY 2007. Concerning the objection to assigning CPT code 0101T to APC 0050 due to the lack of claims data, we believe that the clinical characteristics and expected resource use for CPT code 0101T will be similar to other ESWT treatments such as those described by CPT codes 28890 and CPT 0102T. As indicated in our CY 2007 OPPS proposed rule (71 FR 49549), some of the new Category III CPT codes describe services that we have determined to be similar in clinical characteristics and resource use to HCPCS codes in an existing APC. In these instances, we may assign the Category III CPT code to the appropriate clinical APC. In the case of CPT code 0101T, we believe this procedure is similar in clinical characteristics and resource use to CPT code 28890 and CPT code 0102T.

After carefully considering the public comments received, we are finalizing our proposal without modification to assign CPT codes 28890, 0102T, and 0101T to APC 0050 for CY 2007.

(4) Insertion of Venous Access Device With Two Ports (APC 0623)

For CY 2007, we proposed to reassign CPT code 36566 (Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separately venous access sites: with subcutaneous port(s)) from New Technology APC 1564 (New Technology—Level XXVII ($4500–$5000)), to APC 0623 (Level III Vascular Access Procedures), with a proposed median cost of $1,703.94. At its August 2006 meeting, the APC Panel recommended that this procedure be moved to an APC with a payment rate no less than that of New Technology APC 1524 (New Technology—Level XXIV ($3000–$3500)) and more than that of New Technology APC 1564 (New Technology—Level XXVII ($4500–$5000)). The APC Panel also recommended that CMS establish a procedure-to-device edit for the service.

Comment: Some commenters objected to the proposed payment rate for CPT code 36566. The commenters asked that CMS establish the median cost for this code based only on claims that contain HCPCS code C1881 (Dialysis access system, implantable) and that we add a device edit that requires that hospitals must bill for HCPCS code C1881 as a condition of being paid for CPT code 36566. They indicated that two devices, totaling $3,500, are required for the procedures.

Response: We agree that CPT code 36566, created in CY 2004, should be assigned to a device-dependent APC, and we calculated median costs for device-dependent APCs in CY 2007 based upon claims that passed the device edits and contained nontoken device charges as described in section IV.A.2 of this preamble. When we calculated the median cost of CPT 36566 based only on that subset of claims with HCPCS code C1881, its median cost was $5,100.26. We are generally accepting the APC Panel's recommendation to assign CPT code 36566 to an APC with an appropriate payment rate and to establish a procedure-to-device edit for CY 2007. For CY 2007, we have placed CPT code 36566 in new APC 0625 (Level IV Vascular Access Procedures) because there is no currently existing clinical APC where CPT code 36566 could appropriately be reassigned based on clinical and resource considerations. We have established APC 0625 as a device-dependent APC because the APCs for the vascular access device services that require devices of significant cost generally have been considered device-dependent since the inception of the OPPS. We have established a device edit, effective for services on or after January 1, 2007, that will not provide payment for CPT code 36566 unless an appropriate device HCPCS code is also reported on the claim. We have calculated the median cost of APC 0625 for CY 2007 using only claims that contain nontoken charges for HCPCS code C1881.

After carefully considering the public comments received, we are finalizing our CY 2007 proposal with modification. We are assigning CPT code 36566 to APC 0625, with a median cost of $5,100.26, and establishing an appropriate procedure-to-device edit for CY 2007.

(5) Stereotactic X-ray Guidance (APC 0257)

For CY 2007, we proposed to reassign CPT code 77421 (Stereoscopic x-ray guidance) from New Technology APC 1502 (New Technology—Level II ($50–$100)) to clinical APC 0257 (Level I Therapeutic Radiologic Procedures), with a proposed median cost of $60.

Comment: Some commenters expressed concern about our proposal to reassign CPT code 77421 from New Technology APC 1502 to clinical APC 0257. The commenters indicated that the proposed payment rate of $60.14 for APC 0257 was insufficient and did not adequately cover the actual costs associated with providing the guidance service described by CPT code 77421. In addition, the commenters believed that the other services currently assigned to APC 0257 were significantly different from CPT code 77421. The commenters stated that the stereotactic x-ray guidance procedure is considerately more sophisticated and technologically more complex, and thus, more resource intensive, than the procedures in APC 0257. Furthermore, the commenters cited the global payment rate of $151.59 for CPT code 77421 under the MPFS, and requested that we take into consideration the MPFS practice expense information for ratesetting rather than relying on very limited hospital claims data. Some commenters requested that CMS reassign CPT code 77421 to APC 0296 (Level II Therapeutic Radiologic Procedures), which had a proposed median cost of $167, to more accurately reflect the true costs associated with providing this service. The commenters further indicated that the other services assigned to APC 0296 were similar clinically and resource-wise to the stereotactic x-ray guidance procedure. Other commenters requested that CMS maintain CPT code 77421 in New Technology APC 1502 with a payment rate of $75 for CY 2007, until CMS has more experience with the CPT code. Some commenters noted that CMS may have mistakenly cross-walked CY 2005 claims data for C9722 (Stereoscopic kilovolt x-ray imaging

with infrared tracking for localization of target volume) to CPT code 77421, based on the belief that both codes described the same services.

Response: While CPT code 77421 was made effective on January 1, 2006, under the OPPS stereoscopic kV x-ray guidance was previously reported with HCPCS code C9722, which was made effective January 1, 2005, and deleted on December 31, 2005, according to our usual practice when services previously described by a C-code can be reported with a CPT code. Based on our claims data, we found 14,794 single claims (out of 15,367 total claims) for HCPCS code C9722 in the CY 2005 data upon which we are basing the CY 2007 relative weights. We believe that services previously reported with HCPCS code C9722 may now be reported with CPT code 77421, although CPT code 77421 may allow reporting of a broader set of technologies. We also believe this CY 2005 volume of services is sufficient to justify setting a relative weight based on claims-based cost information rather than keeping the service in a New Technology APC for another year. In addition, our claims information is not consistent with a payment for the service through clinical APC 0296, which has a final median cost of about $164. We note that, of the claims available for ratesetting for APC 0257, almost 90 percent of them were for HCPCS code C9722; therefore, we are confident that the median cost of APC 0257 appropriately reflects the costs of stereoscopic x-ray imaging. We also believe the other imaging services assigned to APC 0257 share sufficient clinical and resource similarity with CPT code 77421 to support their assignment to the same clinical APC. Moreover, we again note that the MPFS practice expense information for this service is not relevant to the setting of relative weights under OPPS.

After considering all the public comments received, for CY 2007, we are adopting as final without modification our proposal to reassign CPT code 77421 from New Technology APC 1502 to clinical APC 0257, which has a final CY 2007 median cost of $67.06.

(6) Whole Body Tumor Imaging (APC 0408)

For CY 2007, we proposed to reassign CPT code 78804 (Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging) from New Technology APC 1508 (New Technology—Level VIII ($600–$700)) to clinical APC 0408 (Level II Tumor/Infection Imaging) with a proposed median cost of $309.

Comment: Several commenters disagreed with the proposed reassignment of CPT code 78804, which describes a whole body study that requires multiple days of imaging, from New Technology APC 1508 to the same new clinical APC 0408 as the assignment of CPT code 78806 (Radiopharmaceutical localization of inflammatory process; whole body), which describes a single day whole body imaging study. While the commenters acknowledged that the two procedures use similar resources for a day of imaging, they stated that the clinical time and work involved in performing a multiple day imaging study is significantly more intensive than a single day study; therefore, hospitals incur additional costs. As such, the commenters disagreed with our proposal to assign the single and multiple day study CPT codes to the same clinical APC because the hospital resources are not homogeneous for these clinically similar studies. The commenters urged CMS to maintain the single day study as described by CPT code 78806 in its current APC assignment, specifically APC 0406 (Level I Tumor/Infection Imaging), and to create a new APC for CPT code 78804 for assignment of the multiple day study. Furthermore, the commenters recommended that the payment rate for CPT code 78804 be based on the current claims data for the procedure.

Response: After further review of our CY 2005 claims data and consideration of the clinical characteristics of CPT code 78804, we agree with the commenters' recommendation to maintain the single day study, which is described by CPT code 78806, in its current CY 2006 APC 0406. We further agree with the commenters' assignment of CPT code 78804 to a separate APC established as Level II Tumor/Infection Imaging, and therefore, have decided to keep this code as the only code assigned to APC 0408 for CY 2007. Based on our final revised policy, the CY 2007 median cost of APC 0408 is $362.05. The separate APC assignments for the single and multiple day tumor/infection imaging studies adequately achieve both clinical and resource coherence for the services in both APCs. Therefore, we are finalizing our proposed CY 2007 APC assignment of CPT code 78804 to new clinical APC 0408 for CY 2007, with modification to the proposal through reconfiguration of APC 0408 as described above.

(7) Gastroesophageal Reflux Test With pH Electrode (APC 0361)

For CY 2007, we proposed to reassign CPT code 91035 (Esophagus, gastroesophageal reflux test; with mucosal attached telemetry ph electrode placement, recording, analysis and interpretation) from New Technology APC 1506 (New Technology—Level VI ($400–$500)) to clinical APC 0361 (Level II Alimentary Tests) with a proposed payment of $242.

Comment: One commenter disagreed with our proposal to reassign CPT code 91035 from New Technology APC 1506 to clinical APC 0361. The commenter believed that the proposed payment level of $242 for APC 0361 did not adequately reflect the cost of providing the service and that it did not appropriately differentiate between the two types of pH monitoring for detection of gastroesophageal reflux disease (GERD): capsule-based and catheter-based. (CPT code 91035 describes the capsule-based pH monitoring service while CPT code 91034 describes the catheter-based pH monitoring procedure.) The commenter believed that the resource costs for the two procedures are significantly different, and as such, each procedure should be placed in a separate APC to accurately reflect the costs of providing the services. The commenter indicated that the average cost of the capsule is about $184, which is significantly higher than the cost of the catheter used for pH monitoring that is priced at about $45. In addition, the commenter requested that CPT code 91035 be designated as a device-dependent procedure, and also requested that CMS establish a C-code for the capsule to appropriately track its cost. The commenter also requested that CMS compare the costs of single claims with claims that include an endoscopy procedure, with which the pH capsule procedure is very commonly performed, to ensure that all costs were captured and based on the most likely clinical scenario when determining the appropriate payment rate for CPT code 91035.

Response: Since April 2004, the procedure described by CPT code 91035 has been designated as a new technology service under the OPPS. While CPT code 91035 was not effective for reporting until January 1, 2005, its predecessor code, specifically HCPCS code C9712 (Insertion of a pH capsule for measurement and monitoring of gastroesophageal reflux disease, includes data collection and interpretation) was designated as a new technology service and assigned to New Technology APC 1506 from April 2004 until December 31, 2004, when the code was deleted and replaced with CPT code 91035. CPT code 91035 was then assigned to the same New Technology

APC for CY 2005, with a payment rate of $450. As usual, in determining the initial payment level for this service, we took into consideration the costs associated with the procedure, including the necessary capsule device.

We do not believe that our claims data from CYs 2004 and 2005 demonstrate that the resources associated with a capsule-based pH monitoring procedure are significantly greater than those required for a catheter-based pH monitoring procedure, leading to their inappropriate assignments to the same clinical APC. Based on our CY 2005 claims data, the median costs for each procedure are relatively comparable: $260 for CPT code 91034 (based on 2,982 single claims) and $300 for CPT code 91035 (based on 1,160 single claims). We believe that both procedures are fairly similar in terms of device cost, clinical staff time, and other facility resources required for performing the procedures. We note that the median cost for CPT code 91035 was based upon 1,160 single claims out of 4,777 total claims for the procedure. While we understand that capsule-based pH monitoring is often initiated in association with an endoscopy procedure, we have no reason to believe that our median cost from single claims calculated according to our standard OPPS methodology understates the cost of the procedure. Indeed, we would expect that the resources could be less if the service were performed in association with another surgical procedure because of efficiencies, although there would be no payment reduction because APC 0361 has a status indicator of ''X.''

With respect to designation of the procedure as device-dependent, we typically have only designated APCs as device-dependent in the context of historical payment adjustments provided for these APCs. Many device-intensive procedures appropriately reside in clinical APCs along with procedures that do not require expensive devices. Currently device HCPCS codes are only established when new pass-through device categories are approved. Therefore, we will not create a new device code to track charges for this particular device that has not had pass-through status. We expect that hospitals will include their charges for the cost of the capsule either in the line-item charge for the pH monitoring procedure or under a separate revenue code line on their claims.

Because we believe that the median cost of APC 0361 appropriately represents the costs and resources involved in performing both capsule-based and catheter-based pH monitoring procedures, and these services are clinically similar, we are finalizing our assignment of CPT code 91035 to APC 0361 for CY 2007 without modification.

(8) Home International Normalized Ratio (INR) Monitoring (APC 0604)

Since CY 2002, home INR monitoring services have been described by two G-codes, specifically G0248 and G0249, and have been assigned to New Technology APCs. These codes were created effective July 2002 in the context of a National Coverage Determination (NCD) that covers home INR monitoring for patients with mechanical heart valves on warfarin that have been anticoagulated for at least 3 months, who undergo an educational program on anticoagulation management and use of the device prior to its use in the home, and who perform self-testing no more than once a week. The G-codes have been assigned to New Technology APCs for 5 years. Generally, codes remain in New Technology APCs until we can determine an appropriate clinical APC, based on the median cost and clinical characteristics of the services described by the code. This usually ranges from approximately 2 to 3 years.

In CY 2002, G0248 and G0249 were assigned to a New Technology APC with a payment rate of $75. In CY 2003, these codes were reassigned to a New Technology APC with a payment rate of $150, and they have remained there since that time.

Our analysis of hospital data for Medicare single and multiple claims submitted from CY 2002 through CY 2005 indicates that these procedures are rarely performed by hospital outpatient facilities. For claims submitted from CY 2002 through CY 2005, our single claims data show that there were zero claims submitted during CYs 2002, 2003, and 2004, and in CY 2005, only nine single claims for G0248 and only seven for G0249 are available for ratesetting. Looking at total claims, from 2002 through 2004, we had fewer than 20 claims for each of the specific services.

In addition, the median costs for these codes are $95 for G0248 and $128 for G0249 based on CY 2005 claims. Because we received no single claims between CY 2002 and CY 2004 for these codes, we have no prior median cost data.

In the CY 2007 OPPS proposed rule (71 FR 49556), we proposed to assign both G0248 and G0249 to clinical APC 0604 (Level I Clinic Visits), with a proposed median cost of $49.93. We believe these assignments were appropriate based on both clinical and resource considerations, in the context of other services also proposed for assignment to APC 0604.

During the August 2006 APC Panel meeting, one presenter recommended that we either continue to assign G0248 and G0249 to a New Technology APC or move them to an appropriate clinical APC consistent with the clinical and resource cost characteristics of providing these services. This technology is used in monitoring the adequacy of anticoagulation in patients taking warfarin to prevent major thromboembolic events. The presenter indicated that providers have been slow to adopt the technology because they must purchase the monitors and materials. The presenter requested that the codes remain in New Technology APCs or be reassigned to clinical APCs that appropriately make payments for the costs of providing the services, so that use of this technology increases and more data can be collected. The Panel agreed that providing payment at an appropriate rate would encourage more use of home INR monitoring, which would actively engage patients in their own care. The Panel recommended that we assign G0248 and G0249 to APC 0421 (Prolonged Physiologic Monitoring) for CY 2007.

Comment: One commenter expressed concern regarding our proposal to move home INR monitoring from New Technology APC 1503 (New Technology—Level III ($100–$200)) to clinical APC 0604. The commenter was particularly concerned that the proposed clinical APC 0604, which has a payment rate of $49.75, would not compensate for the costs incurred in delivering this service. While the commenter understood the reason for assigning these codes to a clinical APC because these codes have been assigned to a New Technology APC since July 2002 (these codes were made effective in July 2002 and announced through the OPPS July 2002 update, specifically Transmittal A–02–050, dated June 17, 2002), the commenter stated that the technology is fairly new with only a small number of hospital claims, which could therefore warrant its continued assignment to the current New Technology APC 1503. The commenter also indicated that the assignments of HCPCS codes G0248 and G0249 to clinical APC 0604 were neither economically nor clinically coherent because none of the other procedures also proposed for assignment to APC 0604 involved the furnishing of equipment and supplies to patients for use in their homes or involved care extended over a 4-week period. Therefore, the commenter urged CMS to maintain home INR monitoring services

in New Technology APC 1503 with a payment rate of $150 for at least one more year. Alternatively, the commenter requested that CMS assign these codes to clinical APC 0421, which had a proposed payment rate of $101.47, because the reimbursement rate more closely corresponded with the costs of providing the services, and also with the clinical characteristics of the other procedure already assigned to this same APC.

Response: As we indicated above, the APC Panel also recommended that these two HCPS codes be assigned to APC 0421 for CY 2007. We agree with both the commenter and the APC Panel's recommendation to assign these codes to APC 0421.

Therefore, we are finalizing our proposed movement of HCPCS codes G0248 and G0249 from New Technology APC 1503 to a clinical APC for CY 2007 with modification. Effective January 1, 2007, HCPCS codes G0248 and G0249 will be assigned to APC 0421, with a final median cost of $99.43.

(9) Tositumomab Administration and Supply (APC 0442)

For CY 2007, we proposed to assign HCPCS code G3001 (Administration and supply of tositumomab, 450 mg) from New Technology APC 1522 (New Technology—Level XXII ($2000–$2500)) to clinical APC 0442 (Dosimetric Drug Administration), which had a proposed median cost of $1,515.80.

Comment: Several commenters, including a pharmaceutical company, expressed concern with the CMS proposal to assign HCPCS code G3001 from New Technology APC 1522 with a payment rate of $2,250 to clinical APC 0442. The commenters were concerned that the payment rate of $1,510.52 that was proposed for APC 0442 would not adequately cover both the cost of the product and the administration of the product itself since the WAC for the tositumomab product was approximately $2,189. They requested that CMS maintain the current payment rate for G3001 of $2,250 for CY 2007. Furthermore, one commenter recommended that HCPCS code G3001, currently applicable to both doses of the non-radioactive component of therapy and its administration, be amended to apply only to the unlabeled tositumomab product. The commenter urged CMS to assign a specific code that describes the unlabeled tositumomab to enable appropriate payment for the product. The commenter added that unlabeled tositumomab alone is only FDA approved as part of the overall BEXXAR therapeutic regimen, and therefore cannot be used other than as part of BEXXAR therapy. The commenter also recommended CMS permit hospitals to use a CPT code for the 1-hour administration of the nonradioactive component of BEXXAR.

Response: We first established G3001 in CY 2003. As we stated in the CY 2004 OPPS final rule with comment period (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 BEXXAR treatment regimen. We do not make separate payment for supplies used in services provided under the OPPS. Payments for necessary supplies are packaged into payments for the separately payable services provided by the hospital. Administration of unlabeled tositumomab is a complete service that qualifies for separate payment under its own APC. This complete service is currently described by HCPCS code G3001. Therefore, we do not agree with the commenter's recommendation that we assign a separate code to the supply of unlabeled tositumomab, which would not then receive separate payment. Rather, we will continue to make separate payment for the administration of tositumomab through G3001, and payment for the supply of unlabeled tositumomab is packaged into the administration payment.

Based on our CY 2005 claims data that show a final median cost of $1,367 for APC 0442, which contains only the service described by G3001, we had 148 single claims for the service. The median cost of G3001 from CY 2004 claims is $1,210 based on 69 single claims. We expect the annual volume of this service to Medicare beneficiaries to remain modest. By CY 2007, G3001 service will have been assigned to a New Technology APC for 3 years, providing two full years of claims data for our analysis. We believe that the final CY 2007 median cost of APC 0442 accurately reflects the hospital resources required to perform the administration and supply of tositumomab service, and that our data are sufficient at this point to support movement of G3001 out of a New Technology APC and into an appropriate clinical APC for CY 2007. Consequently, we are finalizing the proposed CY 2007 reassignment of HCPCS code G3001 from New Technology APC 1522 to clinical APC 0442, without modification.

(10) Summary of Other New Technology Procedures Assigned to Clinical APCs for CY 2007

After carefully considering all of the public comments received, we are adopting our proposal to reassign the new technology procedures to clinically appropriate APCs with modification to the final APC assignments for CPT codes 19296, 19297, 20982, 36566, and 78804 as shown in Table 10 below.

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Table 10.--APC Reassignment of Other New Technology Procedures to Clinical APCs for CY 2007

HCPCS Code	Short Descriptor	CY 2006 SI	CY 2006 APC	CY 2006 Payment Rate	Final CY 2007 SI	Final CY 2007 APC	Final CY 2007 APC Median Cost
0003T (Deleted 12/31/2006)	Cervicography	S	1492	$15.00	N/A	N/A	N/A
0101T	Extracorp shockwv tx,hi enrg	T	1547	$850.00	T	0050	$1,535.66
0102T	Extracorp shockwv tx,anesth	T	1547	$850.00	T	0050	$1,535.66
0133T	Esophageal implant injexn	T	1556	$1,750.00	T	0422	$1,573.89
19296	Place po breast cath for rad	S	1524	$3,250.00	T	0648	$3,130.45
19297	Place breast cath for rad	S	1523	$2,750.00	T	0648	$3,130.45
20982	Ablate, bone tumor(s) perq	T	1557	$1,850.00	T	0051	$2,510.95
28890	High energy eswt, plantar f	T	1547	$850.00	T	0050	$1,535.66
36566	Insert tunneled cv cath	T	1564	$4,750.00	T	0625	$5,100.26
77421	Stereoscopic x-ray guidance	S	1502	$75.00	S	0257	$67.06
78804	Tumor imaging, whole body	S	1508	$650.00	S	0408	$362.05
79403	Hematopoietic nuclear tx	S	1507	$550.00	S	0413	$323.62
90473	Immune admin oral/nasal	S	1491	$5.00	S	0436	$11.06
90474	Immune admin oral/nasal addl	S	1491	$5.00	S	0436	$11.06
91035	G-esoph reflx tst w/electrod	S	1506	$450.00	X	0361	$237.64
C9716	Radiofrequency energy to anu	S	1519	$1,750.00	T	0150	$1,810.00
G0248	Demonstrate use home inr mon	S	1503	$150.00	X	0421	$99.43
G0249	Provide test material,equipm	S	1503	$150.00	X	0421	$99.43
G0293	Non-cov surg proc,clin trial	S	1505	$350.00	X	0340	$37.29
G0294	Non-cov proc, clinical trial	S	1502	$75.00	X	0340	$37.29
G0375	Smoke/tobacco counseling 3-10	S	1491	$5.00	X	0031	$10.79
G0376	Smoke/tobacco counseling >10	S	1491	$5.00	X	0031	$10.79
G3001	Admin + supply, tositumomab	S	1522	$2,250.00	S	0442	$1,366.81

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D. APC-Specific Policies

1. Radiology Procedures

a. Radiology Procedures (APCs 0333, 0662, and Other Imaging APCs)

At its March 2006 meeting, the APC Panel made three recommendations regarding radiology services. These included the following:

- Reaffirmed the CY 2005 recommendation that CMS postpone implementation of the multiple procedure reduction policy for imaging services as included in the CY 2006 OPPS proposed rule for CY 2007, to allow CMS to gather more data on the efficiencies associated with multiple imaging procedures that may already be reflected in the OPPS payment rates for imaging services.
- Recommended that CMS review payment rates for computed tomography (CT) and computed tomographic angiography (CTA) procedures to ensure that their payment rates are comparatively consistent and that they accurately reflect resource use.
- Recommended that CMS invite comments on ways that hospitals can uniformly and consistently report charges and costs related to radiology services.

In the CY 2006 OPPS final rule with comment period (70 FR 68707), we indicated that, based on the APC Panel's recommendations and public comments received, we decided not to finalize our CY 2006 proposal to reduce OPPS payments for some second and subsequent diagnostic imaging procedures performed in the same session. Our analyses did not disprove the commenters' contentions that there are efficiencies already reflected in their hospital costs, and, therefore, in their CCRs and the median costs for the procedures. As noted in the CY 2007 OPPS proposed rule (71 FR 49567), over the past 7 months, we have conducted additional studies of our hospital claims data for single and multiple diagnostic imaging procedures, and our analyses support continued deferral for CY 2007 of implementation of a multiple imaging procedure payment reduction policy in the OPPS. Therefore, we accepted the APC Panel's recommendation to not adopt such a policy for CY 2007 pending the results of further analyses. Depending upon the findings from such studies, in a future rulemaking we may propose revisions to the structure of our rates to further refine these rates in the context of additional study findings.

We received numerous public comments concerning our proposal. A summary of the comments and responses follow:

Comment: Numerous commenters supported the CMS proposal to defer implementing a multiple imaging

procedure payment reduction policy in the OPPS for CY 2007. A number of commenters reiterated that CMS should never implement such a policy in the OPPS, based on the inherent characteristics of the standard methodology that is used to establish OPPS payment rates that already captures the efficiencies of these multiple services in the CCRs used to convert charges to costs on hospital claims. They argued that such discounting is not needed and unwarranted, because discounting has already been considered in setting the APC weights.

Response: We continue to be concerned about making appropriate payments for imaging services in the common circumstances where multiple procedures using the same imaging modality are provided in the same encounter. We will continue to study our single and multiple outpatient hospital claims for diagnostic imaging procedures and consider refinements to our payment rates for these services if results from the analyses suggest that changes to our payment policies would provide more accurate payments for these services.

After carefully considering the public comments received, we are adopting our proposal to defer implementation of a multiple imaging procedure payment reduction for CY 2007, without modification.

As indicated in the CY 2007 OPPS proposed rule (71 FR 49568), we also accepted the APC Panel's recommendation to review the CY 2007 proposed payment rates for CT and CTA procedures to ensure that their rates were comparatively consistent and accurately reflective of hospitals' resource costs. Presenters at the March 2006 APC Panel meeting indicated to the Panel that hospital resources for CTA procedures were similar to those for CT procedures that included scans without contrast followed by scans with contrast, but additional resources were required for the 3-dimensional reconstruction that was part of the CTA procedures. As a result of this image postprocessing, CTA scans displayed the vasculature in a 3-dimensional format rather than in the 2-dimensional cross-sectional images of conventional CT scans. As indicated in our CY 2007 proposed rule (71 FR 49568), based upon CY 2005 claims data, the CY 2007 proposed median cost for APC 0333 for CT procedures that included scans without contrast material, followed by contrast scans to complete the studies was $309, and the CY 2007 proposed median cost for APC 0662 for CTA procedures was $304. As has been the case for the past several years, the proposed median costs associated with these two APCs were virtually identical to one another and were also quite consistent with their historical costs from prior years of claims data. The CY 2007 proposed median costs for APCs 0333 and 0662 were based on about 500,000 and 150,000 single claims, respectively. The stability of these APC median costs, based on large numbers of single claims, was consistent with our belief that the median costs of these APCs accurately reflected hospitals' resource use. From CY 2004 to CY 2005, the number of CTA procedures performed in the outpatient department increased by 50 percent, whereas the number of CT procedures that included a scan without contrast followed by a scan with contrast to complete each full study increased by only about 1 percent. The large annual increases in the OPPS frequencies of CTA procedures through CY 2005 provided no evidence that Medicare beneficiaries were experiencing difficulty accessing these services in the hospital outpatient setting. CTA procedures were being more commonly performed for various clinical indications, likely resulting in more consistent and efficient use of the associated image postprocessing technology. Accordingly, it is not surprising that the hospital costs of typical CTA procedures in contemporary medical practice were very similar to the hospital costs of the more involved and resource-intensive complex CT services that, like CTA procedures, included scans without contrast material, followed by scans with contrast. Thus, we indicated in the CY 2007 proposed rule that we believed that our CY 2007 proposed payment rates for CT and CTA procedures were generally consistent with one another and accurately reflective of hospitals' resource costs.

We received several comments concerning our proposal. A summary of the comments and our responses follows:

Comment: Several comments on our proposed payment rate of $302.85 for the CTA procedures placed in APC 0662 (CT Angiography) indicated that the CTA procedures were reimbursed at a lower rate than conventional CT procedures, although the utilization costs of CTA exceeded conventional CT. The commenters urged CMS to set the payment for APC 0662 at a rate equal to the sum of APC 0333 (Computerized Axial Tomography and Computerized Angiography without Contrast followed by Contrast), which had a proposed payment rate of $307.88, and the postprocessing APC, specifically, APC 0282 (Miscellaneous Computerized Axial Tomography), which had a proposed payment rate of $95.72. Alternatively, the commenters suggested that CMS reassign the CTA procedures from APC 0662 to an existing APC that more closely reflected the resource costs of performing the procedures.

Response: While we acknowledge the commenters' concerns, we believe that our claims data accurately reflect the resource costs associated with providing the CTA services. As we stated in the November 15, 2004 final rule with comment period (69 FR 65722) and further reiterated in the November 10, 2005 final rule with comment period (70 FR 68597), accurate cost information about the costs of image reconstruction for CTA specifically, and for CT alone as utilized with CTA, would be required in order to implement one commenter's suggestion that we make the payment rate for CTA (APC 0662) equal to the sum of the rates for CT alone (APC 0333) plus image reconstruction (APC 0282). However, such cost information is still not available.

We have had several years of robust claims data for CTA procedures, whose code descriptors by definition include the required CT scans and image postprocessing, and have no reason to doubt these data. Based on the full year of CY 2005 data, we note that the median cost of $295.80 for APC 0333 (CT) is almost equal to the median cost of $296.70 for APC 0662 (CTA). Moreover, for specific reasons cited in the CY 2006 OPPS final rule (70 FR 68599), we are not reassigning the CTA procedures to any other clinical APC(s) for CY 2007. We believe that APC 0662 is quite homogeneous and see no other clinical APC where these services could be appropriately assigned based on clinical and resource considerations. We will apply the same standard OPPS ratesetting methodology for CY 2007 that we used for CY 2006 in establishing the payment rate for CTA procedures residing in APC 0662.

After carefully considering the public comments received, we are finalizing our proposal for payment of APCs 0333 and 0662 based on their median costs established according to the standard OPPS methodology, without modification.

With respect to the APC Panel's recommendation regarding the reporting of costs and charges for radiology services, as we noted in the proposed rule, CMS requires hospitals to report their costs and charges through the cost report with sufficient specificity to support CMS' use of cost report data for monitoring and payment. Within generally accepted principles of cost

accounting, we allow providers flexibility to accommodate the unique attributes of each institution's accounting systems. For example, providers must match the generally intended meaning of the line-item cost centers, both standard and nonstandard, to the unique configuration of department and service categories used by each hospital's accounting system. Also, while the cost report provides recommended bases of allocation for the general services cost centers, a provider is permitted, within specified guidelines, to use an alternative basis for a general service cost if it can justify to its fiscal intermediary that the alternative is more accurate than the recommended basis. This approach creates internal consistency between a hospital's accounting system and the cost report, but cannot guarantee the precise comparability of costs and charges for individual cost centers across institutions.

However, in the CY 2007 proposed rule, we indicated that we believed that achieving greater uniformity by, for example, specifying the exact components of individual cost centers, would be very burdensome for hospitals and auditors. Hospitals would need to tailor their internal accounting systems to reflect a national definition of a cost center. It was not clear that the marginal improvement in precision created by such a requirement would justify the additional administrative burden. We believed that the current hospital practice of matching costs to the general intended meaning of a cost center ensures that most services in the cost center would be comparable across providers, even if the precise composition of a cost center among hospitals differed. Further, every hospital provides a different mix of services. Even if CMS specified the components of each cost center, costs and charges on the cost report would continue to reflect each individual hospital's mix of services. At the same time, internal consistency is very important to the OPPS. Costs are estimated on claims by matching CCRs for a given hospital to their own claims data through a cost center-to-revenue code crosswalk. OPPS relative weights are based on the median cost for all services in an APC. The components resulting in CCRs for a given revenue code would have to be dramatically different for the providers contributing the majority of claims used to calculate an APC's median cost in order to impact relative weights.

We accepted the APC Panel's recommendation and specifically invited comments on ways that hospitals can uniformly and consistently report charges and costs related to all cost centers, not just radiology, that also acknowledge the ubiquitous tradeoff between greater precision in developing CCRs and administrative burden associated with reduced flexibility in hospital accounting practices.

We received a number of public comments concerning this APC Panel recommendation. A summary of the comments and our responses follows:

Comment: Several commenters agreed that any steps taken to ensure greater uniformity in the reporting of costs and charges would have to carefully balance the additional administrative burden and loss of flexibility in hospitals' accounting practices. They noted that the difficulty in applying CCRs to arrive at hospital costs is that this requires assumptions of consistency in the relationship of HCPCS codes and revenue codes to revenue center service categories on the cost report. However, the cost report recognizes service categories that reflect the general descriptions of a hospital's service categories, but services that were at one time performed in a specific department of the hospital may now be performed in many departments of hospitals. The commenters noted that inconsistencies occur when determining the cost of a service if the CCR utilized in the calculation is from a different cost report service category than where the service was actually performed. The commenters also urged CMS to recognize the limitations and inconsistencies in the preparation of hospital cost reports, attributable to both hospital and fiscal intermediary behavior. They urged CMS to proceed with care in instructing hospitals because hospitals need the flexibility to set charges and allocate costs in a manner that makes the most sense for the particular hospital based on the mix of services it provides. The commenters noted that even small changes in practice and procedures require significant systems changes, and that CMS should allow time for dissemination of any such changes, coupled with significant provider education.

Response: We appreciate the commenters' observations. We will continue to reflect on the delicate balance between greater accuracy in developing CCRs to convert charges to costs under the OPPS and the needs of hospitals for flexibility in their accounting practices.

After carefully considering the public comments received, we will continue to seek input on this balance as we work on refining the OPPS payment system to pay more accurately for outpatient hospital services.

For CY 2007, we did not propose to make any changes from CY 2006 in our proposed APC assignments of CT, magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA) services, preserving the longstanding APC groupings of these services. In particular, CT services were assigned to APCs 0332 (Computed Tomography without Contrast), 0283 (Computed Tomography with Contrast Material), and 0333 (Computed Tomography without contrast followed by Contrast) based upon their nature as studies without contrast, with contrast, and without contrast followed by contrast, respectively. MRI and MRA procedures were assigned to APCs 0336 (Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast), 0284 (Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast), and 0337 (Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast) based upon their characteristics as studies without contrast, with contrast, and without contrast followed by contrast, respectively.

Comment: One commenter requested that CMS revise the established CT, MRI, and MRA APC groupings to create greater internal clinical and resource consistency. The commenter believed that diagnostic services performed in the same anatomical region have similar resource utilization and should, therefore, be assigned to the same APC grouping. The commenter recommended that CMS differentiate among these services based on two body regions, the core (including the head, neck, thorax, spine, chest, abdomen, and pelvis) and the extremities (including the orbit/ear/fossa, maxillofacial region, upper extremity, and lower extremity). The commenter argued that because the OPPS was being used as the benchmark established by the DRA to limit payment for imaging services under the MPFS, this refinement would assist in ensuring even greater resource similarity of procedures within imaging APCs to establish more accurate payment rates under both the OPPS and the MPFS.

Response: We examined the current APC structure for CT, MRI, and MRA services and observed that there were no violations of the 2 times rule in any of the APCs. The median costs of the services assigned to each APC were relatively close, and we did not identify any code-specific patterns of significantly increased or decreased

costs based on the specific anatomical region of the body imaged. We believe these APCs as currently structured contain services that are quite homogeneous with respect to their clinical and resource characteristics. The OPPS provides payments for APC groups of closely related procedures, and the current imaging groups provide appropriate payments for these services in a manner that is consistent with the payment policies of the OPPS. Accordingly, we see no reason to further distinguish CT, MRI, and MRA procedures into even smaller, more refined groupings. We also do not believe it would be appropriate to adjust these APC groups in order to affect the payments for CT, MRI, and MRA procedures under the MPFS.

After carefully considering the public comment received, we are finalizing our CY 2007 proposal for payment of CT, MRI, and MRA procedures, without modification. b. Computerized Reconstruction (APC 0417)

We proposed to assign HCPCS code G0288 (Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery) to APC 0417 (Computerized Reconstruction) for CY 2007, with a proposed median cost of $192.34. This was the same APC assignment as CY 2006, and this service is the only service assigned to the APC.

Comment: One commenter strongly opposed the proposed payment amount for CY 2007 for HCPCS code G0288. The commenter stated that the OPPS proposed payment amount was not nearly enough to cover the hospital's costs for providing this important service. The commenter believed that implementation of the proposed payment would jeopardize the quality of the HCPCS code G0288 procedures that are performed, limit beneficiary access to the services, and result in postoperative complications due to implantation of poorly fitting stents.

Response: The payment amount proposed for the APC 0417, to which HCPCS code G0288 is the only service assigned, is based on the median cost from 6,028 single claims for this one service. We are confident that these data provide an accurate representation of hospital costs for providing the service. We note that despite reductions in payment rates over the last several years, the number of total procedures billed under the OPPS for HCPCS code G0288 has risen steadily from 2,065 in CY 2002, to 4,733 in CY 2003, to 8,421 in CY 2004, and most recently to 9,395 in CY 2005. We have no evidence that Medicare beneficiaries are having trouble accessing this service based on our hospital claims information. We believe that it is appropriate for us to use our historical hospital cost data as the basis for the CY 2007 payment amount. Therefore, we are finalizing our CY 2007 payment rate for APC 0417 based on a median cost of $197.95.

c. Cardiac Computed Tomography and Computed Tomographic Angiography (APCs 0282, 0376, 0377, and 0398)

In Addendum B of the CY 2007 proposed rule (71 FR 49832), we proposed to assign the eight cardiac computed tomography (CCT) and computed tomographic angiography (CCTA) Category III CPT codes to the APCs as shown in Table 11 below. These services were new for CY 2006, and we did not propose any changes to their APC assignments for CY 2007.

TABLE 11.—PROPOSED CY 2007 APC ASSIGNMENTS FOR CCT AND CCTA CATEGORY III CPT CODES

CPT code	Descriptor	Proposed CY 2007 APC assignment	Proposed CY 2007 APC assignment payment rate
0144T	CT heart wo dye; qual calc	0398	$261.66
0145T	CT heart w/wo dye funct	0376	306.34
0146T	CCTA w/wo dye	0376	306.64
0147T	CCTA w/wo, quan calcium	0376	306.34
0148T	CCTA w/wo, strxr	0377	415.12
0149T	CCTA w/wo, strxr quan calcium	0377	415.12
0150T	CCTA w/wo, disease strxr	0398	261.66
0151T	CT heart funct add-on	0282	95.72

Comment: Several commenters requested that CMS remove the APC assignments for the eight CCT and CCTA procedures because these codes fall within the Category III CPT code section, and because they are carrier-priced and not assigned any relative value units under the MPFS. The commenters believed that the Deficit Reduction Act MPFS provisions should not apply to these procedures.

Response: As we stated in a section III.A.2. of this CY 2007 OPPS final rule with comment period, we implement Category III codes that are released by the AMA in July of a given year for implementation in January of the next year by providing them with new interim assignments in the OPPS final rule for the next update year. These CCT and CCTA codes were released in July 2005 for implementation in January 2006. We received no public comments on their interim final APC assignments published in Addendum B of the CY 2006 OPPS final rule with comment period. As we indicated in our CY 2007 OPPS 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 in an existing APC. 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. We believe that CCT and CCTA procedures are appropriate for separate payment under the OPPS should local contractors provide coverage for these procedures, and, therefore, they warrant status indicator and APC assignments that would provide separate payment under the OPPS. MPFS concerns regarding payment limitations for these procedures are outside the scope of this final rule with comment period.

Comment: Many commenters expressed their appreciation of our recognition of the CPT codes as separately payable services under the OPPS; however, they believed that the CCTA Category III CPT codes (0144T

through 0151T) should be moved from APCs 0282, 0376, 0377, and 0398, to appropriate New Technology APCs so that adequate hospital claims data could be gathered. They provided specific recommendations for the New Technology APC assignments of these services. These same commenters added that once CMS has acquired adequate claims data, pricing information could be used to separate and incorporate the various Category III CCTA CPT codes into clinical APCs. Some commenters were also concerned that CCT and CCTA procedures were not clinically homogeneous with other procedures currently assigned to APCs 0282, 0376, 0377, and 0398, noting that the last three APCs previously contained only nuclear medicine cardiac imaging procedures.

Response: We appreciate the suggestions submitted by the commenters. However, as we indicated above, some of the new Category III CPT codes describe services that we have determined to be similar in clinical characteristics and resource use to HCPCS codes in an existing APC. In these instances, we may assign the Category III CPT code to the appropriate clinical APC. In the case of these eight CCT and CCTA procedures, we believe that their clinical characteristics and resource use are similar to the other procedures assigned to APCs 0282, 0376, 0377, and 0398. We have not limited APCs 0376, 0377, and 0398 solely to nuclear medicine cardiac imaging services. We believe that cardiac imaging services using different modalities may be appropriate for assignment to the same clinical APCs, based on their clinical and resource characteristics. The OPPS is a prospective payment system that provides payment for services based on their assignment to APC groups, and, as such, we think the proposed APC assignments for these CCT and CCTA services, which are the same as their CY 2006 interim final assignments, are appropriate. While we understand that use of CCT and CCTA to image the heart are relatively new applications of specifically refined technology, cardiac imaging using other modalities is already well-established, as is the noncardiac use of CT and CTA. Therefore, for CY 2007, we are continuing with our proposal to assign Category III CPT codes 0144T through 0151T to clinical APCs 0282, 0376, 0377, and 0398. We expect to have claims data for these procedures available for the CY 2008 OPPS update.

After carefully considering the public comments received, we are finalizing our proposal without modification to assign CPT codes 0144T through 0151T to APCs 0282, 0376, 0377, and 0398, all with status indicator ''S.''

d. Radiologic Evaluation of Central Venous Access Device (APC 0340)

For CY 2006, new CPT code 36598 (Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopic guidance) was assigned to APC 0340 (Minor Ancillary Procedures) on an interim final basis. The proposed assignment of the code for CY 2007 was unchanged.

Comment: One commenter requested that CMS assign new CPT code 36598 to APC 0263 (Level I Miscellaneous Radiology Procedures) for CY 2007. The commenter stated that the procedure reported by CPT code 36598 is very similar to that which is coded using CPT code 76080 (Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation), which is assigned to APC 0263 for CY 2006. Further, the commenter stated that the use of contrast and fluoroscopy makes CPT code 36598 more resource intensive than the other procedures assigned to APC 0340, where CMS assigned it with an interim final status for CY 2006.

Response: We will not have data upon which to base our decisions about the APC assignment for this procedure until next year. However, based on our data for many procedures that we believe are similar to that coded by CPT code 36598, we believe that assignment to APC 0340 is appropriate and do not believe that it is appropriate to reassign it to another APC at this time.

We are maintaining the assignment of CPT code 36598 to APC 0340 for CY 2007 and will reevaluate that assignment when data become available.

2. Nuclear Medicine and Radiation Oncology Procedures

a. Myocardial Positron Emission Tomography (PET) Scans (APC 0307)

From August 2000 to December 31, 2005, under the OPPS we assigned to one clinical APC all myocardial positron emission tomography (PET) scan procedures, which were reported with multiple G-codes through March 31, 2005. Effective April 1, 2005, myocardial PET scans were reported with three CPT codes, specifically CPT codes 78492 (Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress), 78459 (Myocardial imaging, positron emission tomography (PET), metabolic evaluation), and 78491 (Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress) under the OPPS. Public comments on the CY 2006 OPPS proposed rule suggested that the HCPCS codes describing multiple myocardial PET scans should be assigned to a separate APC from single study codes because their hospital resource costs are significantly higher than single scans. Review of the CY 2004 claims data for myocardial PET scans revealed a median cost of $2,482 for the 9 G-codes that describe multiple myocardial PET scans, based upon 978 single claims of 2,001 total claims for multiple scan procedures. The CY 2004 claims data showed a median cost of $800 for the 6 G-codes describing single PET studies, based on 391 single claims of 575 total claims. A review of CY 2003 claims data showed a similar pattern of significantly higher hospital costs for multiple myocardial PET studies in comparison with single studies, although there were fewer claims for the procedures in CY 2003 in comparison with CY 2004. In response to the comments received and based on this claims information, myocardial PET services were assigned to two clinical APCs for the CY 2006 OPPS. HCPCS codes for single scans were assigned to APC 0306 with a payment rate of $800.55, and HCPCS codes for the multiple scan procedures were assigned to APC 0307 (Myocardial Positron Emission Tomography (PET) Imaging) with a payment rate of $2,484.88.

Analysis of the CY 2005 claims data for myocardial PET scans for the CY 2007 proposed rule revealed that the APC median costs for the single and multiple myocardial PET codes were $836 and $680 respectively, based on 296 single claims for single studies and 1,150 single claims for multiple scan procedures. Despite more CY 2005 single claims for multiple scan procedures, the median cost of these procedures declined significantly from CY 2004 to CY 2005, dropping below the median cost of single studies. As indicated earlier, there was a significant coding change for myocardial PET services in CY 2005, with the reporting of a single CPT code for multiple studies (CPT code 78492), in comparison with nine G-codes in CY 2004. We examined the single bills for multiple scan procedures from CY 2004 and noted 17 hospitals were represented, with the majority of those claims from a single hospital. In contrast, in the CY 2005 claims, 25 hospitals were represented in the single bills for multiple scan procedures, and no single hospital contributed a majority of claims to the median cost calculation. We also

examined differences in charges associated with G-codes versus the CPT code to determine if hospitals had adjusted the charge for the CPT code to reflect the termination of the multiple study G-codes. However, the individual charging practices of hospitals did not appear to vary with the use of a G-code versus the CPT code in either the CY 2004 or the CY 2005 claims. Greater volume of claims and consistent charging for both the G-codes and CPT code by hospitals suggested that the median appropriately captured the greater variability in relative hospital costs for multiple myocardial PET studies in the CY 2005 claims data.

Based on these claims data, we believe that it is apparent that the use of myocardial PET scan technology had become more widely prevalent in hospitals, and as a result, we had more data to support our proposed payment rates. We believed that the median costs from our CY 2005 claims data for myocardial PET scan services, calculated based upon our standard OPPS methodology and based on almost 1,600 single claims, for both the single and multiple scans, were reflective of the hospital resources required to provide the services to Medicare beneficiaries in the outpatient hospital setting. Based on those data, we concluded in the CY 2007 proposed rule that the differential median costs of the single and multiple study procedures did not support the two-level APC payment structure. Although we acknowledged that some individuals may believe that multiple scan procedures should require increased resources at some hospitals in comparison with single scans, particularly because of the longer scan times required for multiple studies, we noted that our data did not support a resource differential that would necessitate the placement of these single and multiple scan procedures into two separate APCs. As myocardial PET scans are being provided more frequently at a greater number of hospitals than in the past, we believed that it was possible that most hospitals performing multiple PET scans were particularly efficient in their delivery of higher volumes of these services and, therefore, incurred hospital costs that were similar to those of single scans, which were provided less commonly. In fact, the CPT code for multiple scans had a lower median cost than either of the CPT codes for single procedures.

When all myocardial PET scan procedure codes were combined into a single clinical APC, as they were prior to CY 2006, the CY 2007 proposed rule APC median cost for myocardial PET services was about $727, very similar to the $703 median cost of their single CY 2005 clinical APC. Therefore, for CY 2007, we proposed to assign CPT codes 78459, 78491, and 78492 to a single APC, specifically, APC 0307. We believed that the assignment of these three CPT codes to APC 0307 was appropriate, as the CY 2005 claims data revealed that more hospitals were providing multiple myocardial PET scan services, most myocardial PET scans were multiple studies, and the hospital resource costs of single and multiple studies were similar. We believed that the proposed median cost appropriately reflected the hospital resources associated with providing myocardial PET scans to Medicare beneficiaries in cost-efficient settings. Further, we believed that the proposed rates were adequate to ensure appropriate access to these services for Medicare beneficiaries. We specifically invited comments on our proposal to provide a single payment rate for all myocardial PET scans in CY 2007. The myocardial PET scan CPT codes and their CY 2007 proposed APC assignments were displayed in Table 17 of the CY 2007 OPPS proposed rule (71 FR 49567).

Comment: A number of commenters requested that CMS not finalize our proposed APC assignments for CPT codes 78492, 78459, and 78491. The commenters stated that it is inappropriate to assign multiple scan procedures to the same APC with single scan procedures as we proposed, because CPT code 78492 requires more hospital resources than do CPT codes 78459 and 78491. The commenters stated that multiple scans require significantly greater hospital resources due to much longer scan times, and believed that our median cost data were seriously flawed.

The commenters objected to the proposal to assign the multiple scan procedures to the same APC as the single scans because they believed the APC assignment creates a 2 times violation for APC 0306; the proposed payment for the multiple scan procedures decreases by 71 percent between CYs 2006 and 2007; if payment is allowed to decrease to the level proposed by CMS, beneficiary access to these important diagnostic procedures (CPT code 78492) will be seriously restricted; the Medicare program will have to spend more for diagnostic procedures such as cardiac catheterizations if hospitals cannot afford to offer the multiple scan myocardial PET procedures; and CMS does assign other cardiac nuclear medicine studies to separate APCs based on whether they are single or multiple.

The commenters recommended that CMS retain the multiple scan procedures in a separate APC as in CY 2006, and that the payment rate decrease be dampened to mitigate the potential for underpayment, as we have in the past for device-dependent and blood product APCs. One commenter suggested that CMS dampen payment for the multiple scans APC by 15 percent each year for the next 2 to 3 years to moderate the large payment decrease for the multiple myocardial PET scans.

Response: We understand the commenters' objections to the median cost for the multiple myocardial PET scans, but see no reason to modify our proposal to assign them to the same APC with the single scans. We do not believe that our data are erroneous. Myocardial PET scans are not new procedures and the data across years, except for the CY 2004 claims data, have been relatively consistent with regard to median costs, while the frequency of multiple scans has been growing consistently. As described above, we explored many aspects of the CY 2005 claims data in an attempt to explain the decreased costs reported for the multiple scans and to assure ourselves and the public that the data were reliable. Our additional investigations included analyses of claims to determine whether they were submitted by only a few hospitals and whether any of the hospitals accounted for an unusually high number of the multiple scan claims or for unusually low costs. We also examined the claims in an attempt to detect whether there were differences in billing practices for the CPT code compared to the predecessor G-codes for multiple myocardial PET scans. There was no indication that the data are erroneous in any regard. Claims were submitted by at least 25 hospitals (compared to 17 in the CY 2004 claims data), and no hospital was responsible for a disproportionate number of claims (in contrast to what was found in the CY 2004 claims) or for unusually low costs. No systematic hospital coding irregularities were discovered. Further, the number of single claims for the multiple scan procedures increased from 872 in the proposed rule data to 983 in the final rule data and the median cost remained stable, increasing by only $5.00, still lower than the median cost for single scans.

Our data do not support a resource differential that warrants assignment of the multiple myocardial scan procedures to an APC separate from the single scans. Single and multiple scan

procedures are closely related from a clinical perspective, and their hospital resources required, as reflected in our claims data, appear comparable in terms of cost. The 2 times violation for CY 2007 in APC 0307 results from the inclusion of limited data from one G-code for multiple scan procedures that was reported for the first 3 months of CY 2005. The median cost for that G-code is $1,840, based on 129 single claims. However, the code was deleted in CY 2005, and the median cost for the CPT code that replaced it is only $665, based on 983 single claims. We utilized the data from the predecessor G-code in developing the median cost for APC 0307 (where it would be likely to affect the APC median cost by raising it). The fact that data from a deleted code are responsible for the violation leads us to conclude that the violation is not significant. Therefore, based on clinical and resource homogeneity, we are excepting APC 0307 from the 2 times rule for CY 2007.

By assigning the multiple and single scans to the same clinical APC for myocardial PET scans, we are maintaining the clinical and resource use homogeneity in APC 0307, where the APC payment will be slightly higher for the multiple scans than it would have been if we retained the multiple scans in a separate APC.

Similarly, we do not believe that there is a basis for dampening the payment decrease for a separate multiple myocardial PET scan APC. Although we have adjusted payment amounts for device-dependent and blood product APCs in the past, as noted by the commenters, we generally have done so to moderate the effects on payment resulting from inaccurate claims data that failed to fully capture the costs associated with the procedures in ways that we could partially identify. In some of these situations, we had very few single claims, contributing to the problem of unstable payment rates, but myocardial PET scans have significant numbers of single claims. We have examined the claims data thoroughly and found nothing to indicate inaccuracy for myocardial PET scans. To the contrary, with the exception of the CY 2004 claims data, we found that costs from the CY 2005 claims are relatively consistent with costs calculated from claims for myocardial PET scans provided in years before CY 2004. We believe that our CY 2006 APC assignments for multiple and single myocardial PET scans to separate APCs were based on data that were unduly affected by one hospital's unusually high charges for multiple scans.

Without evidence that the claims data for CPT codes 78459, 78491, and 78492 are too flawed to use as a basis for setting weights, we believe it is prudent to establish the CY 2007 payment rate for APC 0307 using the standard OPPS methodology for developing payment rates.

After carefully considering the public comments received, we are finalizing the APC assignments for the myocardial PET procedures as shown in Table 12 below without modification.

TABLE 12.—CY 2007 APC ASSIGNMENT FOR MYOCARDIAL PET

HCPCS code	Short descriptor	CY 2007 SI	CY 2007 APC	CY 2007 median cost	CY 2007 Final APC 307 median cost
78459	Heart muscle imaging (PET)	S	0307	$784.42	$726.98
78491	Heart image (pet), single	S	0307	1,014.61	726.98
78492	Heart image (pet), multiple	S	0307	665.42	726.98

b. Complex Interstitial Radiation Source Application (APC 0651)

APC 0651 (Complex Interstitial Radiation Source Application) contains only one code, CPT code 77778 (Complex interstitial application of brachytherapy sources). The coding, APC assignment, median cost, and resulting payment rate for CPT code 77778 have not been stable since the inception of the OPPS, and that instability has been a source of concern to hospitals that furnish the service and to specialty societies. The vast majority of claims for interstitial brachytherapy are for the treatment of patients with a diagnosis of prostate cancer. The historical coding, APC assignments, and payment rates for CPT code 77778 and the related service CPT code 55859 (Transperitoneal placement of needles or catheters into the prostate for application of brachytherapy sources) were displayed in Table 14 of the CY 2007 OPPS proposed rule (71 FR 49564), and are reproduced below in Table 13.

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Table 13. -- Historical Payment Rates for Complex Interstitial Application of Brachytherapy Sources

OPPS CY	Combination APC	Payment Rate for CPT Code 77778	APC for 77778	Payment Rate for CPT Code 55859	APC for 55859	Source
2000	N/A	$198.31	APC 0312	$848.04	APC 0162	Pass-through
2001	N/A	$205.495	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 (if **prostate** brachytherapy with iodine sources)	G0261 APC 648 $5,154.34	N/A	N/A	N/A	N/A	Packaged
2003 (if **prostate** brachytherapy with palladium sources)	G0256 APC 649 $5,998.24	N/A	N/A	N/A	N/A	Packaged
2003 (if **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

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We have frequently been informed by the public that the instability in our payment rates for APC 0651 creates difficulty in planning and budgeting for hospitals. Moreover, we have been informed that, in this case, reliance on single procedure claims results in use of only incorrectly coded claims for prostate brachytherapy because, for application to the prostate, which is estimated to be 85 percent of all occurrences of CPT code 77778, a correctly coded claim is a multiple procedure claim. Specifically, we have been advised that a correctly coded claim for prostate brachytherapy should include, for the same date of service, both CPT codes 55859 and 77778, brachytherapy sources reported with C-codes, and typically separately coded imaging and radiation therapy planning services. We have been further advised that, in the cases of complex interstitial brachytherapy where sources are placed in sites other than the prostate, the charges for both placing the needles or catheters and for applying the sources may be reported by CPT code 77778 alone because there are no other specific CPT codes for placement of needles or catheters in those sites. In other cases, the placement of needles or catheters may be reported with not otherwise classified codes specific to the treated body area.

At the March 2006 APC Panel meeting, presenters urged the Panel to recommend that CMS use only single procedure claims that contained charges for brachytherapy sources on the same claim with CPT code 77778 to set the median cost for APC 0651. Presenters also urged that CMS adopt a process for using multiple procedure claims to set the median for APC 0651 that would 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. The presenters also urged CMS to provide hospitals with education on correct coding of brachytherapy services and devices of brachytherapy required to perform brachytherapy procedures. 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 believed that these claims 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 procedure than hospitals that did not report the separately payable brachytherapy sources.

The APC Panel recommended that CMS reevaluate the proposed payment for brachytherapy services in APC 0651 for CY 2007. The APC Panel also recommended that CMS formally work with the Coalition for the Advancement of Brachytherapy, the American Brachytherapy Society, and the American Society for Therapeutic Radiology and Oncology to evaluate the methodology for setting brachytherapy service payment rates in APC 0651.

In response to the APC Panel recommendations, we explicitly analyzed the standard OPPS methodology that we used in determining our CY 2007 proposed payment rate for APC 0651 in the context of alternative multiple bill methodologies.

The organizations that the APC Panel asked us to work with have frequently brought their concerns to our attention through the rulemaking process and otherwise. As stated in the CY 2007 OPPS proposed rule, we will consider the input of any individual or organization to the extent allowed by Federal law, including the Administrative Procedure Act (APA)

and the Federal Advisory Committee Act (FACA) (71 FR 49564).

We establish the OPPS rates through regulations. 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.

For the CY 2007 OPPS proposed rule, we developed a median cost for APC 0651 using single procedure claims and the general OPPS methodology, but we also looked at multiple procedure claims that contained the most common combinations of codes used with APC 0651. In the proposed rule, our single procedure claims process using CY 2005 data resulted in using 1,123 claims to calculate a proposed median cost of $1,028.93 for APC 0651. We added CPT code 76965, a CPT code for ultrasound guidance that commonly appeared on claims for complex interstitial brachytherapy, to the bypass list for CY 2007 after close clinical review because we believed that it would typically have little associated packaging. We believed that this change, along with maintenance of CPT code 77290 for complex therapeutic radiology simulation-aided field setting on the bypass list, was responsible for the growth in single procedure claims from the 381 single bills upon which the final APC 0651 median cost was calculated for CY 2006. However, only 6 of these 1,123 single and ''pseudo'' single claims data used in calculating the proposed median cost also included brachytherapy sources used in complex interstitial brachytherapy source application, and the median cost for these 6 claims at $600.68 was significantly less than the median cost for all single claims. It was unclear why so many of these claims did not contain brachytherapy sources, which were separately paid at cost in CY 2005. Because we proposed to pay separately for brachytherapy sources again for CY 2007, we saw no reason to believe that these few claims for brachytherapy services that included sources, which also did not report CPT code 55859 for placement of needles or catheters into the prostate, were more correctly coded than those claims that did not separately report brachytherapy sources. We believed it was possible that hospitals billing CPT code 77778 and not the associated brachytherapy sources may have bundled their charges for the brachytherapy sources into their charge for CPT code 77778.

We also identified multiple procedure claims that contained both CPT codes 55859 and 77778 and also included any one or more of the following procedure codes, which have repeatedly appeared as common procedures that are reported on the same claim with CPT codes 55859 and 77778: 76000, 76965, or 77290. We then calculated median costs for interstitial prostate brachytherapy in two different ways: (1) Bypassing the line item charges for these three ancillary codes; and (2) packaging the costs of these three ancillary codes. We applied this methodology both (1) to all claims that met these criteria with and without sources; and (2) to claims that met the criteria and also separately reported brachytherapy sources that would be expected to be reported with CPT code 77778. See Tables 15 and 16 published in the CY 2007 OPPS proposed rule (71 FR 49565) and shown below as Table 14–A and Table 14–B for the results of this investigation.

In the proposed rule, we found 10,571 multiple procedure claims with CPT codes 55859 and 77778 reported on the claim, including those both with and without separately reported sources. We found that 7,181 of the 10,571 claims in the proposed rule's data contained any combination of the three ancillary codes (76000, 76965, or 77290). Table 14–A shows the results of bypassing and packaging the line-item costs of the three ancillary procedures based on the data used to construct the proposed rule.

TABLE 14–A.—MULTIPLE PROCEDURE CLAIMS INCLUDING CPT CODES 55859 AND 77778 PROPOSED RULE DATA

	Frequency	Minimum cost	Maximum cost	Mean cost	Median cost
Ancillary Codes Packaged	7180 (1 lost to trimming)	$828.46	$11,202.81	$3,326.50	$3,062.99
Ancillary Codes Bypassed	7181	811.95	11,203.81	3,300.16	3,030.01

We found 9,791 multiple procedure claims in the proposed rule's data with CPT codes 55859 and 77778 reported on the claim that also included brachytherapy sources that would be used with CPT code 77778. We found that 6,748 of the 9,791 claims contained any combination of the three ancillary codes. Table 14-B shows the results of bypassing and packaging the line-item costs of the three ancillary procedures, using the proposed rule's data.

TABLE 14–B.—MULTIPLE PROCEDURE CLAIMS INCLUDING CPT CODES 55859 AND 77778 AND ONE OR MORE BRACHYTHERAPY SOURCES—PROPOSED RULE DATA

	Frequency	Minimum cost	Maximum cost	Mean cost	Median cost
Ancillary Codes Packaged	6,748	$890.56	$10,224.17	$3,240.13	$3,026.62
Ancillary Codes Bypassed	6,748	$912.81	$10,307.37	$3,215.75	$2,992.60

We found that the claims containing CPT codes 55859 and 77778 and any combination of the three identified ancillary codes had mean and median costs that were very close to one another, regardless of whether the hospital billed separately for the brachytherapy sources on the claim with the procedure codes. Moreover, most of the multiple procedure claims we identified contained sources. This led us to conclude that the presence of sources on the claim did not make a significant difference in the median cost of the combined service.

Moreover, when we calculated the total median cost from single bills for the APCs for the two major procedures codes from the proposed rule's data without regard to the separate payments that would be made for CPT codes 76000, 76965, and 77290, the sum of the CY 2007 proposed medians for APC

0651 and APC 0163 was $3,197.07, which was greater than the combination medians, even when the three ancillary services were packaged into the combination median. Under our proposed policies for CY 2007, hospitals would also be paid separately for brachytherapy sources, guidance services, and radiation therapy planning services that may be provided in support of services reported with CPT codes 55859 and 77778.

Therefore, as indicated in the CY 2007 OPPS proposed rule (71 FR 49565), we believed that the summed median cost for APC 0651 and APC 0163 results in an appropriate level of full payment for the dominant type of service provided under APC 0651, interstitial prostate brachytherapy. We proposed to use the median cost of $1,028.93, as derived from all single bills for APC 0651 according to our standard OPPS methodology, to establish the median for that APC.

We recognized that prostate brachytherapy was not the sole use of CPT code 77778, although it was the predominant use. Costs attributable to the placement of needles and catheters and to the interstitial application of brachytherapy sources to sites other than the prostate may also be reported on claims whose data map to APC 0651. As we noted in the proposed rule, this clinically driven variability in the claims data was difficult to assess without adding additional levels of complexity to the issue by considering diagnoses in establishing payments rates. However, recognizing that a prospective payment system is a system based on averages and, to the extent that claims for all types of complex interstitial brachytherapy source application were included in the body of claims used to set the median cost for APC 0651, we believed that the payment for these services as proposed for CY 2007 was appropriate.

We received several public comments concerning our proposal. A summary of the comments and our responses follow:

Comment: The commenters generally supported the proposed median cost for APC 0651. One commenter encouraged CMS to consider calculating a packaged combination median cost for both CPT codes 55859 and 77778 and splitting the cost between the two codes, should the median cost for APC 0651 drop by a significant percent in future years as it has sometimes done in the past.

Response: The median cost for APC 0651 calculated using CY 2005 claims data as updated for this final rule with comment period is $1,029.47, virtually the same as the proposed rule median cost of $1,028.93. Together with the median cost for APC 0163 of $2,134.32, and separate payment for each source applied (section VII. of this preamble), we believe that the OPPS will make appropriate payment for brachytherapy services in CY 2007.

After carefully considering the public comments received, we are finalizing our proposal to develop a median cost for APC 0651 using single procedure claims and the general OPPS methodology as discussed above without modification.

c. Proton Beam Therapy (APCs 0664 and 0667)

For CY 2007, we proposed to pay for the following four CPT codes that describe proton beam therapy: 77520 (Proton treatment delivery; simple, without compensation), 77522 (Proton treatment delivery; simple, with compensation), 77523 (Proton treatment delivery; intermediate), and 77525 (Proton treatment delivery; complex). We proposed to assign the simple proton beam therapy procedures to APC 0664 (Level I Proton Beam Radiation Therapy), with a proposed median cost of $1,141, and the intermediate and complex proton beam therapy procedures to APC 0667 (Level II Proton Beam Radiation Therapy), with a proposed median cost of $1,365. These proposed assignments were unchanged from CY 2006. The proposed payment rates for proton beam therapy were based on CY 2005 claims data and showed an increase of about 20 percent over the CY 2006 payment rates.

Comment: Several commenters supported our CY 2007 proposed APC assignments and payment rates for proton beam therapy. The commenters also supported our proposing APC 0664 as an exception to the 2 times rule for CY 2007. They were generally concerned about the payment for the same services furnished in freestanding proton therapy centers located in several States because the OPPS payment rates were very different from the carrier-priced payments for these services. The commenters requested that CMS establish consistent payments for these services under the OPPS and the MPFS because the significant capital costs required to provide proton beam therapy treatments do not vary across delivery settings.

Response: We appreciate the commenters' support for our CY 2007 OPPS proposed payment rates for proton therapy. We note that the OPPS payment rates for these services have increased significantly over the past several years, although we understand that there are only a small number of active hospital-based centers providing proton therapy. In addition, this is the second year in which we have exempted APC 0664 from its violation of the 2 times rule. We also observe that the payment rates for the two proton therapy APCs are quite close for CY 2007, with only a small differential between Levels I and II of therapy. As such, we will continue to monitor our claims data for proton beam therapy in the future to assess the appropriateness of the current APC structure. We are generally concerned about APCs that chronically violate the 2 times rule, especially when those APCs contain few services and we have no specific data concerns regarding the services assigned to them.

With respect to the commenters' request regarding consistent payment for proton therapy under the MPFS and the OPPS, we note the MPFS and the OPPS are completely separate payment systems, whose rates are established based on different methodologies.

After careful consideration of the public comments received, we are finalizing without modification our CY 2007 proposal to provide payment for proton beam therapy through APCs 0664 and 0667, with their payment rates based on the final APC median costs of $1,154 and $1,381, respectively.

d. Urinary Bladder Residual Study (APC 0340)

At its February 2005 meeting, the APC Panel recommended that we move CPT code 78730 (Urinary bladder residual study) from APC 0340 (Minor Ancillary Procedures) to APC 0404 (Level I Renal and Genitourinary Studies) for CY 2006, because the Panel believed that the CY 2003 data for CPT code 78730 may have been derived from incorrectly coded hospital claims. Based on reasons discussed in detail in the CY 2006 OPPS final rule with comment period (70 FR 68602), we maintained the assignment of CPT code 78730 in APC 0340 for CY 2006. For CY 2007, we proposed assignment of CPT code 78370 to APC 0340 once again.

Comment: Several commenters requested that CMS move CPT code 78730 from APC 0340 to APC 0399 (Nuclear Medicine Add-on Imaging). Some commenters indicated that in CY 2005 they disagreed with our APC assignment of APC 0340 for CPT code 78730. One commenter added that the data for CPT code 78730 may have been derived from incorrectly coded hospital claims. The commenters indicated that the CPT Editorial Panel would be revising the service's code descriptor for CY 2007 to more specifically indicate the performance of a nuclear medicine procedure.

Response: In the November 15, 2004 final rule with comment period (69 FR 65705), we stated that CPT code 78730 was originally created and valued for the MPFS as a procedure requiring the services of a nuclear medicine technician, but that the use of the code subsequently had changed to be used primarily by urologists rather than by nuclear medicine physicians. While we reassigned CPT code 78730 to APC 0340 for CY 2005 based on robust CY 2003 claims data, we solicited other physician specialties to submit resource data for us to review in the context of our hospital claims data so that we could reexamine the appropriate APC placement of CPT code 78730 for CY 2006. While we acknowledge the commenters' repeated concern that the median cost for CPT code 78730 may reflect miscoded claims, commenters again provided no supporting evidence for either CY 2006 or CY 2007 of what they believe to be the true resource costs associated with CPT code 78730. In fact, a relatively stable number of single procedure claims has generated a consistent median cost for CPT code 78730 over the past 5 years (that is, ranging from $39 based on the CY 2001 claims data to $42 based on the CY 2005 claims data) and supports our assignment of CPT code 78730 to APC 0340 with an APC median cost of $37, as opposed to APC 0399 with an APC median cost of $92. We are aware that the code descriptor and parenthetical language in the CPT manual for CPT code 78730 indicating other CPT codes to be reported for certain bladder studies will be modified for CY 2007. However, we do not know if these additional instructions will lead to differences in hospital reporting that result in a significant change in the procedure's cost. Therefore, we are maintaining CPT code 78730 in APC 0340 for CY 2007.

After carefully considering the public comments received, we are finalizing our proposal to assign CPT code 78730 to APC 0340 for CY 2007, with a median cost of $37.29.

e. Hyperthermia Treatment (APC 0314)

We did not propose any APC assignment changes for CY 2007 for the CPT codes used to report hyperthermia treatments. The following five hyperthermia treatment CPT codes are the only codes that we proposed to assign to APC 0314 (Hyperthermic Therapies) for CY 2007: 77600 (Hyperthermia, externally generated; superficial); 77605 (Hyperthermia, externally generated; deep); 77610 (Hyperthermia, generated by interstitial probe(s); 5 or fewer interstitial applicators); 77615 (Hyperthermia, generated by interstitial probe(s) more than 5 interstitial applicators); and 77620 (Hyperthermia generated by intracavitary probe(s)). The CY 2007 proposed median cost for APC 0314 was $225.96.

Comment: Several commenters reported that the proposed APC 0314 CY 2007 payment rate was 32 percent less than the CY 2006 payment rate of $332.31 and suggested that the decrease was due to the use of inaccurate CMS claims data.

The commenters believed that the flaws in the CMS claims data were due to a few factors: The variation in hospitals' cost allocation methodologies; CMS' use of hospital CCRs derived from those varying hospital allocation practices and which they reported varied dramatically (from 15 to 50 percent) across hospitals that provided hyperthermia therapies; and low utilization among the few hospitals that reported the services. Further, the commenters expressed an additional concern for one of the procedures, CPT code 77605, for which there were no claims in the CY 2005 data that CMS used for the CY 2007 median calculation proposal. The commenters added that in past years, the procedure had been one of the more frequently reported therapies, and they believed that having no cases in the claims data used to calculate the medians for APC 0314 was indicative of inaccurate data and also contributed to the inappropriately low proposed median cost.

The commenters submitted some estimated hospital costs of hyperthermia treatment for five hospitals, and recommended three options that CMS could use to moderate the proposed CY 2007 payment decrease for APC 0314. The three options are as follows: That CMS could use external hospital survey data to establish a payment rate of $1,005 for APC 0314; that CMS could apply an average cost for CPT code 77605 using the medians calculated for CY 2004 through CY 2006 to establish a more appropriate payment amount for CY 2007; or that CMS could maintain the CY 2006 payment rate for CY 2007.

Response: In our analysis, we found that there were 55 claims reported for CPT code 77605 in the CY 2005 data, but that all were excluded from the data because they did not meet the criteria for use in calculating the median costs due to any number of factors. Included among the reasons for removing the claims for CPT 77605 from the CY 2005 data that were used to calculate median costs were that the reporting hospitals' claims were excluded because their CCRs were outside of the allowed range, or the reporting hospital was a CAH or an otherwise excluded hospital (as explained in section II. of this final rule with comment period).

We exclude claims from the data to be used for calculation of median costs every year to ensure that the claims we use are accurate and valid representations of claims for the services. The method for identifying claims that meet the criteria for inclusion in the median cost development process for CY 2007 was performed similarly to the methodology applied for past OPPS updates and should not have had a disproportionate effect on hyperthermia procedures.

As noted by the commenters, median costs for the hyperthermia procedures have been somewhat unstable across the years due to low volume and the small number of facilities reporting the procedures. For CY 2007, the decrease is more pronounced than changes in past years and we appreciate the providers' concerns. We note that these historical changes have served both to increase and decrease payments for the treatments over time. We agree with the commenters' observation about the relative median cost instability for these procedures and the probable reasons for that, but given that we do not observe specific inaccuracies in our claims data that are used in the standard OPPS methodology, it appears these fluctuations are in keeping with the historical charges.

The median costs for the individual procedures assigned to APC 0314 vary from approximately $194 to $431. The median for the APC overall is significantly lower than the highest service-specific median because 195 of the 225 single claims for the APC are for CPT code 77600, which has a median cost of $194. In the past, CPT code 77605 has contributed a significant number of claims to the number of single claims in the APC and has also had a higher median than CPT 77600. Thus, the lack of claims for that procedure may have contributed to the lower APC median for CY 2007, but the median cost calculated for the APC is accurate and reflects costs for those services based upon the CY 2005 claims data that meet our criteria for use in calculating APC medians. We have no reason to doubt the accuracy of those data and, therefore, have no basis for diverging from the established method of calculating the median cost for APC 0314.

For these reasons, we will not accept any of the options recommended to us by the commenters and are finalizing the CY 2007 payment rate for APC 0314

based on its median cost of $204, calculated using our CY 2005 claims data as proposed.

f. Unlisted Procedure for Clinical Brachytherapy (APC 0312)

For CY 2007, we proposed to move CPT code 77799 (Unlisted procedure, clinical brachytherapy) from APC 0313 (Brachytherapy) to APC 0312 (Radioelement Applications) for the CY 2007 OPPS.

Comment: Several commenters objected to the proposal to reassign CPT code 77799 from APC 0313 to APC 0312 for CY 2007. The commenters stated that APC 0312 is titled ''Radioelement Applications,'' while APC 0313 is titled ''Brachytherapy,'' and that it is in keeping with the intent of APC classification to group procedures that are similar in clinical characteristics and resource use. Therefore, the commenters believed that because APC 0313 was the lowest payment level brachytherapy APC, it would be most appropriate to continue to assign CPT code 77799 to APC 0313 with other brachytherapy procedures.

Response: We disagree. CPT code 77799 has no meaningful definition that would enable us to place it accurately in one brachytherapy APC versus another APC based on clinical homogeneity or resource considerations. While the APC title for APC 0312 does not contain the term brachytherapy explicitly, all of the procedures assigned to APC 0312 are from the section of the CPT manual called ''Clinical Brachytherapy.'' Furthermore, APC 0312, not APC 0313, is the lowest payment level brachytherapy procedure APC. In CY 2005, we finalized the OPPS policy of assigning all unlisted or ''not otherwise classified'' HCPCS codes to the lowest level APC that is appropriate to the clinical nature of the service (69 FR 65725). Therefore, we believe that our reassignment of CPT code 77799 to APC 0312 is appropriate.

After carefully considering the public comments received, we are finalizing our CY 2007 proposal for the assignment of CPT code 77799 to APC 0312, without modification.

3. Cardiac and Vascular Procedures

a. Electrophysiologic Recording/Mapping (APC 0087)

At its March 2006 meeting, the APC Panel heard testimony from a presenter who asked that the Panel recommend that CPT codes 93609 (Intraventricular and/or intra-atrial mapping of tachycardia, add-on); 93613 (Intracardiac electrophysiologic 3–D mapping); and 93631 (Intra-operative epicardial and endocardial pacing and mapping to localize zone of slow conduction for surgical correction) be removed from APC 0087. The presenter asked the APC Panel to recommend that these codes be placed in APC 0086 (Ablate Heart Dysrhythm Focus) for improved clinical and resource alignment. The presenter indicated that the median costs for these CPT codes were more than two times the median cost of the least costly HCPCS code in APC 0087 and, therefore, constituted a 2 times rule violation. The presenter also indicated that the median cost of APC 0087 had declined in recent years, and argued that the payment rate for APC 0087 was too low to adequately compensate providers for these services.

The APC Panel did not recommend that CMS move these codes from APC 0087 to APC 0086, but instead recommended that CMS maintain the three codes in APC 0087 for CY 2007. The APC Panel noted that, due to the low volume of these and other services assigned to APC 0087, under the CMS' rules there was no 2 times violation in APC 0087. Moreover, the APC Panel found that the services under discussion were cardiac electrophysiologic mapping services like other procedures also assigned to APC 0087, and were, therefore, clinically coherent with other services in APC 0087. The APC Panel did not believe that these three cardiac electrophysiologic mapping procedures were similar clinically or from a resource perspective to the intracardiac catheter ablation procedures residing in APC 0086. We agreed with the APC Panel's assessment and accepted this APC Panel recommendation. Therefore, we proposed that CPT codes 93609, 93613, and 93631 remain assigned to APC 0087 for CY 2007.

We did not receive any public comments concerning our proposal. Therefore, we are adopting our CY 2007 proposal as final without modification.

b. Endovenous Laser Ablation Procedures (APC 0092)

We proposed to reassign CPT codes 36478 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous laser; first vein treated;) and 36479 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous laser; second and subsequent veins treated in a single extremity, each through separate access sites) from APC 0091 (Level II Vascular Ligation) for CY 2007 to APC 0092 (Level I Vascular Ligation), with a proposed median cost of $1,518.22 for CY 2007.

Comment: A few commenters requested that CMS retain CPT codes 36478 and 36479 in APC 0091 for CY 2007 instead of assigning them to APC 0092, as we proposed. The commenters believed that the percutaneous laser procedures should be assigned to the same APC as CPT codes 36475 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated); and 36476 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites), because the hospital costs for both types of procedures are very similar. The proposed APC assignment for CPT codes 36475 and 36476 was to APC 0091.

Response: In our review of APCs for the CY 2007 proposed rule, we found that the procedures assigned to APCs 0091 and 0092 were appropriate clinically, but that the median costs within both of the APCs had become heterogeneous so there was not significant differentiation between the medians for the two levels of vascular APCs. In addition, CPT codes 36475 through 36479 were new in CY 2005 and, as such, their median costs were available to us for the first time in our development of the CY 2007 proposed rule.

In order to remedy the heterogeneity within APCs 0091 and 0092, we reconfigured them to achieve greater differentiation between the median costs of the two APCs and to improve internal homogeneity. In that reconfiguration, CPT codes 36478 and 36479 were assigned to APC 0092, with other procedures with similar resource requirements. The median costs for CPT codes 36478 and 36479 are $1,521 and $1,241, respectively, and the median cost for APC 0092 is $1,520. There are more than 800 single claims for CPT code 36478, and we are confident that the data reflect hospital costs for the procedure. We believe that these procedures fit appropriately into the APC 0092.

In contrast, CPT codes 36475 and 36476 were assigned to APC 0091, which has a median cost of $2,122. The median costs for those procedures are $2,295 and $3,017, respectively, and there are more than 900 single claims for CPT code 36475. Although the endovenous ablation procedures described by CPT codes 34675 through 36479 are clinically related, we do not believe that they belong in the same

APC. In this case, there exist separate APCs into which each procedure type is appropriately assigned to reflect more similar usage.

The reconfiguration resulted in improved differentiation between the two APCs. For CY 2006, the difference between the APC median costs was only about $140. For CY 2007, that difference is about $600, and the internal homogeneity in each APC is improved.

For these reasons we are finalizing our proposal to assign CPT codes 36478 and 36479 to APC 0092 for CY 2007.

c. Repair/Repositioning of Defibrillator Leads (APC 0106)

For CY 2007, we proposed to assign CPT code 33218 (Repair of single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator), and CPT code 33220 (Repair of two transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator) to APC 0106 (Insertion/Replacement/Repair of Pacemaker and/or Electrodes), with a proposed median cost of $2,754.86. These procedures were both assigned to APC 0106 for CY 2006.

Comment: Several commenters asked CMS to reassign CPT codes 33218 and 33220 from APC 0106 to APC 0105 (Revision/Removal of Pacemakers, AICD, or Vascular Devices) because these two codes do not require a device like other codes in APC 0106 and their median costs are closer to the proposed median cost of APC 0105 of $1,449.44.

Response: We agree and have moved CPT codes 33218 and 33220 out of APC 0106 and into APC 0105 for CY 2007. The final rule median cost for APC 0106 is $3,596.86.

After carefully considering the public comments received, we are finalizing our CY 2007 proposal with modification to reassign CPT codes 33218 and 33220 from APC 0106 to APC 0105. We also are modifying the titles of these APCs to reflect their new composition. APC 0106 is retitled ''Insertion/Replacement of Pacemaker Leads and/or Electrodes.'' APC 0105 is retitled ''Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices.'' The final median cost of APC 0106 is $3,596.87, and the final median cost of APC 0105 is $1,565.27.

d. Thrombectomy Procedures (APCs 0103 and 0653)

For CY 2006, new CPT codes 37184 (Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel); 37187 (Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injection(s) and fluoroscopic guidance); and 37188 (Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injection(s) and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy) were provided interim final assignments to APC 0653 (Vascular Reconstruction/Fistula Repair with Device). New CPT codes 37185 (Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family) and 37186 (Secondary percutaneous transluminal thrombectomy (e.g., nonprimary mechanical, snare basket, suction technique), noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy) were provided interim final assignments to APC 0103 (Miscellaneous Vascular Procedures). The proposed assignments of these codes for CY 2007 were unchanged.

Comment: One commenter who addressed our CY 2006 APC assignments for CPT codes 37184, 37187, and 37188 believed that all of the new codes should have been assigned to APC 0088 (Thrombectomy). The commenter stated that the procedures reported by the new CPT codes were very similar to the procedures reported by CPT code 92973 (Percutaneous transluminal coronary thrombectomy), that was assigned to APC 0088 because they required the use of a costly mechanical thrombectomy catheter. The commenter stated that the procedures coded with CPT codes 37184 through 37188 also required the use of costly catheters and were clinically more similar to the other procedures assigned to APC 0088 than to those assigned to either APC 0103 or APC 0653.

Response: Although we will not have data for these procedures until next year, based on the information in the comment and our further review, we agree with the commenter that a more appropriate assignment for the procedures is APC 0088 for CY 2007. We believe the reassignments provide more accurate payment for these thrombectomy procedures.

After careful consideration of the public comment received, we are finalizing our proposal for the APC assignments of CPT codes 37184, 37185, 37186, 37187, and 37188 with modification. All five procedures are assigned to APC 0088 for CY 2007.

4. Gastrointestinal and Genitourinary Procedures

a. Insertion of Mesh or Other Prosthesis (APC 0195)

During the March 2006 APC Panel meeting, a presenter requested that we reassign CPT code 57267 (Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach) to a more clinically and resource-appropriate APC than its CY 2006 assignment to APC 0154 (Hernia/Hydrocele Procedures). The presenter expressed concern that the procedure was currently assigned to an APC with a ''T'' status indicator and stated that payment would be more accurate if it were assigned to an APC that has an ''S'' status indicator. The mesh insertion procedure is a CPT add-on code and is, by definition, performed at the same time as certain other procedures and will, therefore, be discounted every time it is performed. The presenter objected to our assignment of CPT code 57267 to an APC that was subject to the multiple procedure discount because it was always a secondary procedure, and the discounted payment amount was not adequate to pay even for the cost of the implantable mesh. The presenter also believed that its assignment to an APC where hernia and hydrocele procedures were also assigned was clinically inappropriate.

The APC Panel recommended that CMS reassign CPT code 57267 to a more clinically and resource-appropriate APC.

As stated in the CY 2007 OPPS proposed rule, in the CY 2005 claims data, the median cost for CPT code 57267 was $529.14, the lowest by far for procedures in APC 0154, which had a proposed APC median cost of $1,821 for CY 2007 (71 FR 49562). However, the proposed median cost of CPT code 57267 was based on only 6 single claims of the total 1,038 claims submitted for the service. Because the procedure always was performed in addition to other related procedures, we expected that claims for this service would be multiple claims. Therefore, we were not confident that the procedure's median

cost based upon the six single claims was accurate.

Therefore, at the time of the proposed rule, in order to obtain more information about the cost of the procedure, we performed additional analyses of CY 2005 claims data in an attempt to specifically explore the cost of the mesh implant packaged into the payment for CPT code 57267. We believe that a significant portion of the procedural cost should be related to the cost of the mesh, based on information presented at the March 2006 APC Panel meeting. We looked at all claims that included charges for the HCPCS code for implantable mesh (C1781) and either CPT code 57267 or 49568 (Implantation of mesh or other prosthesis for incisional or ventral hernia repair). We examined the bills for CPT code 49568 in addition to those for CPT code 57267 because it was a high volume procedure that also used implantable mesh, and we expected that the extra volume would improve our chances of identifying meaningful charge data.

We found 210 claims with charges reported for both CPT code 57267 and HCPCS code C1781 on the same day and 6,345 claims with reported charges for both CPT code 49568 and HCPCS code C1781 on the same day. Costs developed from these two claims subsets included the cost of the implanted mesh device that was used in performing the procedure. Table 13 published in the CY 2007 OPPS proposed rule displayed the median costs from those claims (71 FR 49562). The costs shown in the column titled ''Line-item Median Cost'' of Table 13 were those we obtained by looking at all CY 2005 OPPS claims upon which charges for both the procedure code (either CPT code 57267 or 49568) and the code for the implantable mesh (HCPCS code C1781) were reported. The costs shown in the column titled ''Single Claims Median Cost'' were the median costs calculated using only single procedure claims for the specific procedure that also included the C-code for the mesh.

Our additional data analysis supported the APC Panel presenter's assertion that the cost of the mesh was greater than 50 percent of the total cost of CPT code 57267, but it also indicated that the mesh cost was far less than 50 percent of the payment amount for APC 0154. In CY 2006, the payment rate for APC 0154 was $1,704.59, and the payment when the multiple procedure discount was taken was $852.30, which was much greater than both the line-item median cost of the mesh and the median single claims cost of CPT code 57267 (which explicitly included the implantable mesh) reflected in our claims data.

We agreed with the APC Panel that the procedure should be assigned to a more clinically appropriate APC, and therefore, we proposed to accept its recommendation and reassign CPT code 57267 to APC 0195 (Level IX Female Reproductive Procedures), with status indicator ''T'' for CY 2007. The proposed median cost of APC 0195 was $1,777 for CY 2007, very comparable to the CY 2006 median cost of APC 0154, where CPT code 57267 was assigned for CY 2006. The median cost for the procedure remained very low in comparison with other procedures assigned to APC 0195; therefore, we believe that payment for the service when the multiple procedure reduction was applied would be appropriate. While not affecting the procedure's payment significantly, this reassignment improved the clinical homogeneity of APCs 0154 and 0195.

Comment: The commenters generally believed that CPT code 57267 should be assigned to APC 0202 (Level X Female Reproductive Procedures), which is a device-dependent APC and for which the proposed CY 2007 median cost is $2,534.46. They stated that the analyses that CMS performed for the proposed rule to identify costs for the procedure described by CPT code 57267 when billed with the HCPCS code C1781 for the mesh implant were incorrect because the mesh devices that are used in pelvic floor repair are best described by HCPCS codes C1762 (Connective tissue, human (includes fascia lata)) and C1763 (Connective tissue, non-human (includes synthetic)). One commenter provided data showing the costs of four procedures, including CPT codes 57240 (Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele) and 57250 (Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy), when performed with and without the graft insertion procedure, CPT code 57267. Their data indicated that the median cost for CPT code 57267, including the device (C1762 or C1763), ranged from $946 to $1,465, and that, on average, the cost was $1,254.

Response: In response to the comments, we performed additional analyses of claims for CPT code 57267 that included the two types of mesh/connective tissues devices coded with HCPCS codes C1762 and C1763, as well as those with device code C1781 that we presented in the proposed rule. We analyzed all single and ''pseudo'' single claims and multiple claims for CPT code 57267 reported with one of the 3 device codes (C1762, C1763, and C1781) and examined the line-item cost for each of the three devices, based upon our belief that the cost of the add-on repair procedure was principally due to the device cost. The results of our study showed that the median line-item costs for device codes C1762 and C1763 on claims for the pelvic floor repair procedure were $810.72 and $503.71, respectively, compared to $352.20 for device code C1781.

Although the commenters stated that the graft insertion procedure to repair the pelvic floor was performed using only the connective tissue products coded by device codes C1762 and C1763, there is no guidance with regard to use of the CPT code 57267 that specifically restricts the type of device that may be reported with that code. In the list of device category codes and their definitions posted on the CMS Web site, we indicate that device code C1781 is defined as, ''A mesh implant or synthetic patch composed of absorbable or non-absorbable material that is used to repair hernias, support weakened or attenuated tissue, cover tissue defects, etc.'' We also note in the definition that other device codes should be used for reporting connective tissue when used to treat urinary incontinence. There are far more CY 2005 claims for CPT code 57267 with device code C1781 than with either of the device codes presented by the commenters. Therefore, the CY 2005 claims data for the procedure are more reflective of the use of the mesh reported with device code C1718 than of the mesh the commenters believed was most often used. Table 15 displays the numbers of claims and the median costs found in our analyses.

We continue to believe that assignment of CPT code 57267 to APC 0195 is appropriate and ensures adequate payment for the procedure, even when the multiple procedure discount is taken. Based on the typical cost of any one of the mesh/connective tissue devices that are used in the service, 50 percent of the payment for APC 0195, based on its CY 2007 median cost of $1742.20, should be appropriate. Assignment to APC 0202, with a median cost of $2,534.46, would result in overpayment for the procedures.

TABLE 15.—MEDIAN COSTS OF HCPCS CODES C1762, C1763 AND C1781 AND 57267

HCPCS code	Short descriptor	CY 2005 frequency of total claims	CY 2005 line-item median cost
C1762 (billed with 57267)	Conn tiss, human (inc fascia)	22	$810.72
C1763 (billed with 57267)	Conn tissue, non-human	55	503.71
C1781 (billed with 49568)	Mesh (implantable)	175	352.20

After carefully considering the public comments received, we are finalizing our proposal to reassign CPT code 57267 to APC 0195 without modification.

b. Percutaneous Renal Cryoablation (APC 0423)

During the March 2006 APC Panel meeting, a presenter requested that we reassign CPT code 0135T (Ablation renal tumor(s), unilateral, percutaneous, cryotherapy) from APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures) to APC 0423 (Level II Percutaneous Abdominal and Biliary Procedures). The presenter provided information about the costs of performing these procedures and compared the resource requirements for the procedures to those for CPT code 47382 (Ablation, one or more liver tumor(s), percutaneous, radiofrequency), which is currently assigned to APC 0423. The presenter proposed reassignment of CPT code 0135T to APC 0423 because that was where CPT code 47382 was assigned, and stated that the costs of the two procedures were very similar.

Based on the information presented, the APC Panel recommended that we reassign CPT code 0135T from APC 0163 to APC 0423 for CY 2007.

CPT code 0135T is new for CY 2006 and, therefore, we had no claims data upon which to base our APC assignment decision. The procedure currently has an interim assignment to APC 0163, with a CY 2006 payment amount of $1,999.35.

In the CY 2007 OPPS proposed rule, we proposed to accept the APC Panel's recommendation to reassign CPT code 0135T to APC 0423 for CY 2007. We believed that assignment of CPT code 0135T to APC 0423 was clinically appropriate, and the CY 2007 proposed median cost of APC 0423 of $2,410.33 was reasonably close to our expectations regarding the resource requirements for the renal cryoablation procedure. The APC Panel did not discuss this procedure again at its August 2006 meeting, nor were there any public presentations on this issue at that meeting.

Comment: Several commenters approved of the proposed reassignment of CPT code 0135T from APC 0163 to APC 0423 for CY 2007 because this move placed the percutaneous cryoablation procedure with other similar procedures. However, the commenters were concerned that the payment rate for CPT code 0135T was inadequate and did not reflect the total cost incurred by hospitals in providing this service. The commenters also indicated that the payment rate for CPT code 0135T was not based on timely data or accurate hospital claims. The commenters believed that the proposed payment rate would not cover the costs of the expensive cryoablation probes used in performing the procedures. One commenter indicated that the average cost of one probe was about $1,000, and the average procedure used between 2.3 and 2.5 probes. Another commenter submitted copies of invoices showing the costs of the probes. The commenter urged CMS to reevaluate the payment for APC 0423, because an underpayment could result in hospitals not offering this procedure, thereby creating an access barrier for Medicare patients. Several commenters requested that CMS use all available data, including external data, to determine the appropriate payment rate for APC 0423.

Response: We reviewed the data for APC 0423, considered the comments, and examined all available information regarding the procedure described by CPT code 0135T, as well as other procedures that are separately payable under the OPPS and for which we have claims data. In addition, we reviewed the recommendation of the APC Panel from its March 2006 meeting that was based upon the request of a presenter. Based on our evaluation, we believe that we have appropriately assigned CPT code 0135T to APC 0423 for CY 2007 based on clinical and resource homogeneity considerations. Under the standard OPPS methodology, the APC payment rate is established based on CY 2005 claims data for those services for which there are data. One service also assigned to APC 0423 has significant claims volume, and its median costs have been stable over the past several years. The final median cost of APC 0423 upon which the payment rate for CPT code 0135T is based is $2,283.08. We believe that this payment will be sufficient to ensure access to this service for Medicare beneficiaries.

Comment: Several commenters acknowledged that cryoablation and radiofrequency percutaneous ablation procedures for renal tumors were clinically similar; however, there were major resource differences in the required equipment and the technology-specific probes. One commenter indicated that the radiofrequency ablation procedure involves the use of only one probe, while the cryoablation procedure requires, on average, 2.5 probes.

Response: We believe that CPT code 0135T is appropriately assigned to APC 0423 because it is placed with other procedures that share clinical and resource homogeneity. 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 cyroablation probes used to perform CPT code 0135T as the units of HCPCS code C2618 (Probe, cryoablation), 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 indicated that in the CY 2007 OPPS proposed rule we acknowledged the lack of claims data to set the payment rate for the renal cryoablation procedure reported with CPT code 0135T. They believed that CMS should assign CPT code 0135T to a New Technology APC and base its payment on the actual cost of performing the procedure. One commenter reported that the renal cryoablation procedure was a relatively new procedure that had only rarely been performed in the outpatient setting. The commenter also noted that assigning CPT code 0135T to a New Technology

APC would allow CMS time to obtain meaningful outpatient cost information for the procedure, so that CMS could eventually place the procedure in an appropriate clinical APC. The commenter added that prior to January 1, 2006, there was no specific HCPCS code that accurately described the renal cryoablation procedure, and, as a result, the service was reported by those hospitals performing the procedure under the general unlisted CPT code 53899. Because of the use of the unlisted CPT code, the commenter indicated that it would be impossible to identify the historical hospital outpatient claims that were related to percutaneous renal cryotherapy.

Response: While we previously acknowledged the lack of claims data in setting the payment rate for CPT code 0135T, we have commonly assigned a new service or procedure without claims data to a clinical APC that we believed appropriately reflected the cost and clinical features of the procedure. We often have relevant information available to us based on claims data for other services historically paid under the OPPS, as well as data provided to us by the public. In the case of CPT code 0135T specifically, the APC Panel at its March 2006 meeting recommended that we reassign this code from APC 0163 to APC 0423 for CY 2007. Based on this recommendation and our comprehensive review of the procedures assigned to APC 0423, we believe that we have assigned the renal cryoablation procedure to an appropriate clinical APC, specifically APC 0423, which reflects clinical homogeneity and comparable resource costs among the procedures assigned to the APC for CY 2007. We note that we expect to have claims data for CPT code 0135T available for the CY 2008 OPPS update.

After carefully considering all the public comments received, we are reassigning CPT code 0135T to APC 0423, as proposed, without modification. The final APC 0423 median cost is $2,283.08.

c. Ultrasound Ablation of Uterine Fibroids with Magnetic Resonance Guidance (MRgFUS) (APCs 0195 and 0202)

We received many public comments concerning the APC assignments for HCPCS codes 0071T and 0072T.

In the CY 2006 final rule we assigned magnetic resonance guided focused ultrasound ablation of uterine fibroids (MRgFUS) procedures, CPT codes 0071T and 0072T, to APCs 0195 (Level IX Female Reproductive Procedures) and 0202 (Level X Female Reproductive Procedures), respectively, for CY 2006. We made those reassignments in response to public comments to our proposed rule of July 25, 2005, in which we had proposed to assign the procedures to APC 0193 (Level V Female Reproductive Procedures) for CY 2006. These services had been assigned to APC 0193 since their implementation in the OPPS in CY 2005. We proposed no changes to their final CY 2006 assignments for CY 2007.

Comment: Although our assignments of the procedures were to separate, higher paying APCs for CY 2006 than their assignments for CY 2005, commenters on the CY 2007 proposed rule believed that the procedures' assignments still resulted in significant underpayment. The commenters asserted that while MRgFUS treats anatomical sites that are similar to other procedures assigned to APCs 0195 and 0202, the resources utilized differ dramatically. Further, they stated that treatment of uterine fibroids using the MRgFUS procedure is more cost effective for the Medicare program and for beneficiaries because the recovery time is shorter, and beneficiaries would be spared the need for hysterectomies.

The commenters indicated that the most appropriate 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. The similarities between the two technologies that were presented by the commenters included their clinical indication to treat non-invasive tumors by using focused ionizing radiation (stereotactic radiosurgery) or acoustic waves (MRgFUS) to destroy the tumor tissue.

Further, the commenters argued that the procedures require similar hospital resources: planning prior to treatment; specialized equipment housed in treatment rooms; continuous monitoring during treatment; and 120 to 300 minutes to perform the treatment.

One commenter sent data that compared the hospital charges for three MRgFUS cases to those for five stereotactic radiosurgery (SRS) procedures. Those data showed charges for CPT code 0071T of $18,215 and for 0072T, $22,122 and $23,463, and for SRS, charges ranging from $21,360 to $28,790. In addition, many of the commenters reported that their hospitals charge between $18,000 and $24,000 for each MRgFUS treatment.

Response: As we stated in the November 10, 2005 final rule, we believe that MRgFUS treatment bears a significant relationship to technologies already in widespread use in hospitals, in particular magnetic resonance imaging (MRI) and ultrasound services. 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 believe that MRgFUS therapy is a new and integrated application of existing technologies (MRI and ultrasound) and that the technology used in this service fits as well into existing clinical APCs for female reproductive services, as do many other modalities that are currently assigned to those clinical groups. Retaining them in clinical APCs with other female reproductive procedures will enable us both to set accurate payment amounts and to maintain appropriate clinical homogeneity of the APCs.

The similarity of the charges for MRgFUS and SRS as reflected in the examples provided by one commenter does not convince us that the level of hospital resources used to provide MRgFUS is the same as for SRS. APC assignments are made based on consideration of both hospital resources and clinical homogeneity. There are many OPPS claims with similar charges, but where the reported procedures have nothing in common with one another clinically. We do not assign those procedures to the same clinical APC.

In our CY 2005 claims data, there are two claims for CPT code 0071T but none for CPT code 0072T and 3,346 claims for the single SRS service assigned to APC 0127. Those data show the median cost for SRS is $8,461 and the median cost for the two MRgFUS claims is $1,026. We realize the limited nature of the data from which to draw any conclusions about cost, but because treatment of uterine fibroids is most common among women younger than 65 years of age, we do not expect that there ever will be many Medicare claims for those procedures. Nevertheless, we do not see a compelling reason to except MRgFUS from our established policy to rely on our claims as the basis for weight-setting under the OPPS.

Further, and in contrast with SRS, the MRI equipment used to provide the MRgFUS therapy can also be used to perform conventional MRI procedures and does not necessarily represent an additional capital expense for the hospital. Those costs should be allocated accordingly so that amortization will be shared by those other tests. In addition, we remind commenters that the OPPS was originally set up to be budget neutral to the prior system, which under several provisions of the statute, paid

approximately 82 percent of reported hospital outpatient department costs as shown on the cost reports. Therefore, payment rates for individual services are set, in effect, to reflect relative resource use within a payment system that pays, on average, at what was a discount of approximately 18 percent. Because the OPPS is a prospective payment system as well, payment may be more or less than a provider's costs in any specific case. We expect that our payment rates generally will reflect the costs that are associated with providing care to Medicare beneficiaries in cost-efficient settings.

Prior to assigning CPT codes 0071T and 0072T to APCs 0195 and 0202 respectively, we compared the necessary hospital resources for the MRgFUS procedures, including specialized equipment, MRI/procedure room time, personnel, anesthesia and other required resources, to various other procedures for which we have historical hospital claims data. In addition, we took into consideration projected costs for the MRgFUS procedures submitted to us, and other available information regarding the clinical characteristics and costs of those services. We do not believe that there are significant clinical similarities between MRgFUS and the multi-source photon SRS procedure assigned to APC 0127. This SRS procedure is generally performed on intracranial lesions, and requires immobilization of the patient's head in a frame that is screwed into the skull. Several hundred converging beams of gamma radiation are applied to the target lesion, requiring their accurate placement to the fraction of a millimeter. In contrast, during MRgFUS, MRI guidance is utilized to confirm tissue heating, while multiple sonications at various points in the fibroid treatment area are executed until the entire target volume has been treated. Therefore, we do not think these two types of procedures are clinically similar, nor do we believe they require comparable hospital resources based on the considerations described previously that went into our CY 2006 APC assignments for MRgFUS and SRS procedures.

We continue to believe that the assignments of CPT codes 071T and 072T for MRgFUS procedures to APCs 0195 and 0202 respectively for CY 2007 will make appropriate OPPS payments for MRgFUS services, thereby ensuring access for Medicare beneficiaries who need them.

After careful consideration of the public comments received, we are finalizing our proposed CY 2007 APC assignments of CPT codes 071T and 072T, without modification.

d. Laser Vaporization of Prostate (APC 0429)

For CY 2007, we proposed to assign CPT code 52648 (Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)) to APC 0429 (Level V Cystourethroscopy and other Genitourinary Procedures), with a proposed median cost of $2,651.79. The procedure was assigned to APC 0429 for CY 2006.

Comment: One commenter indicated that the proposed assignment of CPT code 52648 to APC 0429 seemed appropriate but asked CMS to use only claims for CPT code 52648 that also contained HCPCS code C9713 (Noncontact laser vaporization of prostate, including coagulation control of intraoperative and postoperative bleeding) to calculate the median cost for APC 0429. The commenter believed that by using single bills that did not also contain HCPCS code C9713, CMS may have excluded the correctly coded claims.

Response: We agree that assignment of CPT code 52648 to APC 0429 is appropriate, but we disagree that we should require HCPCS code C9713 to be on all claims for CPT code 52648 as either a condition of payment for CPT code 52648 or to calculate the median cost of APC 0429. HCPCS code C9713 was created to describe the service for laser vaporization of the prostate because we did not believe that CPT code 52648, as defined before January 1, 2006, described the same service, and HCPCS code C9713 should not have been included on any claims with CPT code 52648. HCPCS code C9713 was deleted effective December 31, 2005, as a result of the change to the descriptor of CPT code 52648. Hospitals that billed both codes on the same claim in CY 2005 were billing incorrectly, as HCPCS code C9713 did not describe the device used to furnish the service.

After carefully considering the public comment received, we are finalizing our CY 2007 proposal to assign CPT code 52648 to APC 0429 for CY 2007. The CY 2007 final median cost of APC 0429 is $2,633.85.

e. Gastrointestinal Procedures with Stents (APC 0384)

For CY 2007, we proposed to calculate the median cost of APC 0384 (GI Procedures with Stents) using only claims that pass the device edits and which do not contain token charges for the device HCPCS codes on the claims. The proposed rule median cost of APC 0384 was $1,400.71.

Comment: The commenters asked that CMS calculate the median by applying the same device edits for CPT codes 43268 (Endoscopic retrograde cholangiopancreatography (ECRP); with retrograde insertion of tube or stent into bile or pancreatic duct); 43269 (Endoscopic retrograde cholangiopancreatography (ECRP); with retrograde removal of foreign body and/or change of tube or stent); and 43219 (Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent) that were applied to calculate the CY 2006 OPPS median cost. The commenters stated that CMS used only claims containing stent device codes to calculate the median cost for APC 0384 for CY 2006 OPPS. They believed that the CY 2007 OPPS median cost for APC 0384 would be significantly higher if only claims that contained the stent device codes were used in the calculation.

Response: We have not calculated the CY 2007 median cost for APC 0384 using only claims that contain the HCPCS codes for stents for the procedures reported under CPT codes 43268 and 43219, because the procedures may be performed with tubes rather than stents. There are no device HCPCS codes for the tubes that may be used. Similarly, the procedure identified by CPT code 43269 may or may not use either a stent or a tube, and, therefore, it would be erroneous to require that a stent be reported on the claim. We assume that where a stent HCPCS code is not reported on the claim, the charge for the procedure incorporates the charge for the tube if one was used in the case of CPT codes 43268 and 43219, or in the case of CPT code 43269, we assume that no stent or tube was used at all. It is also possible that if the hospital inserted a tube, the hospital provided a charge for the tube under a revenue code with no HCPCS code. The other CPT codes in the APC require the use of a stent (and make no provision for substitution of a tube) and, therefore, we require that a stent HCPCS C-code be reported on the claims for those services. This is the same methodology and the same set of device edits for these procedures that were applied to calculate the median cost of APC 0384 to establish its CY 2006 OPPS payment rate. Our discussion of our final policy for setting the payment rates for device-dependent APCs, including APC 0384, is included in section IV.A.2. of this final rule with comment period.

See the OPPS device edits at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* under ''downloads'' for the device edits in place for this APC for each calendar quarter since October 2005.

After carefully considering the public comments received, we are finalizing our CY 2007 proposal for APC 0384 without modification. The final median cost for APC 0384 is $1,402.31.

f. Endoscopy With Thermal Energy to Sphincter (APC 0422)

CPT code 43257 (Upper gastrointestinal endoscopy, including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease), effective January 1, 2005, is used for esophagoscopy with delivery of thermal energy to the muscle of the lower esophageal sphincter and/or gastric cardia for the treatment of gastresophageal reflux disease. This code describes the Stretta procedure, including use of the Stretta System and all endoscopies associated with the Stretta procedure. Prior to CY 2005, the Stretta procedure was recognized under HCPCS code C9701 from January 1, 2004, through December 31, 2004, in the OPPS. For the CY 2005 OPPS, HCPCS code C9701 was deleted and CPT code 43257 was utilized for the Stretta procedure. In CY 2005, the Stretta procedure was transitioned from a New Technology APC to clinical APC 0422 (Level II Upper GI Procedures) based on several years of hospital cost data. Procedures within APC 0422 were similar to the Stretta procedure in terms of clinical characteristics and resource use. For both CYs 2005 and 2006, we specifically calculated the median cost for the Stretta procedure reported with CPT code 43257 taking into account the codes that hospitals billed for the service in CYs 2003 and 2004, which included HCPCS code C9701 and one unit of endoscopy service. For CY 2007, we proposed to continue with the current APC assignment for the Stretta procedure, with no need for a special median cost calculation.

We received several public comments in response to the CY 2007 proposed payment rate for the Stretta procedure, in particular with a focus on the median cost methodology.

Comment: Some commenters objected to the APC assignment of the Stretta procedure to APC 0422 and cited the use of the CY 2004 claims data in determining its median cost for CY 2007. The commenters indicated that CMS should recalculate the median cost for CPT code 43257 to ensure that all claims contributing to the median reflect the resources of the endoscopic procedures that are part of this procedure.

Response: The commenters cited the CY 2004 claims as part of their objection. However, we used claims data from CY 2005 for all services, including CPT code 43257, in determining the payment rates for CY 2007. As we stated in the CY 2007 OPPS proposed rule, median costs for the CY 2007 OPPS update were based on the CY 2005 hospital claims data. APC assignments are based on clinical homogeneity and comparable resource utilization for all CPT and HCPCS codes within an APC. In the case of APC 0422, we believe that the procedures assigned to this APC are similar in costs and resource consumption, with median costs for the significant procedures assigned to the APC of $1,475 to $2,084, well within the 2 times rule limits.

Comment: Several commenters requested that CMS create a new APC that includes both CPT codes 43257 and 0008T (Upper gastrointestinal endoscopy, including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, with suturing of the esophagogastric junction) to appropriately cover the costs associated with performing these procedures. One commenter requested that CMS create a new APC to which CMS would assign CPT codes 43257 and 0008T, and that CMS use a different methodology to calculate the median cost. The commenter indicated that because CPT codes 43228 and 43830 have higher volumes but lower costs, the inclusion of them in the same APC as CPT code 43257 does not lead to payment of CPT code 43257 at a level that is appropriate to pay the costs of the service. The same commenter indicated that the continued inclusion of CPT codes 43228 and 43830 decrease the payment rate for many of the procedures placed in APC 0422. The commenter believed that creating the new APC was analogous to what CMS proposed to do for vascular access devices in the proposed rule.

Response: We disagree with the commenters. We believe that the procedures in APC 0422 contain similar procedures for the treatment of gastroesophageal reflux disease, and these services are, therefore, appropriately assigned based on clinical homogeneity and resource use. Thus, for CY 2007, CPT code 43257 will remain in APC 0422. CPT code 0008T will be deleted as of January 1, 2007. For the CY 2007 OPPS, the payment for APC 0422 is based on the final median cost of $1,573.89. Furthermore, with regard to the commenter's analogy to a new APC for vascular access devices, such a comparison was misplaced as we did not propose to create a new APC for vascular access devices in the CY 2007 OPPS proposed rule.

Comment: One commenter requested that CMS recompute the median cost for CPT code 43257, and suggested two specific options for determining a revised median cost. One option suggested by the commenter was that CMS add the median cost for CPT code 43235 to the cost of all claims for HCPCS code C9701 (CPT code 43257 in CY 2005) that did not also contain at least one unit of an endoscopy code on the claim. The commenter indicated that these inflated claims costs would then be combined with all claims for HCPCS code C9701 that also contain at least one unit of an endoscopy code and with the claims for CPT code 0008T to set the median cost for the APC they wanted CMS to create. The commenter suggested that another option would be to use only claims that contained both HCPCS code C9701 and CPT codes 43234, 42235, or any other endoscopy code to calculate the median cost, which the commenter admitted would not yield as robust a set of claims for setting medians.

Response: We no longer have a need for special calculations to develop the median cost of CPT code 43257 because the code itself was reported by hospitals in CY 2005 and includes all endoscopies. In addition, HCPCS code C9701 was deleted for CY 2005 so we have no claims for the service from that year. Further, as we indicated in the CY 2006 OPPS final rule with comment period that addressed this same issue and similar comment (70 FR 68606), we see no reason to create a new APC for CPT codes 43257 and 0008T. We believe that the procedures in APC 0422 contain similar procedures for the treatment of gastroesophageal reflux disease, and therefore, the APC is appropriately structured based on clinical homogeneity and resource use.

After carefully considering the public comments received, we are finalizing our proposal for assignment of CPT code 43257 to APC 0422 for CY 2007, with a median cost of $1,573.89.

5. Ocular Procedures

a. Keratoprosthesis (APC 0293)

CPT code 65770 (Keratoprosthesis) is a surgical procedure for implantation of a keratoprosthesis, an artificial cornea. In the CY 2007 proposed rule, we indicated that we believed that the keratoprosthesis device that is required

for the implantation is described by HCPCS code C1818 (Integrated keratoprosthesis), a device category that received transitional pass-through payment under the OPPS from July 2003 through December 2005. When the pass-through status for the device expired for CY 2006 and the costs of the device were packaged into the implantation procedure, CPT code 65770 continued to be assigned to APC 0244 (Corneal Transplant), with a payment rate of about $2,275, despite an increase in the median cost of the implantation procedure of about $1,200 associated with the packaging of the device. There is no 2 times violation in APC 0244 for CY 2006.

At the March 2006 meeting of the APC Panel, following a presentation regarding the procedure to implant a keratoprosthesis that described the clinical and hospital resource characteristics of CPT code 65770, the Panel recommended moving CPT code 65770 to a more appropriate APC in order to make appropriate payment. We agreed with the recommendation of the APC Panel. At the time of the proposed rule, claims data from CY 2005 demonstrated that the median cost for implantation of a keratoprosthesis of $3,127.51 remained significantly higher than the median costs of other procedures assigned to APC 0244, although there was no 2 times violation. In addition, CPT code 65770 contributed less than 1 percent of the single claims in the APC available for ratesetting, and it was likely to continue to be an uncommon procedure among Medicare beneficiaries, resulting in its persistent small contribution to the median cost of APC 0244. Therefore, for CY 2007, we proposed to create a new APC 0293 (Level V Anterior Segment Eye Procedures) with a median cost of $3,127.51 and to move CPT code 65770 into that APC in order to more appropriately pay for the procedure and the related device. CPT code 65770 was the only code proposed for assignment to that APC.

Comment: One commenter and a presenter to the APC Panel during its August 2006 meeting requested that the procedure be paid at a higher rate than the proposed payment rate. They believed that our cost data were inaccurate and understated the cost of the implantable device, HCPCS code C1818. The commenters reported that the device, a biointegratable artificial cornea, costs approximately $7,000, far more than the proposed $3,116.62 OPPS payment rate for the procedure to implant the device.

At its August 2006 meeting, the APC Panel recommended that CMS consider external data for these procedures to validate whether the claims used for ratesetting were properly coded and make appropriate adjustments to the OPPS payment rate if necessary. Further, the Panel recommended that CMS implement a device edit that would ensure that the device code (HCPCS code C1818) is included on claims for the keratoprosthesis procedure.

The commenters provided hospital data that showed that many hospitals that performed the procedure which may be reported for implantation of the costly biointegratable artificial cornea described by HCPCS code C1818 did not report charges for the device on their bills to Medicare. Further, one commenter performed analyses of Medicare hospital outpatient claims data and found that if CMS used only single procedure claims that included HCPCS code C1818 and CPT code 65770 to establish the median cost for APC 0293, it would be more than $10,000 and would result in a payment rate that would be adequate to cover the costs of implantation of the integrated keratoprosthesis device.

Response: In response to the comments and the APC Panel's recommendations, we performed additional analyses of our claims data. We noted that a new alphanumeric HCPCS code L8609 (Artificial cornea) was established in CY 2006, but there would not have been any claims reported for this code in the CY 2005 claims data used for this CY 2007 OPPS update. We found that only 8 of the 47 single claims for CPT code 65770 included the HCPCS device code C1818. The median cost for those few claims was $10,715.30, consistent with the commenter's data analyses.

Upon further exploration of the background of HCPCS device code C1818, we noted that we had provided specific guidance concerning the device code in the June 2003 Transmittal A–03–051, explaining, ''The device is composed of a flexible, one-piece biocompatible polymer * * *.'' We are aware of at least one other device that may be inserted during the procedure described by CPT code 65770, and that keratoprosthesis is a two-part device that would not be appropriately described by HCPCS code C1818. We have been told that the device is significantly less costly than the device described by HCPCS code C1818, the one-piece biointegratable keratoprosthesis. Because there are at least two devices with different costs that could have been used in CY 2005 to perform CPT code 65770, but there was no HCPCS code in CY 2005 for the two-part keratoprosthesis not described by HCPCS code C1818, it would not be appropriate for us to use only claims reporting HCPCS code C1818 to calculate the median cost for CPT code 65770. If we were to follow the recommendation of the commenter, we could be systematically and incorrectly excluding claims for CPT code 65770 that may have been correctly coded at the time by hospitals implanting a two-part keratoprosthesis with a lower device cost than the cost of the one-piece device coded by CPCS code C1818.

The OPPS is a prospective payment system that pays based on the median cost of procedures assigned to APC groups, and to the extent that various devices with dissimilar costs may be used to provide the same procedure, those different device costs are packaged into the procedural payment in relationship to their utilization in the procedure. Therefore, we do not believe the 47 single claims from CY 2005 used for ratesetting for APC 0293 were miscoded, and we do not believe adjustments to the payment rate for APC 0293 established based on the standard OPPS methodology are needed for CY 2007.

Where 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 have commonly instituted device edits that prevent payment of claims that do not include both the procedure and an acceptable device code. In that way, hospitals become aware of the proper coding requirements, and we can be confident that our procedure claims include charges for the necessary devices so we can establish appropriate payment rates for those procedures.

Because there was a new, more general HCPCS L-code (L8609) created for the artificial cornea in CY 2006 that may be used to report all keratoprostheses not already described by HCPCS code C1818, we are accepting the APC Panel's recommendation regarding the establishment of device edits for CPT code 65770. We will establish a device edit in CY 2007 for CPT code 65770 that requires reporting of an appropriate device HCPCS code to ensure that all claims for CPT code 65770 in CY 2007 and future years include charges for a required device. However, to the extent that devices with different costs are used to provide the keratoprosthesis procedure, unless the CPT code descriptor for the service is revised or more specific CPT codes are developed, our claims data will continue to reflect highly variable costs

for the services that are provided using the full spectrum of keratoprosthesis devices.

After carefully considering the comments received, we are adopting our proposal without modification to assign CPT code 65770 to APC 0293, with a median cost of $3,177.05 for CY 2007. We are also assigning a procedure-to-device edit for CPT code 65770 with APC 0293.

b. Eye Procedures (APCs 0232, 0235, and 0241)

In Addendum B of the CY 2007 proposed rule (71 FR 49702), we proposed to assign a payment rate of $368.07 for APC 0232 (Level I Anterior Segment Eye Procedures), a payment rate of $250.82 for APC 0235 (Level I Posterior Segment Eye Procedures), and a payment rate of $1,529.55 for APC 0241 (Level IV Repair and Plastic Eye Procedures).

Comment: Several commenters questioned the reasoning behind the payment reductions for APCs 0232, 0235, and 0241 when their facilities experienced increased costs for the procedures assigned to these APCs. Specifically, the commenters questioned why the payment rate for APC 0232 declined from $411.84 for CY 2006 to the proposed payment rate of $368.07 for CY 2007; why the payment rate for APC 0235 declined from $285.21 for CY 2006 to the proposed payment rate of $250.82 for CY 2007; and why the payment rate for APC 0241 declined from $1,806.03 for CY 2006 to the proposed payment rate of $1,529.55 for CY 2007. At the same time, several commenters supported the proposed payment increases for APCs 0242 (Level V Repair and Plastic Eye Procedures), 0245 (Level I Cataract Procedures without IOL Insert), 0247 (Laser Eye Procedures Except Retinal), 0248 (Laser Retinal Procedures), 0673 (Level IV Anterior Segment Eye Procedures), and 0699 (Level IV Eye Tests and Treatment). The commenters requested that CMS reexamine the proposed payments for APCs 0232, 0235, and 0241.

Response: Each year, we reevaluate APC assignments for procedures, services, and items paid under the hospital OPPS based on claims data paid by Medicare to set annual payment rates. Based on our analyses, we make changes to the APC assignments when necessary. As we stated in the CY 2007 OPPS proposed rule (71 FR 49514), we used approximately 50.7 million whole claims that reflected services furnished on or after January 1, 2005, and before January 1, 2006, to recalibrate the APC relative payment weights for CY 2007. While the payment rates for many APCs remain stable over time, in the absence of APC reconfiguration, it is not unusual for the payment rates for certain APCs to vary modestly from year to year, similar to the approximately 10-percent decrease in median costs observed for APCs 0232 and 0235 for CY 2007. However, as the commenters noted, other eye procedure APCs also had proposed increases for CY 2007. The CY 2007 median costs for APCs 0232 and 0235 have been calculated based upon CY 2005 claims using the standard OPPS methodology. In the case of APC 0241, the commenter is mistaken to believe that the CY 2006 OPPS payment rate for the APC was $1,806.03. The CY 2006 OPPS payment rate for APC 0241 was $1,378.76. Therefore, the proposed payment rate of $1,529.55 for APC 0241 was a proposed payment rate increase for CY 2007.

After carefully considering the public comments received, we are finalizing our CY 2007 proposal for APCs 0232, 0235, and 0241 without modification, with final median costs of $370.77, $240.36, and $1,543.32, respectively.

c. Amniotic Membrane for Ocular Surface Reconstruction

In Addendum B of the CY 2007 proposed rule (71 FR 49845), we proposed to assign HCPCS code V2790 (Amniotic membrane for surgical reconstruction, per procedure) to status indicator ''N'' (packaged).

Comment: Several commenters requested that CMS consider assigning status indicator ''F'' (paid at reasonable cost) to HCPCS code V2790 rather than status indicator ''N''. One commenter indicated a discrepancy in payment policy and status indicator assignment for two types of tissues currently used for ocular surface transplants; that is, HCPCS code V2785 (Processing, preserving and transporting corneal tissue), which is assigned to status indicator ''F'' and HCPCS code V2790, which is assigned to status indicator ''N,'' are not treated similarly with regard to status indicator assignments and OPPS payment policy. The commenters added that payment for items and services assigned to status indicator ''N'' is packaged into payment for the associated procedures, while payment for items and services assigned to status indicator ''F'' is made at reasonable cost, not under the OPPS.

The commenters believed this discrepancy could create a competitive disadvantage and financial disincentive for hospitals to promote the treatment of ocular surface diseases using amniotic membrane tissue, and ultimately impede beneficiary access to this unique ocular reconstructive procedure. The commenters requested that CMS reassign HCPCS code V2790 from status indicator ''N'' to status indicator ''F'' for CY 2007.

Response: We appreciate the commenters'' interest in payment for tissues used in ocular treatments. 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. Therefore, there is no need for HCPCS code V2790 to be paid based on reasonable cost outside of the OPPS. Instead, like many items under the OPPS used in surgical procedures, its prospective payment is appropriately packaged into payment for the procedures in which it is used.

After consideration of the public comments received, we are finalizing our proposed CY 2007 payment policies without modification for HCPCS codes V2785 and V2790 as reflected in their assigned status indicators.

6. Other Procedures

a. Skin Replacement Surgery and Skin Substitutes (APC 0025)

For CY 2006, the AMA made comprehensive changes, including code additions, deletions, and revisions, accompanied by new and revised introductory language, parenthetical notes, subheadings and cross-references, to the Integumentary, Repair (Closure) subsection of surgery in the CPT book to facilitate more accurate reporting of skin grafts, skin replacements, skin substitutes, and local wound care. In particular, the section of the CPT book previously titled ''Free Skin Grafts'' and containing codes for skin replacement and skin substitute procedures was renamed, reorganized, and expanded. New and existing CPT codes related to skin replacement surgery and skin substitutes were organized into five subsections: Surgical Preparation, Autograft/Tissue Cultured Autograft, Acellular Dermal Replacement,

Allograft/Tissue Cultured Allogeneic Skin Substitute, and Xenograft.

As part of the CY 2006 CPT code update in the newly named ''Skin Replacement Surgery and Skin Substitutes'' section, certain codes were deleted that previously described skin allograft and tissue cultured and acellular skin substitute procedures, including CPT code 15342 (Application of bilaminate skin substitute/neodermis; 25 sq cm), CPT code 15343 (Application of bilaminate skin substitute/neodermis; each additional 25 sq cm), CPT code 15350 (Application of allograft, skin; 100 sq cm or less), and CPT code15351 (Application of allograft, skin; each additional 100 sq cm). Thirty-seven new CPT codes were created in the ''Skin Replacement Surgery and Skin Substitutes'' section, and these codes received interim final status indicators and APC assignments in the CY 2006 final rule with comment period and were subject to comment. At its March 2006 meeting, the APC Panel heard several presentations on some of the new CY 2006 CPT codes for skin replacement and skin substitute procedures, and CMS has received additional information from the public regarding a number of these services. In particular, 18 new CPT codes that were created to more specifically describe skin allograft, skin replacement, and skin substitute procedures were the subject of the APC Panel discussion and recommendations. These codes are as follows:

- CPT code 15170 (Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT code 15171 (Acellular dermal replacement, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof)
- CPT code 15175 (Acellular dermal replacement, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT code 15176 (Acellular dermal replacement, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof)
- CPT code 15300 (Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT code 15301 (Allograft skin for temporary wound closure; trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof)
- CPT code 15320 (Allograft skin for temporary wound closure, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT code 15321 (Allograft skin for temporary wound closure, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof)
- CPT code 15340 (Tissue cultured allogeneic skin substitute; first 25 sq cm or less)
- CPT code 15341 (Tissue cultured allogeneic skin substitute; each additional 25 sq cm)
- CPT code 15360 (Tissue cultured allogeneic dermal substitute; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT code 15361 (Tissue cultured allogeneic dermal substitute; trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof)
- 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 one percent of body area of infants and children)
- 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 one percent of body area of infants and children)
- CPT code 15420 (Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT code 15421 (Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof)
- CPT code 15430 (Acellular xenograft implant; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT code 15431 (Acellular xenograft implant; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof).

The CY 2006 interim final APC assignments of these codes, the recommendations made by the APC Panel at its March 2006 meeting, and our proposed placement of the codes for CY 2007 were listed in Table 11 of the CY 2007 OPPS proposed rule (71 FR 49557). As noted in the proposed rule, in general, biological skin substitutes and replacements used in procedures described by these CPT codes were proposed for separate payment under the OPPS for CY 2007, according to the methodology outlined in section V. of the preamble of the proposed rule (71 FR 49557) and discussed in this preamble.

As we indicated in the proposed rule (71 FR 49558), we reviewed the presentations to the APC Panel; the APC Panel's recommendations; the CPT code descriptors, introductory explanations, cross-references, and parenthetical notes; the clinical characteristic of the procedures; and the code-specific median costs for all related CPT codes available from our CY 2005 claims data. While we agreed with the APC Panel that the codes currently placed in APC 0024 (Level I Skin Repair) should be assigned to an APC with a higher median cost for CY 2007, we disagreed that these procedures should be placed in APC 0027 (Level IV Skin Repair). The APC Panel presenters reasoned that some of the codes (CPT codes 15170, 15175, 15320, 15340, 15360, 15365, 15420, and 15430) for the first increment of body surface area treated should be placed in APC 0027 because they are similar to CPT code 15300 (Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children). Upon further review of the clinical and expected hospital resource characteristics of CPT code 15300, we asserted in the proposed rule that this procedure was not appropriately placed in APC 0027. Split-thickness and full thickness skin autograft procedures currently assigned to APC 0027 were likely to require greater hospital resources, including additional operating room time and special equipment, in comparison to application of a separately paid allograft skin product. Instead, for CY 2007 we proposed to reassign CPT code 15300 to APC 0025 (Level II Skin Repair), with an APC median cost of $314.58. We agreed, in principle, that other CPT codes for the first increment of body surface area treated with a skin replacement or skin substitute were similar clinically and from a hospital resource perspective to CPT code 15300 and, therefore, we

proposed to assign these procedures to APC 0025 as well for CY 2007.

Similarly, presenters reasoned that the related add-on codes (CPT codes 15171, 15176, 15321, 15342, 15361, 15366, 15421, and 15431) for procedures to treat additional body surface areas are similar to CPT code 15301 (Allograft skin for temporary wound closure, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof) in terms of required hospital resources. CPT code 15301 is assigned to APC 0025 for CY 2006. We proposed to maintain the assignment of CPT code 15301 to APC 0025 for CY 2007 and to reassign the other add-on codes to this APC. Note that APC 0025 has a status indicator of ''T,'' so that the add-on codes would experience the standard OPPS multiple surgical procedure reduction when properly billed with the first body surface area treatment codes that are assigned to the same clinical APC. We asserted in the proposed rule that this reduction in payment for the procedural resources associated with the add-on services was appropriate. (71 FR 49558).

The APC Panel did not hear any presentations or make any recommendations regarding skin substitutes or skin replacement codes and APCs at its August 2006 meeting.

Comment: One commenter on the CY 2006 final rule requested that we reassign CPT codes 15340 and 15341 to APC 0025, where the services would be grouped with clinically related services that require comparable hospital resources. In particular, the commenter noted that APC 0024 did not provide appropriate payment for the costs of surgical debridement of the wound to prepare it properly for application of the allogeneic skin substitute. Several commenters on the CY 2007 proposed rule supported our proposal to assign new CPT codes 15340 and 15341 to APC 0025. One commenter noted that the proposed assignments of these CPT codes for tissue cultured allogeneic skin substitutes to APC 0025 for CY 2007 would correct substantial reductions in payment for application of one product that occurred with the assignment of these CPT codes to APC 0024 for CY 2006. The commenter believed that our proposal represented a significant step toward the appropriate payment for these services. The commenter further claimed that its external analyses of Medicare claims data supported the change, with a median cost for new CPT code 15340 that was higher than the median cost of APC 0025 but lower than the median cost of APC 0027.

Response: We appreciate the recognition from the commenter that the proposed assignments of CPT codes 15340 and 15341 to APC 0025 provides more appropriate payment for these services.

Comment: A commenter supported our CY 2007 proposed assignments of CPT codes 15170 through 15176, 15300–15321, 15340–15366, and 15420–15431 to APC 0025. One commenter agreed that skin substitute or replacement add-on codes (CPT codes 15171, 15176, 15301, 15321, 15341, 15361, 16366, 15421, and 15431) should be placed in APC 0025. Another commenter provided significant clinical detail about dermal replacement services, described by CPT codes 15170 through 15176, and about temporary wound closure by allograft services, described by CPT codes 15300 through 15321. In contrast to our proposal, the commenters believed that, based on the clinical characteristics and expected costs including anesthesia, procedure room time, supplies, and preparation of the products for application, these services would be most appropriately assigned to APC 0686 (Level III Skin Repair). They believed that CMS had underestimated the resources required to perform these procedures.

Response: While the commenters provided comparisons among the expected relative costs of various procedures, the commenter provided no specific cost analyses to persuade us to assign CPT codes 15170 through 15176 and 15300 through 15321 to a skin repair APC that would provide payment at two and a half times the proposed payment rate for these services. We do not agree that the clinical and resource distinctions between these procedures and other services also assigned to APC 0025 would warrant their reassignment to APC 0686, with its significantly higher payment rate than their CY 2007 proposed payment rate. We note that we will have claims data for all of these CPT codes available for the CY 2008 OPPS update.

After carefully considering the public comments received, we are finalizing our proposed assignments of skin substitute and skin replacement procedures as shown in Table 16 below without modification.

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Table 16.--CY 2007 Assignments of Skin Substitute and Skin Replacement Procedures

CPT Code	Short Descriptor	CY 2006 Assignment			APC Panel Recommendation	CY 2007 Assignment		
		APC	SI	APC Median		APC	SI	APC Median
15170	Cell graft trunk/arm/legs	24	T	$92.22	27	25	T	$321.40
15171	Cell graft t/arm/leg add-on	24	T	$92.22	25	25	T	$321.40
15175	Acellular graft, f/n/hf/g	24	T	$92.22	27	25	T	$321.40
15176	Acell graft, f/n/hf/g/add-on	24	T	$92.22	25	25	T	$321.40
15300	Apply skin allograft, t/arm/lg	27	T	$1081.66	N/A	25	T	$321.40
15301	Apply sknallograft t/a/l addl	25	T	$315.37	N/A	25	T	$321.40
15320	Apply skin allogrft f/n/hf/g	25	T	$315.37	27	25	T	$321.40
15321	Aply sknallogrft f/n/hfg add	25	T	$315.37	25	25	T	$321.40
15340	Apply cult skin substitute	24	T	$92.22	27	25	T	$321.40
15341	Apply cult skin sub add-on	24	T	$92.22	25	25	T	$321.40
15360	Apply cult derm sub, t/a/l	24	T	$92.22	27	25	T	$321.40
15361	Aply cult derm sub t/a/l/ add-on	24	T	$92.22	25	25	T	$321.40
15365	Apply cult derm sub f/n/hf/g	24	T	$92.22	27	25	T	$321.40
15366	Apply cult derm f/hf/g add	24	T	$92.22	25	25	T	$321.40
15420	Apply skin xgraft, f/n/hf/g	25	T	$315.37	27	25	T	$321.40
15421	Apply skn xgraft, f/n/hf/g add	25	T	$315.37	25	25	T	$321.40
15430	Apply acellular xenograft	25	T	$315.37	27	25	T	$321.40
15431	Apply acellular xgraft add	25	T	$315.37	25	25	T	$321.40

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b. Treatment of Fracture/Dislocation (APCs 0062, 0063, and 0064)

APC 0046 (Open/Percutaneous Treatment Fracture or Dislocation) was a large clinical APC to which many procedures related to the percutaneous or open treatment of fractures and dislocations are assigned for CY 2006. Most of the approximately 100 procedures in the APC are relatively low volume, with even fewer single bills available for ratesetting. The median costs of the significant procedures in this APC as configured for CY 2006 range from a low of about $1,415 to a high of about $3,893. We received comments to the CY 2006 proposed rule (70 FR 42674) requesting that we distinguish procedures containing ''with or without external fixation'' in their descriptors to provide greater payments when external fixation is used to treat fractures. The commenters explained that when external fixation devices are used, the costs of the procedures increase, and, therefore, the current APC placement significantly underpays those procedures in those instances. In the CY 2006 final rule with comment period (70 FR 68607), we declined to reassign procedures that could include external fixation at that time but we acknowledged that we had treated APC 0046 as an exception to the 2 times rule for several years. For CY 2006, we again treated APC 0046 as an exception to the 2 times rule, but noted we would ask the APC Panel to consider whether this APC could be reconfigured to improve its clinical and resource homogeneity.

At the March 2006 meeting of the APC Panel, we asked the Panel to consider a possible reconfiguration of APC 0046 based on partial year CY 2005 claims data. The reconfiguration would create three new APCs and would divide the codes in APC 0046 among

them. The APC Panel recommended that CMS continue to evaluate the refinement of APC 0046 into at least three APC levels, with consideration of a fourth level should data support this additional level. We accepted the APC Panel's recommendation and proposed for CY 2007 to split APC 0046 into three new APCs: APC 0062 (Level I Treatment Fracture/Dislocation); APC 0063 (Level II Treatment Fracture/Dislocation); and APC 0064 (Level III Treatment Fracture/Dislocation). To ensure clinical and resource homogeneity in the new APCs, their proposed configurations were based on the procedure code descriptors, clinical considerations specific to each procedure, and service-specific hospital resource utilization as shown in the claims data from CY 2005. Restructuring APC 0046 into these three new APCs eliminated 2 times rule violations in the Fracture/Dislocation series.

The APC Panel did not hear any presentations or make any recommendations regarding APC 0046 or our proposed APCs 0062, 0063, and 0064 at its August 2006 meeting.

We did not propose a fourth APC level in the Fracture/Dislocation series because we did not believe our claims data were sufficiently robust and consistent from year to year to support differential payment for another service level. One code, CPT 27615 (Radical resection of tumor (e.g., malignant neoplasm), soft tissue of leg or ankle area), was not clinically coherent with the other procedures in APC 0046, and we proposed to reassign this procedure outside of the Fracture/Dislocation series to APC 0050 (Level II Musculoskeletal Procedures Except Hand and Foot) for CY 2007.

We received two supportive comments on our proposed reconfiguration of APC 0046. A summary of the comments and our response follow:

Comment: A few commenters supported our proposal to move from one APC (0046) to three APCs (0062, 0063, and 0064) for services that treat fractures and dislocations. The commenters noted that three APCs better recognize the differences in hospital resource utilization. The commenters noted that OPPS payments would increase significantly for the highest level of fracture and dislocation treatment, decrease for the lowest level, and remain relatively stable for the medium treatment level.

Response: We appreciate the acknowledgement that we are attempting to better recognize the differences in hospital resource utilization for fracture and dislocation procedures.

We note that AMA's CPT Editorial Panel has deleted CPT 25611 (Percutaneous skeletal fixation of distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation, with or without external fixation) for CY 2007, replacing it with CPT code 25606 (Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation). AMA's CPT Editorial Panel has also deleted CPT code 25620 (Open treatment of distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation) for CY 2007, replacing it with three CPT codes as refinements: CPT code 25607 (Open treatment of distal radial extraarticular fracture or epiphyseal separation, with internal fixation); CPT code 25608 (Open treatment of distal radial intraarticular fracture or epiphyseal separation; with internal fixation of two fragments); and CPT code 25609 (Open treatment of distal radial intraarticular fracture or epiphyseal separation; with internal fixation of three or more fragments). These changes are effective January 1, 2007. The interim final APC assignments of the new CY 2007 CPT codes for fracture treatments are included in Table 17 below.

After carefully considering the comments received, we are finalizing our proposal without modification to reconfigure CY 2006 APC 0046 for fracture and dislocation procedures into three new APCs for CY 2007, APCs 0062, 0063, and 0064, as displayed in Table 17, and to reassign CPT code 27615 to APC 0050.

TABLE 17.—RECONFIGURATION OF APC 0046

HCPCS code	Description	CY 2007 APC
21336	Treat nasal septal fracture	0063
21805	Treatment of rib fracture	0062
23515	Treat clavicle fracture	0064
23530	Treat clavicle dislocation	0063
23532	Treat clavicle dislocation	0062
23550	Treat clavicle dislocation	0063
23552	Treat clavicle dislocation	0063
23585	Treat scapula fracture	0064
23615	Treat humerus fracture	0064
23616	Treat humerus fracture	0064
23630	Treat humerus fracture	0064
23660	Treat shoulder dislocation	0063
23670	Treat dislocation/fracture	0064
23680	Treat dislocation/fracture	0063
24515	Treat humerus fracture	0064
24516	Treat humerus fracture	0064
24538	Treat humerus fracture	0062
24545	Treat humerus fracture	0064
24546	Treat humerus fracture	0064
24566	Treat humerus fracture	0062
24575	Treat humerus fracture	0064
24579	Treat humerus fracture	0064
24582	Treat humerus fracture	0062
24586	Treat elbow fracture	0064
24587	Treat elbow fracture	0064
24615	Treat elbow dislocation	0064
24635	Treat elbow fracture	0064
24665	Treat radius fracture	0063

TABLE 17.—RECONFIGURATION OF APC 0046—Continued

HCPCS code	Description	CY 2007 APC
24666	Treat radius fracture	0064
24685	Treat ulnar fracture	0063
25515	Treat fracture of radius	0063
25525	Treat fracture of radius	0063
25526	Treat fracture of radius	0063
25545	Treat fracture of ulna	0063
25574	Treat fracture radius & ulna	0064
25575	Treat fracture radius/ulna	0064
25606 (25611 deleted)	Treat fx distal radial	0062
25607 (25620 deleted)	Treat fx rad extra-articul	0064
25608 (25620 deleted)	Treat fx rad intra-articul	0064
25609 (25620 deleted)	Treat fx radial 3+ frag	0064
25628	Treat wrist bone fracture	0063
25645	Treat wrist bone fracture	0063
25651	Pin ulnar styloid fracture	0062
25652	Treat fracture ulnar styloid	0063
25670	Treat wrist dislocation	0062
25671	Pin radioulnar dislocation	0062
25676	Treat wrist dislocation	0062
25685	Treat wrist fracture	0062
25695	Treat wrist dislocation	0062
26608	Treat metacarpal fracture	0062
26615	Treat metacarpal fracture	0063
26650	Treat thumb fracture	0062
26665	Treat thumb fracture	0063
26676	Pin hand dislocation	0062
26685	Treat hand dislocation	0063
26686	Treat hand dislocation	0064
26715	Treat knuckle dislocation	0063
26727	Treat finger fracture, each	0062
26735	Treat finger fracture, each	0063
26746	Treat finger fracture, each	0063
26756	Pin finger fracture, each	0062
26765	Treat finger fracture, each	0063
26776	Pin finger dislocation	0062
26785	Treat finger dislocation	0062
27202	Treat tail bone fracture	0063
27509	Treatment of thigh fracture	0062
27524	Treat kneecap fracture	0063
27566	Treat kneecap dislocation	0063
27615	Remove tumor, lower leg	0050
27756	Treatment of tibia fracture	0062
27758	Treatment of tibia fracture	0063
27759	Treatment of tibia fracture	0064
27766	Treatment of ankle fracture	0063
27784	Treatment of fibula fracture	0063
27792	Treatment of ankle fracture	0063
27814	Treatment of ankle fracture	0063
27822	Treatment of ankle fracture	0063
27823	Treatment of ankle fracture	0064
27826	Treat lower leg fracture	0063
27827	Treat lower leg fracture	0064
27828	Treat lower leg fracture	0064
27829	Treat lower leg joint	0063
27832	Treat lower leg dislocation	0063
27846	Treat ankle dislocation	0063
27848	Treat ankle dislocation	0063
28406	Treatment of heel fracture	0062
28415	Treat heel fracture	0063
28420	Treat/graft heel fracture	0063
28436	Treatment of ankle fracture	0062
28445	Treat ankle fracture	0063
28456	Treat midfoot fracture	0062
28465	Treat midfoot fracture, each	0063
28476	Treat metatarsal fracture	0062
28485	Treat metatarsal fracture	0063
28496	Treat big toe fracture	0062
28505	Treat big toe fracture	0063
28525	Treat toe fracture	0063
28531	Treat sesamoid bone fracture	0063
28545	Treat foot dislocation	0062

TABLE 17.—RECONFIGURATION OF APC 0046—Continued

HCPCS code	Description	CY 2007 APC
28546	Treat foot dislocation	0062
28555	Repair foot dislocation	0063
28576	Treat foot dislocation	0062
28585	Repair foot dislocation	0063
28606	Treat foot dislocation	0062
28615	Repair foot dislocation	0063
28636	Treat toe dislocation	0062
28645	Repair toe dislocation	0063
28666	Treat toe dislocation	0062
28675	Repair of toe dislocation	0063

c. Complex Skin Repair (APC 0024)

In the CY 2007 OPPS proposed rule, we proposed to assign CPT code 13151 (Repair, complex, eyelids, nose, ears and/or lip, 1.1 cm to 2.5 cm, to APC 0024 (Level I Skin Repair) with a payment rate of $91.86.

Comment: One commenter asked why CPT code 13151 (Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm) was assigned to APC 0024, rather than to APC 0025 (Level II Skin Repair). The commenter pointed out that the smaller skin repair represented by CPT code 13150 was assigned to APC 0025 with other more complex skin repair procedures.

Response: We agree with the commenter that CPT code 13151 would be more appropriated assigned to APC 0025 and are making that reassignment effective January 1, 2007.

d. Insertion of Posterior Spinous Process Distraction Device

The AMA released two new Category III codes on July 1, 2006, for insertion of a posterior spinous process distraction device, namely: 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)). These two new codes are effective January 1, 2007. Moreover, we have created a new device category for transitional pass-through payment, effective January 1, 2007, C1821 (Interspinous process distraction device (implantable)), which we expect to be reported with these procedures. At its August 2006 meeting, the APC Panel recommended that CMS review the resources required for these new CPT codes and recommend appropriate APC assignments for them for CY 2007.

Comment: Some commenters indicated that CMS should place new procedure codes 0171T and 0172T into clinical APC 0051 (Level III Musculoskeletal Procedures Except Hand and Foot). Although the level of resources used in performing CPT code 0172T (second and subsequent level implants) is less than those used for CPT code 0171T (the single level implant of the device), the commenters believed that APC 0051 is also appropriate for 0172T because APC 0051 is subject to the multiple procedure discount. CPT code 0172T is an add-on code to the primary procedure reported with CPT code 0171T; therefore, payment for 0172T would always be reduced by 50 percent. One commenter stated that the resource elements they outlined specifically for CPT code 0172T are all costs incurred separately and in addition to the costs of the single level procedure, CPT code 0171T. The commenter believed it would be inappropriate to place CPT code 0172T into an APC based on the claimed resources, and then reduce the payment rate by 50 percent when a multiple procedure discount applies to every case that is correctly coded. The commenter provided charge data from seven claims for six different facilities that performed the single level procedure (CPT code 0171T). The commenter calculated a ''median'' of these charges reduced to cost of $2,727, which the commenter asserted was within the range of median costs of other procedures assigned to APC 0051. The commenter stated that it was unable to obtain any facility charge or cost data for CPT code 0172T. The commenter acknowledged that CMS had also granted transitional pass-through payment status for spinous process distraction devices effective January 1, 2007.

One commenter indicated that it expected the spinous process distraction device to remain on pass-through status through CY 2008 and, therefore, be paid separately through that time. However, the commenter expressed concern that once the device is no longer paid separately under pass-through payment, the device costs, which would be a substantial percentage of total procedural costs, would be packaged into payment for the procedural APC and adjusted by the wage index that is applied to 60 percent of the payment rate. The commenter requested that CMS address this issue, so that once payment for the spinous process distraction device is packaged into the procedural APC payment, hospitals with wage indices below 1.0 would be able to continue offering the procedure to patients.

Another commenter stated that it had performed four spinous process distraction device cases over the past year. All four cases had similar utilization patterns and outcomes. The commenter claimed to have evaluated the time and resources needed to complete the procedure, and compared the costs to other procedures, for example, laminectomies and diskectomies, performed at the hospital, and also extracted single procedure costs for all cases performed in APCs 0049 through 0052. The commenter determined that the costs of the four spinous process distraction device cases were most consistent with the costs of other services assigned to APC 0051.

Response: The commenters provided their recommendation based on their limited cost studies that relied on information from a few hospitals with experience implanting spinous process distraction devices. This is not unusual for new procedures, such as CPT Category III codes. We examined the procedural resource information provided by commenters as well as considered CY 2005 claims data for other musculoskeletal procedures in the OPPS. We believe that both of the procedures describe by CPT codes

0171T and 0172T would be most appropriately assigned to APC 0050 (Level II Musculoskeletal Procedures Except Hand and Foot), based on both clinical and expected resource considerations. Their assignment to the same clinical APC for CY 2007 will ensure appropriate payment for CPT code 0172T when the multiple procedure payment reduction is applied. We note that the device cost of HCPCS code C1821 (Interspinous process distraction device (implantable)), will be paid separately 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 would be packaged into the procedural APC payments for its implantation, most likely CPT codes 0171T and 0172T. At that time, we will further evaluate the most appropriate APC assignments for these procedures, as we will each year. For a discussion about application of the wage index to payments for APCs that have significant device costs, see section IV.A.2 of this final rule with comment period.

After carefully considering the public comments received, we are accepting the APC Panel's recommendation and assigning CPT codes 0171T and 0172T to APC 0050 with status indicator ''T'' for CY 2007. These assignments are interim final, and, therefore, open to comment in this final rule with comment period.

7. Medical Services

a. Medication Therapy Management Services

Following a presentation at its March 2006 meeting, the APC Panel made two recommendations regarding Category III CPT codes for pharmacist medication therapy management services that were new for CY 2006. These services include CPT codes 0115T (medication therapy management services provided by a pharmacist, individual, face-to-face with patient, initial 15 min., w/ assessment and intervention if provided; initial encounter), 0116T (medication therapy management; subsequent encounter), and 0117T (medication therapy management; additional 15 min.). These codes were assigned status indicator ''B'' in the CY 2006 OPPS final rule with comment period, indicating that they are not recognized by the OPPS when submitted on an outpatient hospital Part B bill type, with comment indicator ''NI'' to identify them as subject to comment. The APC Panel recommended that CMS create a new APC, with a nominal payment, to which we would assign these codes; implement the assignment in July 2006, if possible, or otherwise in CY 2007; and provide guidance to hospitals on how and when these codes should be reported. As indicated in the CY 2007 OPPS proposed rule (71 FR 49563), we did not accept the APC Panel's recommendations. Rather, we proposed to continue to assign status indicator ''B'' to CPT codes 0115T, 0116T, and 0117T for CY 2007.

According to the AMA, the purpose of Category III CPT codes is to facilitate data collection on and assessment of new services and procedures. Medication therapy management services are not new services in the OPPS, as they have been provided to patients by hospitals in the past as components of a wide variety of services provided by hospitals, including clinic and emergency room visits, procedures, and diagnostic tests. As such, in the CY 2007 proposed rule, we noted that we believe their associated hospital resource costs were already incorporated into the OPPS payments for these other services that are based on historical hospital claims data. The three Category III CPT codes specifically describe medication therapy management services provided by a pharmacist. We indicated that we had no need to distinguish medication therapy management services provided by a pharmacist in a hospital from medication therapy management services provided by other hospital staff, as the OPPS only makes payments for services provided incident to physicians' services. Hospitals providing medication therapy management services incident to physicians' services may choose a variety of staffing configurations to provide those services, taking into account other relevant factors such as State and local laws and hospital policies.

In the CY 2007 proposed rule, we explained that in general, we do not establish new clinical APCs for new codes and set payment rates for those APCs when we have no cost data for any services populating the APCs. New codes for which we believe that there are no existing clinical APCs compatible with their expected clinical and hospital resource characteristics are often assigned to New Technology APCs until we have sufficient cost data to determine appropriate clinical APC assignments. However, these medication therapy management codes would not be eligible to map to New Technology APCs because they are not new services that are unrepresented in historical hospital claims data. As stated earlier, because we believe the costs of medication therapy management services were imbedded as a component within our claims data, we were confident that our CY 2005 claims data reflected the costs of pharmacist medication management services provided to hospital outpatients who were receiving hospital services.

We received a large number of public comments concerning our proposal for CPT codes 0115T, 0116T, and 0117. A summary of the comments and our responses follows:

Comment: Most commenters requested that Medicare pay separately for medication therapy management because it is difficult for the hospital to provide this service without receiving any payment. One commenter elaborated on the emerging role of a pharmacist and the increasing scope of services provided by the pharmacist to the patient, including proactive assessments rather than simply reactive responses. This commenter stated that although the historical resource costs of the pharmacist's services may be captured in the claims data, it was unlikely that the resource costs of the new responsibilities are represented in the data. Another commenter quoted statistics that estimated that, in 2004, only 30 percent of hospitals had pharmacists who were involved in ambulatory care. Of those who were involved, only 50 percent had involvement in medication therapy management services. Therefore, although there may be cost data embedded in the claims, the fact that these services have historically been provided infrequently means that the costs of these services have minimal impact on our median cost data. Many commenters noted that these pharmacist services reduce costs in the long run by improving the health of patients. One commenter agreed that these services are already accounted for in the claims data and further agreed that there is no need to distinguish between services provided by pharmacists and other providers. One commenter suggested that medication therapy management could be provided to a patient on the same day as a laboratory test and requested that CMS clarify the appropriate billing technique under such circumstances. Another commenter specifically asked if it was appropriate to bill CPT code 99211, the lowest level clinic visit, if the only service provided to a patient is medication therapy management by a pharmacist. One commenter agreed that these services are not technically new, but suggested that CMS map them to New Technology APCs because they are new in the sense that they are now more

readily available independent of a physician's service or clinic procedure. One pharmacy association objected to our statement that these services can be provided by staff other than pharmacists. The association notes that pharmacists have distinct training, skills, and abilities to perform these services, which are reflected in the new Category III codes.

Response: We agree with the commenters that medication therapy management services are important services provided to patients and that providers should receive payments for these services. We would expect the hospital charges for the services provided to the patient to include charges for all hospital resource costs associated with the patient's care, including medication therapy management services, if appropriate. As we stated above, medication therapy management services are not new services, and they have been provided in the past as components of a wide variety of services provided by hospitals, including clinic and emergency room visits, procedures, and diagnostic tests. Although we do not make separate payment for medication therapy management provided by a pharmacist, the costs for this service are included in the costs of other services furnished by the hospital on the same day. Therefore, we continue to believe that the costs for these services are embedded in our claims data, and are reflected in our payment rates, thereby providing payments for these important services. While we acknowledge commenters' concerns that hospitals are providing medication therapy management services more frequently than in the past, we continue to disagree that they are new and should be assigned to a New Technology APC. To the extent that medical management services evolve over time to require more facility resources due to their greater complexity, we expect those higher costs to be reflected in hospitals' charges for the associated services, which will then provide the basis for future ratesetting under the OPPS.

To clarify our billing requirements, if the only service provided to a patient is a laboratory test to determine medication levels, the laboratory test is all that should be billed. If a hospital provides a distinct, separately identifiable service in addition to the test, the hospital is responsible for billing the HCPCS code that most closely describes the service provided. Billing a visit code in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate. A hospital may bill a visit code, based on the hospital's own coding guidelines which must reasonably relate the intensity of hospital resources to the different levels of HCPCS codes. Services furnished must be medically necessary and documented.

After carefully considering the comments received, we are continuing to assign status indicator ''B'' to CPT codes 0115T, 0116T, and 0117T for CY 2007 and finalizing our proposed policy without modification.

b. 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 2007. Multiple allergy tests are 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 2005 claims data available for the CY 2007 proposed rule did not yet reflect the improved and more consistent hospital billing practices of ''per test'' for single allergy tests. Some claims for single allergy tests still appeared to provide charges that represented a ''per visit'' charge, rather than a ''per test'' charge. Therefore, consistent with our payment policy for CY 2006, we proposed to calculate a ''per unit'' median cost for APC 0381, based upon 349 claims containing multiple units or multiple occurrences of a single CPT code, where packaging on the claims was allocated equally to each unit of the CPT code. Using this methodology, we calculated a median cost of $13.29 for APC 0381 for CY 2007. As indicated in the CY 2007 OPPS proposed rule (71 FR 49566), we were hopeful that the better and more accurate hospital reporting and charging practices for these single allergy test CPT codes beginning in CY 2006 would allow us to calculate the median cost of APC 0381 using the standard OPPS process in future OPPS updates.

We did not receive any public comments concerning our proposed methodology for differentiating single allergy tests from multiple allergy tests for OPPS payment in CY 2007. The final CY 2007 APC 0381 median cost calculated based upon 382 single claims, using the methodology as proposed, is $16.43.

c. 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 and 2006. For CY 2007, we proposed to continue using the same methodology to estimate a ''per unit'' median cost for HCPCS code C1300. Using 50,311 claims with multiple units or multiple occurrences, we estimated a median cost of $98.36 for CY 2007.

Comment: One commenter agreed with CMS' approach to determining the median costs for HCPCS code C1300

(HBOT) to the extent that it eliminated services that were obviously billed incorrectly. The commenter believed that use of the hospital's overall CCR appeared to be the best option at this time. However, the commenter asked that hospitals be allowed to bill these services with multiple revenue codes (not just respiratory therapy), so that hospitals could bill the services under the revenue code that was most closely linked to the cost center where the services were furnished. The commenter also requested that the revenue code to cost center crosswalk be revised to reflect the use of the hospital's overall CCR for HBOT.

In contrast, another commenter was concerned that CMS' claims data do not accurately reflect the costs of this therapy because of potential hospital miscoding. The commenter believed that the use of hospitals' overall CCRs did not reflect the relationship between costs and charges specific to HBOT. The commenter believed that the payment rate for HCPCS code C1300 continued to be inadequate as proposed for CY 2007 and asked that the rate be increased based on the external data provided by an association to the APC Panel.

Another commenter objected to erratic payment rates for HBOT over a period of years, particularly a drop in payment between CYs 2004 and 2005. The commenter attributed this instability both to the confusion of hospitals regarding proper coding of treatment units and to CMS' inability to determine an appropriate CCR for HBOT because hospitals reported their costs under many cost centers. The commenter recommended that CMS use an external analysis that it indicated reproduces an accurate CCR for HBOT, calculated using a consistent and transparent methodology.

Response: We believe that the final median cost for APC 0659 ($97.20 per unit) is an appropriate relative cost to be used to set the weights upon which the HBOT payment will be based.

CY 2007 is the third year in which we have used 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 3 years. We believe that this adjustment through use of the hospitals' overall CCRs is all that is necessary to yield a valid median cost for establishing a scaled weight for HBOT services.

After carefully considering the public comments received, we are finalizing our proposed methodology for estimating a ''per unit'' median cost for HCPCS code C1300, assigned to APC 0659, without modification for CY 2007.

d. Guidance for Chemodenervation (APC 0215)

For CY 2006, new CPT codes 95873 (Electrical stimulation for guidance in conjunction with chemodenervation) and 95874 (Needle electromyography for guidance in conjunction with chemodenervation) were provided interim final assignments to APC 0215 (Level I Nerve and Muscle Tests). The proposed APC assignments of the codes for CY 2007 were unchanged.

Comment: One commenter requested that CMS reevaluate the APC assignments for CPT codes 95873 and 95874 when data become available. The commenter believed that it would be appropriate to assign the codes to two different payment levels based on their different resource requirements, but the commenter understood the CMS decision to assign them both to one APC pending data development.

Response: We appreciate the commenter's request, and we will reevaluate the assignment for both of the new codes for the CY 2008 update to the OPPS.

After carefully considering the public comment received, we are finalizing our proposal to assign CPT codes 95873 and 95874 to APC 0215 for CY 2007, without modification.

e. Pathology Services (APC 0344)

In Addendum B of the CY 2007 proposed rule (71 FR 49709), we proposed to assign a payment rate of $49.90 to APC 0344 (Level IV Pathology Services).

Comment: Many commenters considered the proposed payment rate for APC 0344 to be low, especially when compared with the MPFS payment for these same laboratory CPT codes that are assigned to APC 0344. Several commenters indicated that the payment rate of $49.90 was far below the level of payment necessary for performing these tests in the hospital outpatient settings. One commenter cautioned that the cost differential between the hospital OPPS and the MPFS would result in a site-of-service differential. The commenter submitted a table showing differences in payments between the OPPS and the MPFS. The commenter believed that the payment levels for these laboratory services should be the same as or equal under both Medicare payment systems. The commenter asked that CMS establish payment equity for the same service furnished in these respective settings. Several commenters urged CMS to review the payment rate for APC 0344, and assign a payment rate that reflects the complexity and resource costs associated with providing these services.

Response: The statutory method for calculating payment for physicians' practice expenses under the MPFS differs from the general statutory method we use for establishing payment rates in the hospital outpatient setting. Consequently, the application of the different methodologies results in different payment amounts in the two settings.

Payment for services assigned to APC 0344 for CY 2007 will be made based upon the median cost of the APC, established according to the standard OPPS methodology from CY 2005 hospital outpatient claims. The median costs of individual services assigned to APC 0344 do not violate the 2 times rule. The claims data used to establish the APC median cost are stable and robust, and the APC is appropriately structured to include only those procedures with common clinical and resource features.

After carefully considering the public comments received, we are finalizing the APC 0344 structure as proposed without modification. The final CY 2007 median cost of APC 0344 is $48.44, upon which its payment rate is based.

IV. OPPS Payment Changes for Devices

A. Treatment of Device-Dependent APCs

1. Background

Device-dependent APCs are populated by HCPCS codes that usually, but not always, require that a device be implanted or used to perform the procedure. For the CY 2002 OPPS, we used external data, in part, to establish the device-dependent APC medians used for weight setting. At that time, many devices were eligible for pass-through payment. For the CY 2002 OPPS, we estimated that the total amount of pass-through payments would far exceed the limit imposed by statute. To reduce the amount of a pro rata adjustment to all pass-through

items, we packaged 75 percent of the cost of the devices, using external data furnished by commenters on the August 24, 2001 proposed rule and information furnished on applications for pass-through payment, into the median costs for the device-dependent APCs associated with these pass-through devices. The remaining 25 percent of the cost was considered to be pass-through payment.

In the CY 2003 OPPS, we determined APC medians for device-dependent APCs using a three-pronged approach. First, we used only claims with device codes on the claim to set the medians for these APCs. Second, we used external data, in part, to set the medians for selected device-dependent APCs by blending that external data with claims data to establish the APC medians. Finally, we also adjusted the median for any APC (whether device-dependent or not) that declined more than 15 percent. In addition, in the CY 2003 OPPS we deleted the device codes (''C'' codes) from the HCPCS file because we believed that hospitals would include the charges for the devices on their claims, notwithstanding the absence of specific codes for devices used.

In the CY 2004 OPPS, we used only claims containing device codes to set the medians for device-dependent APCs and again used external data in a 50/50 blend with claims data to adjust medians for a few device-dependent codes when it appeared that the adjustments were important to ensure access to care. However, hospital device code reporting was optional.

In the CY 2005 OPPS, which was based on CY 2003 claims data, there were no device codes on the claims and, therefore, we could not use device-coded claims in median calculations as a proxy for completeness of the coding and charges on the claims. For the CY 2005 OPPS, we adjusted device-dependent APC medians for those device-dependent APCs for which the CY 2005 OPPS payment median was less than 95 percent of the CY 2004 OPPS payment median. In these cases, the CY 2005 OPPS payment median was adjusted to 95 percent of the CY 2004 OPPS payment median. We also reinstated the device codes and made the use of the device codes mandatory where an appropriate code exists to describe a device utilized in a procedure. In addition, we implemented HCPCS code edits to facilitate complete reporting of the charges for the devices used in the procedures assigned to the device-dependent APCs.

In the CY 2006 OPPS, which was based on CY 2004 claims data, we set the median costs for device-dependent APCs for CY 2006 at the highest of: (1) The median cost of all single bills; (2) the median cost calculated using only claims that contained pertinent device codes and for which the device cost is greater than $1; or (3) 90 percent of the payment median that was used to set the CY 2005 payment rates. We set 90 percent of the CY 2005 payment median as a floor rather than 85 percent as proposed, in consideration of public comments that stated that a 15-percent reduction from the CY 2005 payment median was too large of a transitional step. We noted in our CY 2006 proposed rule that we viewed our proposed 85 percent payment adjustment as a transitional step from the adjusted medians of past years to the use of unadjusted medians based solely on hospital claims data with device codes in future years (70 FR 42714). We also incorporated, as part of our CY 2006 methodology, the recommendation of commenters to base payment on medians that were calculated using only claims that passed the device edits. As stated in the CY 2006 OPPS final rule with comment period (70 FR 68620), we believed that this policy provided a reasonable transition to full use of claims data in CY 2007, which would include device coding and device editing, while better moderating the amount of decline from the CY 2005 OPPS payment rates.

2. CY 2007 Payment Policy

For CY 2007, we proposed to base the device-dependent APC medians on CY 2005 claims, the most current data available. As stated earlier, in CY 2005 we reinstated the use 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 edits to facilitate complete reporting of the charges for the devices used in the procedures assigned to the device-dependent APCs. We implemented the first set of device edits on April 1, 2005, for those APCs for which the CY 2005 payment rate was based on an adjusted median cost. We continued to take public comment on the remaining device edits after April 1, 2005, and implemented device edits for the remaining device-dependent APCs on October 1, 2005. Subsequent to the implementation of the device edits, we received public comments that caused us to remove the requirement for edits for several APCs on the basis that the services in them do not always require the use of a device, or there may be no suitable device codes available for reporting all devices that may be used to perform the procedures.

For example, we removed the requirement for device codes for APC 0080 (Diagnostic Cardiac Catheterization) based on the information provided by hospitals that the codes assigned to this APC do not always require a device for which there is an appropriate HCPCS code. Therefore, we no longer consider this APC to be device-dependent and have removed it from the list of device-dependent APCs. In the case of some procedures assigned to other device-dependent APCs, where we determined that no device was required to provide a particular service or where there were no HCPCS codes that described all devices that could be used to furnish the service, we removed the requirement for a device code for the individual procedure code but retained the device requirement for other procedure codes assigned to that device-dependent APC.

At its February 2006 meeting, the APC Panel recommended that CMS consider calculating the median costs for APCs 0107 (Insertion of Cardioverter Defibrillator) and 0108 (Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads) by bypassing the line-item costs of CPT code 33241 (Subcutaneous removal of single or dual chamber pacing cardioverter-defibrillator pulse generator) and packaging the line item-costs of CPT codes 93640 (Electrophysiological 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 time of initial implantation or replacement) and 93641 (Electrophysiological 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 time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator) when these codes, separately or in combination, are reported on the same claim with HCPCS codes 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(s) for dual chamber pacing cardioverter defibrillator and insertion

of pulse generator), which are assigned to APCs 0107 and 0108. The APC Panel recommended bypassing the line-item costs for CPT code 33241 because members believed that when a pacing cardioverter-defibrillator (ICD) pulse generator removal is performed in the same operative session as the insertion of a new pulse generator described by a procedure code assigned to APC 0107 or APC 0108, the packaging on the claim is appropriately assigned to the procedure code in APC 0107 or APC 0108. Moreover, CPT codes 93640 and 93641 may only be correctly coded when the electrophysiologic evaluation of ICD leads is performed at the time of initial implantation or replacement of an ICD pulse generator and/or leads, with or without testing of the pulse generator. Thus, the APC Panel expected that the costs of the evaluations of the ICD leads (CPT codes 93640 and 93641) could be appropriately packaged with the procedure codes that describe the insertion of ICD generators, which are assigned to APCs 0107 and 0108, or the insertion of ICD leads assigned to APCs 0106 (Insertion/Replacement/Repair of Pacemaker and/or Electrodes), 0108, and 0418 (Insertion of Left Ventricular Pacing Elect). Because APCs 0107 and 0108 have typically had very few single bills on which the medians have been based, and because the APC Panel indicated that it believed that we could use many more claims if we bypassed CPT code 33241 and packaged CPT codes 93640 and 93641, we calculated median costs for APCs 0107 and 0108 using these rules. We excluded claims that did not meet the device edits, and we also excluded token claims.

The effect of packaging CPT codes 93640 and 93641 into claims that both passed the device edits and contained no token charges for devices were shown in Table 19 of the CY 2007 OPPS proposed rule (71 FR 49573) and below. This affected APCs 0106, 0107, 0108, and 0418. Bypassing the line-item cost of CPT code 33241 could not be done for all claims on which this CPT code was reported because there are clinical circumstances in which the ICD pulse generator is removed and no new device is implanted. Therefore, the APC assignment of CPT code 33241 and the payment for that code need to reflect the packaging associated with the procedure when it is performed alone. Because of this problem with assigning packaging in all of the circumstances in which the procedure may be reported, we decided against proposing to bypass CPT code 33241, either in general for all procedures or selectively, when it is reported with the procedures in APCs 0107 and 0108.

However, CPT codes 93640 and 93641 are always performed during an operative procedure for ICD initial implantation or replacement or with implantation, revision or replacement of leads, and, therefore, we believed that it would be appropriate to package them into the surgical procedure with which they are performed. Moreover, as a result of the descriptors of the lead evaluation CPT codes, they should never be billed as single procedure claims, and packaging them would also resolve the problem of setting their payment rates in part on the basis of claims that reflect erroneous coding. As we noted in the CY 2007 proposed rule, packaging the costs of intraoperative electrophysiologic testing of the ICD leads yielded many more single bills on which to set median costs and also increased the median costs for APCs 0106, 0107, 0108, and 0418. Therefore, we proposed to package CPT codes 93640 and 93641 for CY 2007.

Furthermore, the APC Panel, at its August 2006 meeting, recommended that CMS use readily available external data to validate the costs derived from claims data. While CMS reviews all information that comes to our attention, we have not systematically used external data to validate the median costs derived from our claims data, because external data are typically furnished by parties with special interest in a particular item or service. Therefore, it is of limited usefulness in determining the relative cost of all items and services paid under the OPPS. In a system of relative weights, it is the relativity of the costs of services to one another, as derived from a standardized system that uses standardized inputs and a consistent methodology, that is the foundation of the system. The relationship between the actual acquisition cost of a particular item or service compared to the relative cost derived from the standard system for a single item or service is of little value.

For the proposed rule, we calculated the median cost for device-dependent APCs using two different sets of claims. We first calculated a median cost using all single procedure claims for the procedure codes in those APCs. We also calculated a second median cost using only claims that contain allowed device codes and also for which charges for all device codes were in excess of $1.00 (nontoken charge device claims). 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 charge was less than $1.01, and we removed those claims also.

As expected, the median costs calculated using all single procedure bills, including both bills that lacked appropriate device codes (where there are edits) and bills with token charges for devices, were in many cases less than the medians calculated using only claims that contained appropriate device codes without token charges for the devices. In some cases, the medians were significantly different when claims either without device codes or which had only token device charges were removed. In the CY 2007 proposed rule, we noted that we believed that the claims that reflected the best estimated costs for these APCs, including the costs of the devices, were those claims that contain appropriate device codes without token charges for devices. (See section IV.A.4. below for our discussion of payments when the hospital incurs no cost for the principal device required for the service.)

Therefore, we proposed to base the payment rates for CY 2007 for these device-dependent APCs on median costs calculated using claims with appropriate device codes with no token charges for devices reported on the claim. We did not believe that adjustment of these median costs was necessary to provide adequate payment for these services, and, therefore, we did not propose to adjust the median costs for these APCs to moderate any decreases in medians from CY 2006 to CY 2007. However, we noted in the proposed rule that, notwithstanding the device edits, it may continue to be necessary for purposes of median cost calculations to remove claims that do not contain devices because it is likely that there would be incidental occurrences of interrupted procedures in which a device is not used and does not appear on the claim. (The interrupted procedure modifier nullifies the device edit.) Moreover, we noted that there are likely to continue to be incidental occurrences of token charges for devices as a result of devices that are replaced without cost by the manufacturer. However, each of these circumstances could cause the procedure code median cost to underrepresent the cost of the complete procedure, including the device cost, where the hospital purchases the device.

Therefore, we proposed that use of claims that met the device edits and that

did not contain token charges for devices were the appropriate claims to use to set the median costs for the device-dependent APCs, ensuring that the costs of the principal devices were included in the APC medians. In addition, we proposed that, with our proposed changes to the OPPS packaging status of two codes for electrophysiologic evaluation of ICD leads, no special payment policies would be needed to establish payment rates that correctly reflect the relative costs of these procedures to other procedures paid under the OPPS.

We received a number of public comments concerning our CY 2007 proposed payment policies for device-dependent APCs.

Comment: The commenters supported limiting the set of claims used to calculate median costs for device-dependent APCs to claims that passed the device edits and did not contain device charges less than $1.01 to calculate median costs. In addition, some commenters asked CMS to remove claims with residual charges in cases in which recalled devices were replaced by upgraded devices or a different type of device, as was done when we removed token charge claims, so that the full cost of the device would be wholly represented in the procedure claims used for ratesetting. Several commenters objected to the proposed payment rates on the basis that hospitals report the units and charges for devices incorrectly, leading to incomplete and inaccurate claims data. They also believed that the CMS methodology of applying CCRs to charges for device-intensive services results in median costs that do not reflect the true relative costs of those services. They believed that hospitals do not mark up their charges for high cost items sufficiently to result in the actual cost of the item, a phenomenon generally known as ''charge compression.'' The commenters stated that hospitals are inhibited by market and other forces from charging at a level necessary for the application of the CCR to result in an accurate estimate of the cost of the device. Some commenters offered specific statistical strategies for calculation of adjustment factors that could be applied to the charges for devices to overcome the effects of charge compression. The commenters urged CMS to examine these strategies for their potential application to calculation of median costs and to use the charge compression analysis currently underway for Medicare inpatient billings to initiate a similar analysis for Medicare outpatient hospital payments. They indicated that the proposed payment rates for device-dependent APCs would set payments at such a low level that hospitals were likely to cease furnishing these services so that beneficiaries would no longer have access to needed care. The commenters urged CMS to use external data in place of median costs derived from claims data and to protect all such external data used for ratesetting from public disclosure.

Response: We continue to believe that it is appropriate to calculate the median costs to be used for establishing the payment rates in CY 2007 for device-dependent APCs using only claims that do not contain token charges for devices and that contain the devices that are appropriate for the procedure code, where there are HCPCS codes for such devices. We proposed to exclude all claims containing token charges because there were a number of actions in CY 2005 (the year of claims being used for the CY 2007 OPPS update) that caused hospitals to replace devices that they received without cost from manufacturers, and we advised hospitals to report a token charge for these devices. We will reassess whether exclusion of token charges is necessary for future years because, effective January 1, 2006, devices furnished without cost to the provider will be identified with modifier ''FB'' and exclusion of claims with token charges may no longer be necessary. We proposed to exclude claims that did not contain appropriate devices, as defined by the device edits on the CMS Web site, to maximize the likelihood that we would be basing the median costs for device-dependent APCs on claims that contained the full charge for the service, including the device. However, we did not exclude claims that contained residual charges for upgrades of replaced devices for which hospitals received credits from manufacturers because it was not possible to identify them systematically. Moreover, because we are calculating a median cost and commenters inform us that upgraded devices represent only 10 to 15 percent of cases in which devices are replaced without cost or with credit for the replaced device, we believe that those claims would have minimal influence on the calculation of the device-dependent APC median cost used for ratesetting. By basing weights on the median cost where the median is the 50th percentile of the array, a relatively small number of unusually low values (as would likely be represented by 10 to 15 percent of a relatively small number of devices replaced without any or full cost) is not likely to significantly affect the median cost. We recognize that the use of the hospital's CCR, even at the departmental level, results in computed costs and relative weights that may be more or less than the actual costs for items in specific cases. We believe that this average is appropriate and inherent in PPS. One of the principles behind the use of median costs for weight setting in a budget neutral payment system like the OPPS is to determine the appropriate relativity in resource use among services, thus allowing fair and equitable distribution of payment among hospitals based on their mix of services provided to Medicare beneficiaries. The median costs are not intended to represent the actual acquisition costs of the services being furnished. They 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 PPS and are not intended to pay reasonable costs. For this reason, 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 important to the system's integrity. Similarly, we do not believe that it is appropriate to remove specific claims from contributing to ratesetting if the hospital charge for a particular item does not exceed an established threshold.

However, we recognize that there may be value in exploring the extent to which the estimated relative costs derived from claims and cost report data deviate so substantially from acquisition costs that payment adjustments may be appropriate. Therefore, we are interested in further studying the analytic technique suggested in the comments that would involve the use of a regression analysis to identify adjustments that could be made to the CCRs to account for charge compression. We note that the regression model furnished with some comments was only applied to expensive medical supplies and devices. It was not applied uniformly to develop potential adjustments that could be made to costs and charges across all revenue codes and cost centers that could potentially be subject to charge compression. If such a model were to be applied in the OPPS, we believe further analysis would have to be undertaken to determine whether it should apply to all costs and cost centers. At this time, we intend to study whether a rigorous model could provide a payment adjustment for charge compression to the extent it exists.

We recognize that the issues the commenters raise regarding charge compression apply both to the OPPS weight setting and to the setting of the DRG weights that are an important determinant of payment under the IPPS for inpatient hospital services. Accordingly, CMS has awarded a 1-year contract to RTI International to study methods of improving estimates of the cost of Medicare inpatient hospital discharges used in constructing the DRG relative weights. The RTI contract will focus on methods of improving the accuracy of the adjustment of charges to cost to account for the fact that hospitals tend to mark up high cost items to a lesser extent than they mark up low cost items, the phenomenon known as charge compression. The study will also examine how charge compression interacts with other variables in the construction of the DRG relative weights, such as the number of cost centers included and whether hospital-specific relative values are used. To the extent that we find charge compression exists, we will further study potential models that could adjust for it so we might develop a more accurate system of cost-based weights to better reflect the relative costs of the different types of services provided under the OPPS. We plan to fully involve appropriate stakeholders in future analysis of this issue to the extent feasible. Before implementing such an adjustment, we would thoroughly describe our analysis and a potential proposed adjustment as part of the OPPS rulemaking process. Further, we intend to use the charge compression study that we will conduct over the next year as an opportunity to better understand the costs of medical devices.

With regard to the comment that providers are ceasing to provide services that require devices, we have no data that causes us to believe that there is a problem with access to care. In fact, the volume and intensity of OPPS services are growing significantly each year. As we indicated in section XIX. of this final rule with comment period, Medicare program payment under the OPPS is expected to reach $32.54 billion in CY 2007, an increase of approximately 9 percent from the projected program payment of $29.809 billion in CY 2006.

Comment: A number of commenters urged CMS to make adjustments to the CY 2007 payment rates for device-dependent APCs to account for charge compression. Specifically, some commenters recommended that CMS set the APC payment rates based on the higher of the median cost calculated using only claims that contain appropriate devices and do not contain token charges for devices or 90 percent of the CY 2006 payment median because to do otherwise would result in discontinuation of some services that require high cost devices. Other commenters urged CMS to set the median cost at no less than 100 percent of the CY 2006 median cost plus the market basket update for CY 2007. Some commenters believed CMS should use only claims on which the charges for their devices equaled or exceeded minimum thresholds that would be set based on amounts they specified. In several cases, the commenters asked that CMS do this due to the billing of residual charges for upgraded devices that replaced recalled devices. In other cases, they recommended thresholds because they believed that hospital charges for devices were too low, thereby resulting in inadequate APC median costs for establishing the CY 2007 payment rates for device-dependent procedures and their packaged devices.

Response: We do not believe that it is necessary or appropriate to set the median cost for these device-dependent APCs at 100 percent of the CY 2006 payment median plus the update factor or at 90 percent of the CY 2006 payment median, or to otherwise override the estimated median costs derived from the claims process proposed, using only claims that contained device codes where appropriate and that did not contain token charges. Because the devices that are required for many of these services came off pass-through payment in CY 2003, we have implemented device edits to maximize the likelihood that the charges for the devices are included on the claim. Over the past several years, we provided for adjustments to the median costs of device-dependent APCs where the cost data for the OPPS update resulted in a decline in the median from one year to the next. We indicated in the CY 2006 final rule (70 FR 68620) that we fully expected to be able to transition to full use of the claims data without adjustment for CY 2007. We see no reason why we should limit the decrease in CY 2007 median cost for those APCs for which the median cost declines compared to the adjusted CY 2006 payment median cost. The nature of a payment system that is based on relative weights is that the weights vary from year to year. Any change in the median cost for an APC, whether one with a high device cost or not, is a function of many complex factors, including, but not limited to, the extent to which hospitals increase charges for some items and services at a different rate than charges for other items and services. As such, the median cost of any particular item or service is largely a function of both its costs and the various charging practices of the hospitals that bill the services. Hospitals have now had 6 years experience with the OPPS, 4 of which were after the expiration of pass-through payments for most devices. We believe that hospitals make thoughtful decisions regarding how they want to report and charge for device-dependent procedures in the context of the effects of those decisions on their payments by Medicare and other payers.

Comment: Some commenters objected to the application of the wage index to the payment for device-dependent APCs. They argued that it creates inequities for hospitals that have low wage indices, due to the application of the wage adjustment to 60 percent of the APC rate, even though the cost of the device is often much more than 60 percent of the APC payment and the device costs are the same regardless of the location of the facility. The commenters objected to hospitals in high cost areas receiving a premium for providing these service, and hospitals in low cost areas receiving what they viewed as a payment penalty for furnishing these services. The commenters asked that the wage index be applied only to 20 percent, rather than the current 60 percent, of the payment for certain device-dependent APCs, specifically 0039, 0107, 0108, 0222, 0224, 0225, 0226, 0227, 0315, 0418, 0654, 0655, and 0656.

Response: The immediate effect of changing the application of the wage index from 60 percent to 20 percent for these APCs is likely to lower payments to hospitals in high cost areas, which we believe likely provide the higher volumes of these services, and to raise payments in low cost areas that likely furnish fewer services. Therefore, we believe that such a change would actually result in lower overall OPPS payment for the procedures. Moreover, any such suggested change could not be done in isolation. At the beginning of the OPPS, we performed a regression analysis resulting in a determination to wage adjust 60 percent of the payment for each APC. This analysis examined the extent to which the body of costs for services furnished in the outpatient department was split between wage and nonwage costs. We determined that 60 percent is an average across all service types, many of which have significant labor costs (for example, visits, drug administration services, and diagnostic tests). We reaffirmed the appropriateness of applying the wage

index to 60 percent of the APC payment during our development of the CY 2006 OPPS (70 FR 68533). By definition, as an average across all services, a standard wage adjustment could not be linked to specific services, particularly the least expensive and most expensive services. To change the application of the wage index for certain device-dependent APCs as commenters request would require reassessing the application of the wage index to all services. In the CY 2006 OPPS final rule, we committed to assessing the effects of the wage index on the device-dependent APCs. We are continuing our efforts in this area.

Comment: Some commenters fully supported packaging CPT codes 93640 (Electrophysiological evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation) and 93641 (Electrophysiological evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation; with testing of single or dual chamber cardioverter defibrillator) because this approach greatly increased the number of single bills that were available for calculating the median costs of APCs 0107 and 0108. Other commenters objected to the packaging of these CPT codes where they appeared on a claim unless the claim also contained a HCPCS code assigned to APCs 0107, 0108, and 0106. Some commenters also objected to packaging 93640 and 93641 into services assigned to APC 0418 because they believed that the packaged services were not performed at the time that procedures in APC 0418 were performed. They were concerned that packaging these testing codes inappropriately raised the median cost of APC 0418.

Response: We continue to believe that the costs of CPT codes 93640 and 93641 are appropriately packaged because they are performed only during the course of identifiable surgical procedures. Under the OPPS data development process, the cost of a packaged HCPCS code on a claim is added to the cost of the single major procedure code that is reported on the same claim, along with other packaged costs also on the claim. In that manner, separate payment for the procedure provides payment for the packaged HCPCS code as well. Because of the enormous number of HCPCS codes, it is not practical to include logic that specifies that a particular HCPCS code is packaged with specified services but not with others. We rely upon hospitals to correctly code the claims they report to Medicare because they have significant incentives to do so (such as, payment and audit concerns).

After carefully considering the public comments received, we are finalizing our proposed payment policies for device-dependent APCs for CY 2007. The CY 2007 payment rates for device-dependent APCs are based on their median costs calculated from CY 2005 nontoken claims that passed the device edits, without application of a maximum payment reduction floor in comparison with CY 2006 payment medians. 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.

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Table 18.--Median Costs of Device-Dependent APCs for CY 2007

APC	SI	Group Title	CY 2006 Unadjusted Median	CY 2006 Payment Median	CY 2007 All Bill Total Freq	CY 2007 Pass Edit, Nontoken Freq	CY 2007 Payment Median Cost (Pass Edit, Nontoken Median)
0039	S	Level I Implantation of Neurostimulator	$9,836.02	$11,590.21	1986	680	$11,450.84
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	$3,021.79	$3,021.79	13270	1402	$3,457.00
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	$5,552.67	$5,552.67	2600	265	$5,145.22
0081	T	Non-Coronary Angioplasty or Atherectomy	$1,947.72	$2,512.59	154368	2258	$2,623.80
0082	T	Coronary Atherectomy	$4,531.43	$5,431.72	232	8	$4,412.00
0083	T	Coronary Angioplasty and Percutaneous Valvuloplasty	$2,887.41	$3,285.85	4603	327	$3,592.66
0085	T	Level II Electrophysiologic Evaluation	$2,030.08	$2,033.39	21399	1435	$2,094.88
0086	T	Ablate Heart Dysrhythm Focus	$2,499.71	$2,499.71	10789	723	$2,902.28
0087	T	Cardiac Electrophysiologic Recording/Mapping	$814.47	$1,962.17	14812	52	$2,010.43
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	$6,307.74	$6,957.99	4710	388	$7,557.38
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	$5,362.17	$5,362.17	7348	505	$6,007.21
0104	T	Transcatheter Placement of Intracoronary Stents	$4,510.86	$4,802.39	5191	396	$5,360.43
0106	T	Insertion/Replacement of Pacemaker leads and/or Electrodes	$1,834.34	$3,325.21	4338	427	$3,596.87
0107	T	Insertion of Cardioverter-Defibrillator	$14,062.73	$16,614.09	18654	584	$18,607.21
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	$18,699.78	$22,309.44	10837	3045	$23,205.37
0115	T	Cannula/Access Device Procedures	$1,872.60	$2,198.37	8951	1453	$1,785.21
0202	T	Level X Female Reproductive Proc	$2,396.88	$2,451.09	17482	4451	$2,627.08
0222	T	Implantation of Neurological Device	$9,739.50	$11,443.14	7510	2007	$11,099.02
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	$13,794.14	$14,912.04	1058	83	$13,514.45
0227	T	Implantation of Drug Infusion Device	$8,131.78	$9,216.76	3461	319	$10,657.85
0229	T	Transcatherter Placement of Intravascular Shunts	$3,660.15	$3,943.56	55540	882	$4,184.15
0259	T	Level VI ENT Procedures	$21,236.83	$23,406.07	1291	472	$25,351.03
0315	T	Level II Implantation of Neurostimulator	$12,425.59	$18,570.33	762	516	$14,845.73
0384	T	GI Procedures with Stents	$1,262.06	$1,598.64	22744	6574	$1,402.31

APC	SI	Group Title	CY 2006 Unadjusted Median	CY 2006 Payment Median	CY 2007 All Bill Total Freq	CY 2007 Pass Edit, Nontoken Freq	CY 2007 Payment Median Cost (Pass Edit, Nontoken Median)
0385	S	Level I Prosthetic Urological Procedures	$4,384.16	$4,384.16	932	267	$4,840.44
0386	S	Level II Prosthetic Urological Procedures	$7,148.86	$7,545.49	5174	1788	$8,395.82
0418	T	Insertion of Left Ventricular Pacing Elect.	$6,398.41	$10,067.34	5726	169	$18,777.92
0425	T	Level II Arthroplasty with Prosthesis	$6,017.66	$6,226.13	1166	410	$6,550.59
0427	T	Level III Tube Changes and Repositioning	$595.11	$595.11	7354	1913	$712.38
0622	T	Level II Vascular Access Procedures	$1,263.02	$1,263.02	61632	25264	$1,385.14
0623	T	Level III Vascular Access Procedures	$1,613.80	$1,613.80	70232	23187	$1,741.82
0625	T	Level IV Vascular Access Procedures	$4,750.00	$4,750.00	721	20	$5,100.26
0648	T	Breast Reconstruction with Prosthesis	$2,917.03	$3,182.21	1456	356	$3130.45
0652	T	Insertion of Intraperitoneal and Pleural Catheters	$1,704.49	$1,745.63	6020	3676	$1,805.28
0653	T	Vascular Reconstruction/Fistula Repair with Device	$1,805.31	$2,196.11	31015	702	$1,978.84
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker	$5,908.47	$6,659.66	28406	1179	$6,891.44
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	$7,970.77	$8,134.94	14483	876	$9,327.71
0656	T	Transcatheter Placement of Intracoronary Drug-Eluting Stents	$6,428.89	$6,428.89	26638	2700	$6,618.18
0670	S	Level II Intravascular and Intracardiac Ultrasound and Flow Reserve	$1,505.28	$1,709.36	9395	133	$1,972.95
0674	T	Prostate Cryoablation	$5,950.05	$6,620.83	3317	1737	$6,646.07
0680	S	Insertion of Patient Activated Event Recorders	$3,765.01	$4,452.85	2263	972	$4,436.69
0681	T	Knee Arthroplasty	$7,993.50	$8,052.87	642	301	$12,569.11

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3. Devices Billed in the Absence of an Appropriate Procedure Code

As we discussed in the proposed rule (71 FR 49573), in the course of examining claims data for creation of the payment rates for the CY 2007 OPPS proposed rule, we identified circumstances in which hospitals billed a device code but failed to also bill any procedure code with which the device could be used correctly. These errors in billing have led to the costs of the device being packaged with an incorrect procedure code and also have caused the hospital to be paid incorrectly for the service furnished if the device was appropriately reported. We discussed the billing of devices with incorrect procedure codes with the APC Panel at its March 2006 meeting, and the APC Panel recommended that we explore the extent to which it would be appropriate to establish edits for HCPCS device codes to ensure that hospitals also bill procedures in which the devices would be used on the same claim.

As we stated in the proposed rule, we examined our CY 2005 claims data and found that incorrect billing occurred more often with some devices than with others. As noted in the CY 2007 OPPS proposed rule (71 FR 49573), we expected to implement device to procedure code edits for the specified devices and their associated procedures, that we believed must be reported on a claim with the specified device for the claim to be correctly coded and the device costs properly attributed to procedures with which they were used. The devices for which we expected to implement edits are shown below in Table 19, as well as in Table 20 of the proposed rule (71 FR 49573 and 49574), and are posted on the CMS outpatient hospital Web site, along with our initial draft of all the procedures with which they could be appropriately used and thus reported. As noted in the proposed rule (71 FR 49573), we believed that the establishment of claims edits reflected merely standard operational and administrative practice. However, as the public may assist in establishing appropriate edits, we, therefore, asked that comments regarding the specific associations of device codes and procedure codes be provided to the following email address: *OutpatientPPS@cms.hhs.gov.* This is the same email address to which comments on the existing procedure to device edits should be directed. Comments submitted on this issue to this mail box were not comments on the proposed rule and as stated in our proposed rule (71 FR 49573), we are not responding to them in this CY 2007 OPPS final rule.

However, we are taking this opportunity to advise the public that we will implement these edits effective with the January 2007 OCE. The edits will be posted on the OPPS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/,* and as with the device edits currently in place, we will continue to accept comments on them indefinitely at the email address identified above.

TABLE 19.—DEVICES WHICH MUST BE BILLED WITH ASSOCIATED PROCEDURE CODES

Device	Description
C1721	AICD, dual chamber.
C1722	AICD, single chamber.
C1767	Generator, neuro non-recharg.
C1777	Lead, AICD, endo single coil.
C1778	Lead, neurostimulator.
C1779	Lead, pmkr, transvenous VDD.
C1785	Pmkr, dual, rate-resp.

TABLE 19.—DEVICES WHICH MUST BE BILLED WITH ASSOCIATED PROCEDURE CODES—Continued

Device	Description
C1786	Pmkr, single, rate-resp.
C1820	Generator, neuro rechg bat sys.
C1882	AICD, other than sing/dual.
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.

4. Payment Policy When Devices Are Replaced Without Cost or Where Credit for a Replaced Device Is Furnished to the Hospital

As we discuss above in the context of the calculation of median costs for ICDs and pacemakers, in recent years there have been several field actions and recalls with regard to failure of these devices. In many of these cases, the manufacturers have offered replacement devices without cost to the hospital or credit for the device being replaced if the patient required a more expensive device. In some circumstances manufacturers have also offered, through a warranty package, to pay specified amounts for unreimbursed expenses to persons who had replacement devices implanted. In addition, we noted in the proposed rule that we believed that incidental device failures that are covered by manufacturer warranties occur routinely. While we understood that some device malfunctions might be inevitable as medical technology grows increasingly sophisticated, we believed that early recognition of problems would reduce the number of people with the potential to be adversely affected by these device problems. We indicated our belief that the medical community needs heightened and early awareness of patterns of device failures, voluntary field actions, and recalls so that they can take appropriate action to care for our beneficiaries. Systematic efforts must be undertaken by all interested and involved parties, including manufacturers, insurers, and the medical community, to ensure that device problems are recognized and addressed as early as possible so that people's health is protected and high quality medical care is provided. As indicated in the CY 2007 OPPS proposed rule (71 FR 49574), we are taking several steps to assist in the early recognition and analysis of patterns of device problems to minimize the potential for harmful device-related effects on the health of Medicare beneficiaries and the public in general.

In recent years, CMS has recognized the importance of data collection as a condition of Medicare coverage for selected services. In 2005, CMS issued a National Coverage Determination (NCD) that expanded coverage of ICDs and required registry participation when the devices were implanted for certain clinical indications. The NCD included this requirement in order to ensure that the care received by Medicare beneficiaries was reasonable and necessary and, therefore, appropriately reimbursed. Presently, the American College of Cardiology—National Cardiovascular Data Registry (ACC–NCDR) in partnership with the Heart Rhythm Society collects these data and maintains the registry.

In addition to ensuring appropriate payment of claims, collection, and ongoing analysis of ICD implantation, data can speed public health action in the event of future device recalls. The systematic recording of device manufacturer and model number can enhance patient and provider notification. Analysis of registry data may uncover patterns in complication rates (for example, device malfunction, device-related infection, and early battery depletion) associated with particular devices that signify the need for a more specific investigation. Patterns found in registry data may identify problems earlier than the currently available mechanisms, which do not systematically collect such detailed information surrounding procedures.

As we indicated in the proposed rule, we encouraged the medical community to work to develop additional registries for implantable devices, so that timely and comprehensive information is available regarding devices, recipients of those devices, and their health status and outcomes. While participation in an ICD registry is required as a condition of coverage for ICD implantation for certain clinical conditions, we believe that the potential benefits of registries extend well beyond their application in Medicare's specific national coverage determinations. As medical technology continues to swiftly advance, data collection regarding the short and long term outcomes of new technologies, and especially concerning implanted devices that may remain in the bodies of patients for their lifetimes, will be essential to the timely recognition of specific problems and patterns of

complications. This information will facilitate early interventions to mitigate harm and improve the quality and efficiency of health care services.

Moreover, data from registries may help further the development of high quality, evidence-based clinical practice guidelines for the care of patients who may receive device-intensive procedures. In turn, widespread use of evidence-based guidelines may reduce variation in medical practice, leading to improved personal and public health. Registry information may also contribute to the development of more comprehensive and refined quality metrics that may be used to systematically assess and then improve the safety and quality of health care. Such improvements in the quality of care that result in better personal health will require the sustained commitment of industry, payers, health care providers, and others towards that goal, along with excellent and open communication and rapid system-wide responses in a comprehensive effort to protect and enhance the health of the public. We look forward to further discussions with the public about new strategies to recognize device problems early and how to definitively address them, in order to minimize both the harmful health effects and increased health care costs that may result.

In addition, in the proposed rule we stated that we believed that the routine identification of Medicare claims where hospitals identify and then appropriately report selected services performed under the OPPS when devices are replaced without cost to the hospital or with full credit to the hospital for the cost of the replaced device, should provide comprehensive information regarding the outpatient hospital experiences of Medicare beneficiaries with certain devices that are being replaced. Because Medicare beneficiaries are common recipients of implanted devices, this claims information may be particularly helpful in identifying patterns of device problems early in their natural history so that appropriate strategies to reduce future problems may be developed.

In addition to our concern for the public health, we also noted that we have a fiduciary responsibility to the Medicare trust fund to ensure that Medicare pays only for covered services. Therefore, we proposed, effective for services furnished on or after January 1, 2007, to reduce the APC payment and beneficiary copayment for selected APCs in cases in which an implanted device is replaced without cost to the hospital or with full credit for the removed device. Specifically, we proposed to revise the existing regulations by adding new § 419.45, Payment and copayment reduction for replaced devices. This proposed regulation was intended to cover certain devices for which credit for the replaced device is given or which are replaced as a result of or pursuant to a warranty, field action, voluntary recall, involuntary recall, and certain devices which are provided free of charge. As proposed, it would provide for a reduction in the APC payment rate when we determine that the device is replaced without cost to the provider or beneficiary or when the provider receives full credit for the cost of a replaced device. We proposed that the amount of the reduction to the APC payment rate would be calculated in the same manner as the offset amount that would be applied if the implanted device assigned to the APC had pass-through status as defined under § 419.66. We also proposed that the beneficiary's copayment amount would be calculated based on the reduced APC payment rate.

We indicated that we believed that this would be appropriate because in these cases the full cost of the replaced device would not be incurred and, therefore, we believed that an adjustment to the APC payment would be necessary to remove the cost of the device. We also indicated that we believe that the averaging nature of the calculation of the amount of the adjustment would cause it to be appropriately applied to cases of credit for the replaced device, regardless of whether there is a residual cost due to the implantation of a more expensive device.

Moreover, we stated that we also believe that the proposed adjustment was consistent with section 1862(a)(2) of the Act, which excludes from Medicare coverage an item or service for which neither the beneficiary nor anyone on his or her behalf has an obligation to pay. Payment of the full APC payment rate in these cases in which the device was replaced under warranty or in which there was a full credit for the price of the recalled or failed device effectively results in Medicare payment for a noncovered item. Moreover, it results in creation of a beneficiary liability for the copayment associated with the device for which the beneficiary has no liability. Therefore, we proposed to adjust the APC payment rate in these circumstances under the authority of section 1833(t)(2)(E) of the Act, which permits us to make equitable adjustments to the OPPS payment rates.

As we indicated in the proposed rule, we recognized that in many cases, the packaged cost of the device is a relatively modest part of the APC payment for the procedure into which the device cost is packaged. In the case of devices of modest cost, we believed that the averaging nature of payments under the OPPS based on the conversion of charges to costs with CCRs would incorporate any significant savings from a warranty replacement, field action, or recall into the payment rate for the associated procedural APC and that no specific adjustment would be necessary or appropriate. However, in other cases, such as implantation of an ICD, the cost of the device is the majority of the cost of the APC and payment at the full payment rate for the procedural APC would pay the hospital much in excess of its incurred cost for the service.

As we discuss above, we proposed to set the APC payment rates for device-dependent APCs for the CY 2007 OPPS using only claims that contain appropriate devices to ensure that we make appropriate full payment when the hospital initially incurs the full cost of the device. Beginning in CY 2005, we required that device codes be billed for devices used and specifically required that hospitals bill certain device codes for some services. We are using the CY 2005 claims to set the payment rates for the CY 2007 OPPS. Currently, where the device is furnished without cost to the hospital, we have authorized hospitals to charge less than $1.01.

We authorized this charge because the CMS device edits require that the hospital must report an appropriate device if they bill for certain codes that cannot be performed without a device or the claim will be returned. Moreover, the Fiscal Intermediary Standard System will not accept the claim unless there is a charge for each HCPCS code billed. In addition, we were seeking a means of identifying these recall cases in the data. Therefore, by authorizing hospitals to charge less than $1.01 for the device we enabled the claim to be paid and also provided a mechanism for identifying devices for which the hospital incurred no expense.

Where we set the payment rates for these device-dependent APCs using only claims that contain the full costs of devices when they are purchased by hospitals and exclude claims for which there is no appropriate device code or a charge for the device of less than $1.01, the proposed APC payments into which the full costs of the devices have been packaged would result in excessive program payments and beneficiary copayments for the services being furnished if the devices were provided without cost to hospitals. To avoid

excessive payments in these circumstances, as noted previously we proposed to adjust the APC payment rates when implanted devices have been replaced without cost to the hospital or beneficiary or where full credit for such a device has been given because the replacement device was of greater cost than the originally implanted device.

We proposed that the adjustment would be limited to the APCs listed in Table 21, of the CY 2007 OPPS proposed rule (71 FR 49577) but only when the purpose of the procedure was to replace a device that was reported by a HCPCS code in Table 22 of that rule (71 FR 71 FR 49578), which was furnished without cost or at full credit by the manufacturer. We proposed that the following three criteria must each be met for an APC to be subject to the adjustment. We selected the APCs in Table 21 of the proposed rule on the basis of these three criteria.

The first criterion we proposed was that all procedures assigned to the selected APCs must require implantable devices that would be reported if device replacement procedures were performed. Therefore, the device being replaced must be necessary for the service to be furnished and without the devices, the services assigned to the APCs could not be performed. For services, and, therefore, their assigned APCs, where a device was not needed or where it might or might not be needed to perform a procedure, we did not believe that reducing the payment for the APCs would be appropriate because the charges for the devices were unlikely to be a significant factor in establishing the rates for the APCs.

The second criterion we proposed was that 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. We believed this was necessary to establish that the replacement device was a direct replacement for the device being removed. In cases of failures of devices that were surgically inserted or implanted but did not remain in the patient's body after the conclusion of procedures, we believe that it was highly likely that the replacement device was not specifically used to care for the patient on whom the original defective device was used and that, where a defective device of this type was used, there was no savings to the hospital. For example, if a vascular catheter failed during a procedure, we believed that the physician would probably use another similar catheter to finish the procedure. In these cases the hospital would correctly charge for the catheter that was used, and there would be no savings to the hospital from that procedure. The hospital would likely charge for both the defective device and the device used to complete the procedure because both catheters were used to provide the full service. We believed that if a replacement catheter was furnished to the hospital under warranty from the manufacturer, it would be used at a much later date on a different patient, it would most likely be charged to that patient account, and it would be unlikely to be specifically identified as being furnished without cost to the hospital. In these cases, we expected that any cost savings from the replacement devices such as these (for example, catheters) that are furnished without cost would be incorporated into the median costs for the procedures in the normal course of the data process through application of the CCRs generated from the cost reports.

The third criterion we proposed was that the offset percent for the APC (that is, the median cost of the APC without device costs divided by the median cost of the APC with devices) must be significant. For this purpose, we defined a significant offset percent as exceeding 40 percent. We believed that this percent was appropriate because our studies have shown that approximately 60 percent of the cost of OPPS services is wage-related, and that approximately 40 percent of the cost of OPPS services is not wage related. This is why we wage adjust 60 percent of the APC payment rates for all APCs, including APCs for which a greater percentage of the APC payment is for the cost of a device.

We believed that once the device share of an APC exceeded the 40 percent we attribute to costs other than wage costs (for example, device costs, capital costs, plant costs, and supplies other than devices), the device cost is a significant part of the APC cost. Therefore, where the device costs in an APC exceed 40 percent, which is the average of all types of nonwage-related costs across all APCs, we proposed to define the device costs as ''significant'' for purposes of this proposed policy.

We recognized in the proposed rule that it might be appropriate to define ''significant'' for this purpose at a different percentage of the APC cost because there are costs other than device costs (for example, capital costs and other supply costs) in the 40 percent of service costs to which the wage adjustment does not apply. We indicated that we would reassess for future years whether it is appropriate to define ''significant'' for this purpose at a level other than 40 percent.

For purposes of making the proposed adjustment, we proposed to adapt the methodology that we have employed to establish an offset for the device costs incorporated into APCs in cases where a pass-through device is also being billed. We currently calculate the offset amount by first calculating a median including device costs and then calculating a median excluding device costs using single bills that contain devices. We then divide the ''without device'' median by the ''with device'' median and subtract the percent from 100 to acquire the percent of cost attributable to devices in the APC. We apply this percent to the payment rate of the APC to determine the offset amount. For example, this is the methodology we used to calculate the offset amount for APC 0222 (Implantation of Neurological Device) when current pass-through device C1820 (Generator, neuro rechg bat sys) is billed on the same claim. We indicated in the proposed rule that we believed that it was appropriate to apply this same methodology in circumstances when we needed to remove the cost of the device from the APC payment, not because the device was being paid under pass-through but because the hospital was either not incurring the cost for the replaced device or had been given full credit for the replaced device (71 FR 49576). In both cases, the intent was to remove the cost of the device from the APC payment rate.

Using this methodology, we calculated the proposed offset amounts by first calculating an APC median cost including device costs and then calculating a median cost excluding device costs, using only single bills that met our device edits and did not have token charges for devices. We then divided the ''without device'' median cost by the ''with device'' median cost and subtracted the percent from 100 to acquire the percent of cost attributable to devices in the APC. We next applied this percent to the payment rate for the APC to determine the offset amount.

The following is an example of the payment reduction we proposed in the case of replacement of an ICD under warranty. Where the cardioverter defibrillator pulse generator described by HCPCS code C1721 (AICD, dual chamber) is replaced under warranty during a procedure described by HCPCS code G0298 (Insertion of dual chamber pacing cardioverter defibrillator pulse generator), the hospital would report HCPCS code G0298 with a specified modifier and would also report HCPCS code C1721 with a token charge for the device. Assuming the hospital had a wage index of 1, based upon CY 2007

proposed rule data the payment rate for APC 0107 after adjustment would be $1862.27. That is, the adjusted payment rate would equal the unadjusted payment rate for APC 0107 ($17,185.34) less the warranty reduction percentage (Table 21 of the proposed rule at 71 FR 49577) of 89.13 percent ($15,317.29). Because the adjustment amount is set for the APC, the same adjustment amount would be removed if devices reported under HCPCS code C1722 or C1882 were reported with HCPCS code G0297. This would be identical to the amount of adjustment that would apply to the payment for a pass-through device if there were, hypothetically, a new ICD to which we had given pass-through status (no ICD currently has pass-through status) and if the reduction amount in Table 21 of the proposed rule were the appropriate reduction amount.

We proposed to both adjust the APC payment to remove payment for the device furnished without cost to the hospital or beneficiary and also to decrease the beneficiary copayment in proportion to the reduced APC payment so that the beneficiary would, in many but not all cases, share in the cost savings attributable to the provision of the device without cost by the manufacturer. We proposed that when a device was replaced without cost to the hospital under warranty or recall or a credit was provided for the cost of a failed or recalled device (unlike cases of offset for a pass-through device), the beneficiary's copayment would be calculated based on the reduced APC payment rate, maintaining the same percentage copayment as would apply to the unadjusted APC payment if the inpatient deductible were not exceeded. We proposed this because we believed that it was appropriate to reduce the beneficiary copayment in these cases because the device was being furnished or credited by the manufacturer without obligation on the part of the beneficiary. We noted, however, that in the case of some high cost APCs, making the payment adjustment in a recall or warranty situation might not result in reduction of the copayment because the copayment, although based on the reduced payment rate, might continue to exceed the inpatient deductible and, therefore, would continue to be set at the inpatient deductible.

As we discussed in the proposed rule, this contrasted with the case of pass-through devices, where the beneficiary was liable for the copayment on the full APC amount (which, in the case of high cost APCs, was limited to the Medicare inpatient deductible) but paid no copayment for the incremental cost of the pass-through device. We stated that this was appropriate in the case of payment for pass-through devices because the hospital incurred costs for both the service and the device, and Medicare paid for both the service through the full APC payment and for the incremental cost of the pass-through device above the costs of associated devices already reflected in the APC payment at charges reduced to cost by a CCR. The pass-through payment amount was reduced only to prevent the program from making duplicate payment for a portion of the device, once as part of the APC payment and once through the pass-through payment.

We proposed to implement the adjustment through the use of an appropriate modifier specific to a device replacement without cost or crediting of the cost of a device by the manufacturer. We proposed that hospitals would be required to report the modifier appended to a specific procedure on claims for services when two conditions are met. The first condition was that the procedure was assigned to one of the APCs in Table 21 of the proposed rule. We have discussed above the criteria that we employed for selecting the APCs to which we proposed that this policy would apply. We proposed that the second condition would be that the device for which the manufacturer furnished a replacement device (or provided credit for the device being replaced) would be one of the devices included in Table 22 of the proposed rule. We proposed to restrict the devices to which the adjustment would apply to those included in Table 22 of the proposed rule in order to ensure that the adjustment would not be triggered by the replacement of an inexpensive device whose cost would not constitute a significant proportion of the total payment rate for an APC.

We also proposed that the presence of the modifier would trigger the adjustment in payment for the APCs in Table 21 of the proposed rule. While we recognized that this would create a reporting burden for hospitals, we indicated that we believed that the reporting requirement would be unavoidable. Only hospitals could report whether the circumstances for reduced payment as described above were met and, therefore, we saw no option other than to have hospitals report this information to us. We recognized that the current FB modifier (''Item furnished without cost to provider, supplier or practitioner'') might not be appropriate in cases in which the replacement device was a more expensive device than the device being removed and that it might need to be changed to expand its use for all potential APC payment adjustment scenarios.

We noted in the proposed rule that we believed that our proposed policy would accomplish three important goals. First and foremost, it would advise us of the extent to which devices are being replaced due to device failures so that, if patterns are identified, we could explore them to see if there are systemic problems with certain devices. We believed that the reporting of a specific modifier with certain procedure codes would allow us to examine patterns of delivery of specific hospital services when implanted devices are replaced without cost or with full credit for the cost of a device by the manufacturer, in comparison with publicly available information about problematic devices. We also stated that we believed that analysis of outpatient hospital claims would serve as an additional source of information to the medical community about patterns of device failures, voluntary field actions, and recalls, contributing to improved awareness and understanding of problems.

Secondly, we explained that we believed that it would ensure equitable adjustment to the payments for surgical procedures to replace problematic devices by providing payments to hospitals only for the nondevice-related procedural costs when a device is replaced without cost to the hospital for the device or with full credit for the removed device. Thirdly, we noted that we believed that it would also identify those claims that contained reduced device charges due to the full credit provided by the manufacturer for a replaced device so that in the future we could assess the impact of these claims on median costs for the services into which the device costs are packaged.

We proposed that the policy would be effective for services furnished on or after January 1, 2007. We believed that this proposed policy was necessary to enable us to secure claims data that might be used to identify trends in device problems that led to device replacements, and that it would also be necessary to fulfill our fiduciary responsibility to the Medicare program by not providing payments for items that were excluded from coverage under Medicare law because neither the beneficiary nor any party on his or her behalf had an obligation to pay.

At its August 2006 meeting, the APC Panel recommended that CMS evaluate the proposed percentage adjustments in cases in which the device is furnished without cost or with credit for the replaced device to ensure that they have taken into account the administrative

resources required for hospitals to provide the replacement devices. In reviewing this recommendation, we have carefully considered the issue of administrative costs involved in furnishing the replacement devices and have concluded that the residual payment for the procedure should adequately compensate the provider for all administrative costs of furnishing the services, whether the device is furnished with or without cost to the provider. We elaborate on our responses to this recommendation in the discussion below.

We received a number of comments on our discussion of data collection and the potential use of that data from a public health perspective. We agree with commenters that only data elements required to answer predefined questions should be collected. In addition to serving a public health role, we agree that data collection in registries may offer transparency once devices are on the market.

We also agree with commenters that registry data may not be sufficient to develop clinical practice guidelines, and we believe that the process in place by many medical professional societies appropriately establishes guidelines based on the strength of evidence in which evidence from controlled clinical trials would be stronger than registry data.

We received a number of public comments regarding Coverage with Evidence Development (CED) and registry funding that are outside the scope of this rule; therefore, we are not responding to them in this final rule with comment period.

We received several public comments concerning our proposal for CY 2007. A summary of the comments and our responses follow.

Comment: Some commenters supported the proposed policy in cases in which the hospital incurs no cost for the device being replaced under warranty or otherwise without cost by the manufacturer. However, other commenters stated that the proposal to remove 100 percent of the cost of the devices is not appropriate because of the acquisition, handling, and administrative costs associated with the acquisition of the replacement device. The commenters indicated that although the hospital does not pay for the device, the hospital must record the special ''no charge'' status of the device, advise the finance and patient accounts departments how to charge for it, and report to Medicare that the procedure involves replacement of a defective device. They pointed out that although the device may be acquired without cost to the hospital, the hospital nevertheless incurs costs due to the special handling of the billing and accounting for the device. One commenter proposed that CMS reduce the APC payment by 70 to 80 percent of the offset amount rather than by the entire offset amount. Another commenter agreed with the proposed policy, provided that CMS excludes claims for these APCs that are reported with condition code 50 from the median cost calculation because including them would understate the device costs that should be packaged.

Some commenters objected to the application of the policy in the case of upgraded devices in which the hospital is given a credit for the device that is covered under warranty but the hospital must pay the difference between the manufacturer's charge for the replaced device and the upgraded device being inserted and in the case of replacement under warranty in which there is a partial credit because the warranty does not cover the full replacement cost of the device. The commenters indicated that the same issue arises when one type of device is replaced with a different type of device (for example, a pacemaker being replaced under warranty by an ICD), whose procedural payment may be provided through a different APC than the procedural APC associated with the device being replaced. The commenters argued that these cases should be exempt from any reduction, notwithstanding that the hospital receives a credit for the device being replaced. Other commenters urged CMS to reduce the amount of the adjustment to the APC payment rate in these cases. They offered to work with CMS to develop the amount of the reduction that would apply in such situations.

Response: We continue to believe that it is appropriate to reduce the amount of the APC payment by the full estimated percentage of device cost, both in cases in which the hospital receives the device without cost and in cases in which the hospital receives a credit toward an upgrade for the device that is being replaced. We are concerned about a payment policy that would apply a smaller APC payment percentage reduction in upgrade cases, because we have no way of estimating an appropriate offset amount based on the CY 2005 claims data. We are unable to identify upgrade cases in our CY 2005 claims data, and we will not be able to identify such claims until our CY 2007 data are available for the CY 2009 OPPS update. In the meantime, we believe that our two alternatives would be either to provide the full APC payment or reduce the APC payment by the relevant full offset amount. We believe that making the full APC payment would result in significant overpayment because we are specifically establishing our CY 2007 payment rates based on claims where hospitals incur device costs, and in most cases those claims would include the full device costs. If we were to take no APC payment reduction in upgrade cases, such an approach would favor device upgrades, rather than replacement with a comparable device, in warranty or recall cases where the surgical procedure to replace the device with an upgraded device is only medically necessary because of the original defective device, for which the manufacturer bears responsibility.

As discussed above, we calculated the CY 2007 payment rates for the APCs subject to the reduction policy using only claims which contained appropriate devices and for which there were no token charges for the devices. We used this methodology to maximize the probability that we captured all of the costs of the devices in these APCs in all situations where hospitals incurred costs to provide the devices. Therefore, in our median cost calculations for these device-dependent APCs, we used both claims where the hospital bore the full cost of the device and those where the hospital bore a partial device cost due to a manufacturer credit in an upgrade situation. The amounts by which we will reduce the payment for these APCs are calculated using the device costs that are found in the very same set of claims on which we calculated the median costs for the device-dependent APCs. As such, we believe that the percentages represent the best estimate of costs attributable to the devices, for which in most cases the hospital incurs no cost or, in the case of upgraded devices or partial credits, a reduced cost, and those costs are packaged into the APC payments. Moreover, commenters told us that upgrades account for only 10 to 15 percent of the cases where devices are replaced under warranty or recall. Thus, we believe it is appropriate to use the same device percentage for the APC payment reduction in both cases of device replacement without cost to the hospital and device upgrade with a manufacturer credit. We recognize that in some cases the estimated amount of device cost, and therefore the amount of the payment reduction, will be more or less than the hospital cost of the device in a specific clinical circumstance, but as averaging is inherent in a prospective

payment system, we do not believe that it is inappropriate.

As described below in reference to the use of modifier FB in CY 2007, once we have CY 2007 claims data we expect that we would be able to examine the costs of device upgrades in recall or warranty replacement cases to see if they are typically significantly greater than the costs of replacement of a device without cost to the hospital. However, until we have data available that permit examination of the differential average costs in these two situations, we intend to provide payment of procedures where a manufacturer credit is provided toward an upgraded device at the same rate we would pay if a replacement device were provided by the manufacturer at no cost, by applying the same APC payment reduction in both situations. In this way, we will avoid significant overpayments while we collect claims data for future examination to see if an alternative payment policy could be warranted.

Moreover, we do not believe that it is necessary to reduce the amount of the adjustment for administrative costs in these cases, as we believe that these costs are part of the payment that remains for the services furnished. Administrative costs vary significantly, with more resource-intensive administrative actions occasionally required even for the simplest services at times. Hence, we believe that the averaging nature of the payment that remains for the hospital procedural services should provide fair and adequate payment for these routine costs.

With regard to the comment that we should exclude claims reported with condition code 50 from the median cost calculation because including them would understate the device costs that should be packaged, we do not agree. Condition code 50, ''Product replacement for known recall of a product—Manufacturer or FDA has identified the product for recall and therefore replacement,'' is placed on the claim at a claim level, not at a line level, and thus does not provide the level of specificity that the FB modifier provides. We expect to use the presence of the FB modifier on the line with the procedure code, as discussed below, to determine which claims should be removed from the set of claims used for calculation of the median cost.

Comment: Several commenters asked how the FB modifier would apply in cases of a credit for an upgrade in a warranty or recall situation. The commenters asked CMS to create a second modifier for use when there is a device upgrade or change in device type so that CMS could exclude those claims from the calculation of the median cost for the devices and more accurately apply an appropriate reduction in these cases. The commenters also questioned how the multiple procedure discount would apply when the procedure is reported with an FB modifier, signifying that the device was replaced or credited under warranty. Specifically, commenters indicated that all of the APCs for which we proposed this policy have status indicator ''T'' and that, therefore, their payment would be reduced by 50 percent if there was a higher paid service on the same date of service. The commenters objected to a policy that would first reduce the payment for the APC due to a recall and then also reduce the payment rate if there was a more costly procedure on the claim with a status indicator of ''T.''

Response: Effective January 1, 2007, the definition of the FB modifier will read: ''Item Provided Without Cost to Provider, Supplier, or Practitioner or credit received for replaced device (Examples, but not limited to: Covered under warranty, replaced due to defect, free sample).'' 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 under warranty, recall or field action is one of the devices in Table 21 below. Claims containing the FB modifier will not be accepted unless the modifier is on a procedure code with status indicator ''S,'' ''T,'' ''V'' or ''X.'' In cases in which the device being replaced is replaced without cost, the provider will report a token device charge. In cases in which the device being inserted is an upgrade (either of the same type of device or to a different type of device), the provider will report as the device charge the difference between its usual charge for the device being replaced and the credit for the replacement device. CMS will be able to identify whether the device was replaced without cost by the presence of the token charge. Where there is not a token charge for the device but there is an FB modifier on a HCPCS code, CMS will assume that an upgrade occurred. Therefore, we believe that with the change in the definition of the FB modifier as of January 2007, we have no need to establish a second modifier for device replacement situations where a manufacturer provides a credit toward an upgraded device.

If the APC to which the procedure code is assigned is one of the APCs listed in Table 20 below, the fiscal intermediary will reduce the unadjusted payment rate for the procedure by an amount equal to the percent in Table 20 times the unadjusted payment rate. We intend to publish the actual adjustment amounts on the CMS website after publication of this final rule with comment period. If the FB modifier is assigned to a procedure code that is not on Table 21, then no adjustment will be taken. The adjustment will occur before wage adjustment and before the assessment to determine if a multiple procedure reduction applies. There may be cases where, after removal of the device cost, the remaining payment for the service is less than the payment for another procedure with a status indicator of ''T,'' and the multiple procedure reduction would apply. We believe this multiple procedure reduction continues to be appropriate even after the APC payment adjustment to remove payment for the device costs, because there would still be the expected efficiencies in performing the procedure if it were provided in the same operative session as another surgical procedure. Thus, it would be appropriate for the remaining procedural payment to be reduced by 50 percent, consistent with our well-established multiple surgical procedure reduction policy. Similarly, if the procedure is interrupted before administration of anesthesia and appended with modifier 73 or if the reduced services modifier 52 appears on the line with the procedure code, the 50 percent reduction will be taken from the adjusted payment amount as well. We believe that it is appropriate to treat the service subject to the APC payment reduction in cases of devices replaced without cost or with a full credit received like any other service and to apply the standard reduction policies.

Comment: One commenter objected to the application of a different offset percentage to APC 0385 (Level I Prosthetic Urology) than for APC 0386 (Level II Prosthetic Urology) for purposes of the adjustment when a device is replaced without cost or with credit for the device being replaced. The commenter stated that the ratio of device costs to overall procedure costs is basically identical for both ,and, therefore, the offset percent should be 60 percent for both.

Response: We disagree. The APC 0385 device percentage is 46.86 percent and the APC 0386 percentage is 61.16 percent. Therefore, we conclude that the device cost in APC 0386 is significantly higher than the device code in APC 385, and it would not be appropriate to assign the same percentage to both.

After carefully considering the public comments received, we are finalizing our proposed CY 2007 policy for reduction of APC payments in cases of

device replacement without cost or when a full credit is received without modification. We are also making a technical change to the title of the regulation at new section 419.45 to better reflect our policy to reduce the APC payment in cases of devices replaced without cost or where full credit is received. The title of the proposed regulation does not reflect the entire policy as proposed or finalized as it references only devices replaced under warranty or as a result of recall. The revised title to section 419.45 is ''Payment and copayment reduction for devices replaced without cost or full credit is received.''

TABLE 20.—ADJUSTMENTS TO APCS IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED

APC	SI	APC group title	CY 2007 offset percent
0039	S	Level I Implantation of Neurostimulator	78.85
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	54.06
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excludin	60.06
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	77.11
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	74.74
0106	T	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	41.88
0107	T	Insertion of Cardioverter-Defibrillator	90.44
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	89.40
0222	T	Implantation of Neurological Device	77.65
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	79.04
0227	T	Implantation of Drug Infusion Device	80.27
0229	T	Transcatherter Placement of Intravascular Shunts	46.17
0259	T	Level VI ENT Procedures	84.61
0315	T	Level II Implantation of Neurostimulator	76.03
0385	S	Level I Prosthetic Urological Procedures	83.19
0386	S	Level II Prosthetic Urological Procedures	61.16
0418	T	Insertion of Left Ventricular Pacing Elect.	87.32
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker	77.35
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	76.59
0680	S	Insertion of Patient Activated Event Recorders	76.40
0681	T	Knee Arthroplasty	73.37

TABLE 21.—DEVICES FOR WHICH THE FB MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR AT FULL CREDIT FOR A REPLACED DEVICE

Device	Description
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.
C1882	AICD, other than sing/dual.
C1891	Infusion pump, non-prog, perm.
C1895	Lead, AICD, endo dual coil.
C1896	Lead, AICD, non sing/dual.
C1897	Lead, neurostim, test kit.
C1898	Lead, pmkr, other than trans.
C1899	Lead, pmkr/AICD combination.

TABLE 21.—DEVICES FOR WHICH THE FB MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR AT FULL CREDIT FOR A REPLACED DEVICE—Continued

Device	Description
C1900	Lead coronary venous.
C2619	Pmkr, dual, non rate-resp.
C2620	Pmkr, single, non rate-resp.
C2621	Pmkr, other than sing/dual.
C2622	Prosthesis, penile, non-inf.
C2626	Infusion pump, non-prog, temp.
C2631	Rep dev, urinary, w/o sling.
L8614	Cochlear device/system.

B. Pass-Through Payments for Devices

1. Expiration of Transitional Pass-Through Payments for Certain Devices

a. Background

Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPPS, a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. The device category codes became effective April 1, 2001, under the provisions of the BIPA. Prior to pass-through device categories, Medicare payments for pass-through devices under the OPPS were made on a brand-specific basis. All of the initial 97 category codes that were established as of April 1, 2001, have expired; 95 categories expired after CY 2002, and 2 categories expired after CY 2003. In addition, nine new categories have expired since their creation. We currently have no category codes for pass-through devices that will expire January 1, 2007. We created one new category effective January 1, 2006, for C1820 (Generator, neurostimulator (implantable), with rechargeable battery and charging system), which we proposed to continue to pay under the pass-through provision in CY 2007 under the OPPS. This category was created after we published modifications to our criteria in the CY 2006 OPPS final rule with comment period on November 10, 2005 (70 FR 68628 through 68631), allowing CMS to refine previous pass-through category descriptions that would have prevented us from making pass-through payments for a new technology that otherwise met our criteria. These modifications amended the original criteria and process for creating additional device categories for pass-through payment that we published on November 2, 2001 (66 FR 55850 through 55857). 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.

In the November 1, 2002 OPPS final rule, we established a policy for payment of devices included in pass-through categories that are due to expire (67 FR 66763). For CY 2003 through CY 2006, we packaged the costs of the devices no longer eligible for pass-through payments into the costs of the procedures with which the devices were billed in the claims data used to set the payment rates for those years. Brachytherapy sources, which are now separately paid in accordance with section 1833(t)(2)(H) of the Act, are an exception to this established policy (with the exception of brachytherapy sources for prostate brachytherapy, which were packaged in the CY 2003 OPPS only).

b. Policy for CY 2007

As we stated earlier, currently we have one effective device category for pass-through payment, C1820, which we created for pass-through payment effective January 1, 2006. For CY 2007, we proposed to continue to make payment under the pass-through provisions for category C1820. We proposed that this category would expire from pass-through payment after December 31, 2007 (71 FR 49578). This would provide the category transitional pass-through payment status for a 2-year period, in accordance with the statutory requirement that no category be paid as a pass-through device for less than 2 years, nor more than 3 years.

We did not receive any public comments concerning this proposal. Therefore, we are finalizing our proposal to expire category C1820, Generator, neurostimulator (implantable), with rechargeable battery and charging system, from pass-through payment after December 31, 2007 without modification.

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 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, 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 is applied only when a new device category is billed with a HCPCS procedure code that is 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 hospitals' 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 percentage 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 thus far, 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 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 an offset amount for that category in Program Transmittal No. 804, dated January 3, 2006.

For CY 2006, we are using 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 codes. In addition, during CY 2005, we implemented device edits for many services that require devices and for which appropriate device 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. We believe that use of the most current claims data to establish offset amounts when they are needed to ensure appropriate payment is consistent with our stated policy; therefore, we proposed to continue to do so for the CY 2007 OPPS. Specifically, if we create a new device category for payment in CY 2007, 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 are already packaged into the existing APC structure, as indicated earlier. If we conclude that some related device costs are packaged into existing APCs, we proposed to use the methodology described earlier and first used for the CY 2003 OPPS to determine an appropriate device offset percentage for those APCs with which the new category would be reported.

We did not publish a list of APCs with device percentages as a transitional policy for CY 2006 because of the previously discussed limitations of the CY 2004 OPPS data with respect to device costs associated with procedures. We stated in the CY 2006 final rule with comment period (70 FR 68628) that we expected to reexamine our previous methodology for calculating the device percentages and offset amounts for the CY 2007 OPPS update, which would be based on CY 2005 hospital claims data where device HCPCS code reporting was required.

b. Policies for CY 2007

For CY 2007, we proposed to continue to review each new device category on a case-by-case basis as we have done in CY 2004, CY 2005, and CY 2006, to determine whether device costs associated with the new category are packaged into the existing APC structure. If we determine that, for any new device category, no device costs associated with the new category are packaged into existing APCs, we proposed to continue our current policy of setting the offset amount for the new category to $0 for CY 2007. There is currently one new device category that will continue for pass-through payment in CY 2007. This category, described by HCPCS code C1820, currently has an offset amount of $8,647.81, which is applied to APC 0222. We proposed to update this offset for CY 2007 based on the full year of claims data for CY 2005, the claims data year for our CY 2007 OPPS update. Based on full year CY 2005 claims data used for this final rule with comment period, the offset amount for C1820 is 77.65 percent of the final CY 2007 payment rate for APC 0222. (See Addendum A of this CY 2007 OPPS final rule with comment period for a listing of the final CY 2007 APC payment rates.)

We proposed to continue our existing policy of establishing new categories in any quarter when we determine that the criteria for granting pass-through status for a device category are met. If we create a new device category and determine that our CY 2005 claims data contain a sufficient number of claims with identifiable costs associated with the new category of devices in any APC, we proposed to reduce the transitional pass-through payment for the device by the related procedural APC offset amount if the offset amount is greater than $0. If we determine that a device offset greater than $0 is appropriate for any new category that we create, we proposed to announce the offset amount in the program transmittal that announces the new category.

In summary, for CY 2007, we proposed to use CY 2005 hospital claims data to calculate device percentages and potential offsets for CY 2007 applications for new device categories. We proposed to publish, through quarterly program transmittals, any new or updated offsets that we calculate for CY 2007, corresponding to newly created categories or existing categories, respectively.

After the CY 2007 proposed OPPS rule was published and prior to the publication of this final rule with comment period, we determined that we would establish two new device categories for transitional pass-through payment. Therefore, we are announcing our offset policy for these two device categories, whose coding and payment information is found in Addenda A and B. We have established device categories L8690 (Auditory osseointegrated device, external sound processor, replacement) and C1821 (Interspinous process distraction device (implantable)) for pass-through payment, effective January 1, 2007. As stated earlier, beginning in CY 2004 and now continuing through CY 2007, we apply an offset to a new device category only when we determine that an APC contains costs associated with a related device. We have determined that we cannot identify device-related costs in the procedural APCs we expect will be billed with either of the new categories L8690 or C1821, that is, in APC 0256 or APC 0050, respectively. Therefore, we are setting the offset amount to $0 for device categories L8690 and C1821 for CY 2007.

We did not receive any public comments concerning our CY 2007 proposals for calculating device percentages and potential offset amounts. Therefore, we are finalizing our proposals without modification, and specifically applying them to device categories C1820, L8690, and C1821, as discussed above.

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 required for certain ''new'' drugs and biological agents that were not being paid for as a hospital outpatient department service as of December 31, 1996, and whose cost is ''not insignificant'' in relation to the OPPS payments for the procedures or services associated with the new drug or biological. Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years. Proposed pass-through drugs and biologicals are assigned status indicator ''G'' in Addenda A and B of the CY 2007 OPPS proposed rule. The pass-through application and review process is explained on the CMS Web site at *http://www.cms.hhs.gov*.

Section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through eligible drugs (assuming that no pro rata reduction in pass-through payment is necessary) as the amount determined under section 1842(o) of the Act. This payment methodology is set forth in § 419.64 of the regulations. 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 terms ''ASP methodology'' and ''ASP-based'' are inclusive of all data sources and methodologies described therein. Additional information on the ASP methodology can be found at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp#TopOfPage*.

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 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 at *http://www.cms.hhs.gov/CompetitiveAcquisforBios*.

For CY 2007, we proposed to pay for drugs and biologicals that are granted pass-through status under the OPPS and that are included in the Part B drug CAP at a payment rate equal to the rate these drugs would be paid under the Part B drug CAP. We had several comments about this proposal.

Comment: Commenters expressed concern that Part B drug CAP rates are insufficient to cover the costs hospitals incur for drugs, as the CAP rate is an average of eligible approved CAP vendor bids, and hospitals are not able to obtain drugs at the CAP rates because they are statutorily excluded from the CAP program. The commenters suggested that the rate for all pass-through drugs should, therefore, be set to the ASP methodology, regardless of the drug's inclusion in the Part B drug CAP.

Response: As discussed above, our proposed methodology for setting payment rates for pass-through drugs that are also a part of the Part B drug CAP program is mandated by section 1833(t)(6)(D)(i) of the Act. In addition, we note that, for the two pass-through drugs that we proposed to pay at the Part B drug CAP rate in CY 2007, the Part B drug CAP rate exceeds the rate resulting from the October update of the ASP methodology for both drugs. Therefore, we disagree that the Part B drug CAP rate undermines hospitals' ability to procure drugs that are paid at this rate while on pass-through.

Comment: Commenters requested that CMS clarify the amount that we would pay for pass-through drugs and biologicals that are also included as part of the Part B drug CAP. Specifically, the commenters asked for clarification of how CMS determines the Part B drug CAP rate.

Response: As discussed above, the statutory language requires that if a drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the OPPS pass-through 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. As of the time of this final rule with comment period, the Part B drug CAP includes one national competitive acquisition area and one national vendor. Therefore, the average payment across all competitive acquisition areas at this time is also equal to the rate paid to the national vendor. We refer the public to the CY 2006 MPFS final rule (70 FR 70236) for a full description of the Part B CAP.

Comment: Commenters stated that pass-through payments were required by law to be paid on a drug-by-drug basis, and therefore a payment based on the Part B drug CAP process that incorporates many drugs across several vendors would violate this drug-specific requirement.

Response: We disagree that these statutory requirements pose a conflict. The Part B drug CAP program payment determination is performed on a drug-by-drug basis and complements the provisions of the pass-through concept. (For more information on the Part B drug CAP payment rate methodology, see section II.C.3. of the Interim Rule entitled ''Competitive Acquisition of Outpatient Drugs and Biologicals Under Part B'' which was published at the **Federal Register** on July 6, 2005 (70 FR 39069) and section II.H.6. of the final rule entitled ''Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006 and Certain Provisions Related to the Competitive Acquisition Program of Outpatient Drugs and Biologicals Under Part B'' which was published in the **Federal Register** on November 21, 2005 (70 FR 70236).)

For the reasons set forth in the section above, we are finalizing our proposed policy to pay for drugs and biologicals with pass-through status in CY 2007 that are also covered under the Part B drug CAP at the rate each drug would be paid under the Part B drug CAP.

2. Drugs and Biologicals With Expiring Pass-Through Status in CY 2006

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 23 of the CY 2007 OPPS proposed rule (71 FR 49580), we proposed to allow the expiration of the pass-through status for 12 drugs and biologicals on December 31, 2006. We also proposed to delete temporary CY 2006 C-codes if an alternate permanent HCPCS code was available for purposes of OPPS billing and payment in CY 2007.

There are seven pass-through drugs, identified with an asterisk (*) in Table22 below, that are paid under the OPPS for CY 2006 at the rate established by the Part B drug CAP. In CY 2007, these drugs, in accordance with OPPS policy for all non-pass through drugs, biologicals, and radiopharmaceuticals, are subject to the established OPPS payment methodologies discussed in section V.B of this final rule with comment period.

Based on our review of the existing permanent HCPCS codes available at the time of the CY 2007 OPPS proposed rule, we determined that HCPCS code J7344 (Nonmetabolic active tissue) appropriately described the product reported under HCPCS code C9221 in the CY 2006 OPPS. We proposed to delete HCPCS code C9221 and instruct hospitals to use HCPCS code J7344 for services furnished on or after January 1, 2007. We did not receive any comments on this proposal. Therefore, we are finalizing our proposal without modification.

Since the publication of the proposed rule, we have determined that HCPCS code J7319 (Sodium hyaluronate injection) appropriately describes the product reported under HCPCS code C9220, and that HCPCS code J7346 (Injectable human tissue) appropriately describes the product reported under HCPCS code C9222 as shown in Table 23 of the CY 2007 OPPS proposed rule. Therefore, in accordance with the policy described above, we are deleting HCPCS codes C9220 and C9222, and instructing hospitals to use HCPCS codes J7319 and J7346, respectively, for services furnished on or after January 1, 2007.

We did not receive any public comments concerning our proposed policy for CY 2007. Therefore, we are finalizing our proposal to discontinue pass-through status as of December 31, 2006, for the 12 drugs and biologicals shown in Table 22 below. In addition, Table 22 indicates the final CY 2007 coding changes for these drugs and biologicals.

TABLE 22.—LIST OF DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES DECEMBER 31, 2006

CY 2007 HCPCS	CY 2006 HCPCS	CY 2007 APC	CY 2007 short descriptor
J7319	C9220	0896	Sodium hyaluronate injection
J7344	C9221	9156	Nonmetabolic active tissue
J7346	C9222	9222	Injectable human tissue
J0128*		9216	Abarelix injection
J0878*		9124	Daptomycin injection
J2357*		9300	Omalizumab injection
J2783		0738	Rasburicase
J2794*		9125	Risperidone, long acting
J7518		9219	Mycophenolic acid
J9035*		9214	Bevacizumab injection
J9055*		9215	Cetuximab injection
J9305*		9213	Pemetrexed injection

* Indicates that the drug was paid at a rate determined by the Part B drug CAP methodology while identified as pass-through under the OPPS.

3. Drugs and Biologicals With Pass-Through Status in CY 2007

In the CY 2007 OPPS proposed rule, we proposed to continue pass-through status in CY 2007 for the nine drugs and biologicals listed in Table 24 (71 FR 49582) that had received pass-through status as of April 1, 2006. We also assigned these APCs and HCPCS codes status indicator ''G'' in Addenda A and B of the CY 2007 proposed rule.

We proposed to pay for drugs and biologicals that are not included in the Part B drug CAP at a rate equal to the payment these drugs and biologicals would receive in the physician office setting in CY 2007, where payment will be determined by the methodology described in § 414.904 and generally be equal to ASP+6 percent.

We received several comments on our proposal to pay for pass-through drugs and biologicals that are not included in the Part B drug CAP at the rate these drugs would receive in the physician office setting.

Comment: Many commenters supported our proposal to provide payment in CY 2007 for drugs and biologicals with pass-through status at the rate these drugs and biologicals would receive in the physician office setting. However, one commenter stated that the purpose of pass-through payments is to recognize additional costs that hospitals incur when providing new and expensive drugs and biologicals that are not yet reflected in the OPPS APC payment rates. Therefore, the commenter added, pass-through drugs and biologicals should be subject to a methodology that provides an additional payment, above the payment methodology provided to non-pass through drugs and biologicals.

Response: We appreciate the commenters' support for our proposed policy. In addition, we agree that the purpose of pass-through payments is to recognize and support hospitals that provide innovative and expensive therapies before these costs are reflected in the OPPS APC payment amounts. However, drugs are paid through their own drug specific APCs, typically at a rate that is based on the ASP methodology that reflects recent market prices. Payment rates for separately payable drugs are updated quarterly and do not rely on the most recent set of OPPS hospital claims data that results in the 2-year difference between hospital claims and OPPS payment rates experienced by other APCs. Therefore, we do not believe that pass-through drugs require a separate methodology or payments above the methodology used to set payment rates for other drugs.

As discussed in section V.A.1. of this preamble, pass-through payments for CY 2007 are made under the OPPS for drugs and biologicals that are also included in the Part B drug CAP at the rate established by the Part B drug CAP. At the time of the proposed rule, two drugs (HCPCS codes J2503 (Pegaptanib sodium injection) and J9264 (Paclitaxel protein bound)) were approved for pass-through payments in CY 2007 that were also covered under the Part B drug CAP.

As we have established above, payment for these drugs will be amounts determined under the Part B drug CAP, which will be at a rate slightly different than the rate determined under the ASP methodology. Pass-through rates for all other CY 2007 pass-through drugs will be at a rate equal to the rate paid in the physician office setting, as determined by the ASP methodology. This information is updated quarterly as part of the ASP methodology process, and OPPS payment rates are adjusted accordingly. Additional information on this ASP methodology is available at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.*

Currently, there are no radiopharmaceuticals that would have pass-through status in CY 2007. In the event that a new radiopharmaceutical agent receives pass-through status in CY 2007, we proposed to base its payment on the WAC for the product as ASP data for radiopharmaceuticals are not available. In addition, we proposed to calculate payment for the radiopharmaceutical at 95 percent of its most recent AWP if WAC information was also not available. We proposed to adopt this interim payment methodology in order to be consistent with how we pay for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes, as discussed in the CY 2006 OPPS final rule with comment period (70 FR 68669). We received several comments on this proposal.

Comment: Several commenters requested that CMS pay separately for all radiopharmaceuticals at hospital charges reduced to cost using the hospital specific overall CCR.

Response: Comments received relating to nonpass-through radiopharmaceuticals are addressed in section V.B.3. of this preamble, and comments received regarding our proposed payment methodology for nonpass-through drugs, biologicals and radiopharmaceuticals without claims data are discussed in section V.B.3.b. of this preamble.

Our CY 2007 proposal to pay for pass-through radiopharmaceuticals at WAC was closely aligned with our proposal to pay for separately payable nonpass-through radiopharmaceuticals based on mean unit costs calculated from CY 2005 hospital claims data. As we discuss in section V.B.3. of this preamble, after careful consideration of all comments received, we are not finalizing this proposal for separately payable nonpass-through radiopharmaceuticals. Therefore, we are also not finalizing our proposal to use a prospective WAC-based payment methodology for pass-through radiopharmaceuticals in CY 2007. We believe it is appropriate to align our payment methodologies, whenever possible, within the OPPS. Therefore, for CY 2007, we are finalizing our payment policy for pass-through radiopharmaceuticals as follows: For CY 2007, hospitals will receive payment for radiopharmaceuticals that are granted pass-through status in CY 2007 at the hospital's charge for the radiopharmaceutical adjusted to the cost, using the hospital's overall CCR. This methodology will provide payment for radiopharmaceuticals granted pass-through status in CY 2007 based on the same payment methodology that will be used to provide payment for separately payable nonpass-through radiopharmaceuticals in CY 2007 in the OPPS.

We discuss in section V.B.3.b. of this final rule with comment period that we are making separate payment in CY 2007 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 office setting (or under section 1847B of the Act, if the drug or biological is covered under a competitive acquisition contract), whether or not we have received a pass-through application for the item. Accordingly, in CY 2007 the pass-through payment amount would equal zero for those new drugs and biologicals that we determine have pass-through status. That is, when we subtract 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), from the portion of the otherwise applicable fee schedule amount or the APC payment rate associated with the drug or biological that would be the amount paid for 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), the resulting difference is equal to zero.

In the proposed rule, we used payment rates based on the ASP data from the fourth quarter of CY 2005 for budget neutrality estimates, impact analyses, and completion of Addenda A and B of the proposed rule because these were the most recent data available to us during the development of the proposed rule. We proposed to update this data with the most recent data available for purposes of the final rule with comment period. We received no comments on this proposal. Therefore, we have updated the payment rates for budget neutrality estimates, impact analyses, and completion of Addenda A and B of this final rule with comment period to reflect payment rates based on ASP data effective October 1, 2006, as this is the most recent data available at the time of this final rule with comment period.

In addition, to be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices, we proposed to make any appropriate adjustments to the amounts shown in Addenda A and B on a quarterly basis on the CMS Web site during CY 2007 if later quarter ASP methodology calculations indicate that adjustments to the payment rates for these pass-through drugs and biologicals are necessary, or in the event that they become covered under the competitive acquisition program. The payment rate for a radiopharmaceutical with pass-through status would also be adjusted accordingly.

In Table 24 of the proposed rule, we listed the drugs and biologicals for which we proposed that pass-through status continue in CY 2007 (71 FR 49581). We assigned pass-through status to these drugs and biologicals as of April 1, 2006 and identified them in Addenda A and B of the proposed rule with status indicator ''G.''

Comment: One commenter supported our pass-through determination for C9228 (Injection, tigecycline), and one commenter supported our pass-through determination for Q4079 (Natalizumab injection) for CY 2007.

Response: We appreciate the commenters' support of our pass-through decisions for these drugs.

Since the time of the proposed rule, we have granted pass-through status in CY 2007 to an additional nine drugs and biologicals. In addition, in accordance with the established policy discussed above, we are deleting six temporary CY 2006 C-codes because we have identified an alternate permanent HCPCS code that is available for purposes of OPPS billing and payment in CY 2007. These temporary codes, and their permanent HCPCS replacement codes, are listed in Table 23 along with all drugs and biologicals that we are finalizing for pass-through payments in CY 2007 under the OPPS. In addition, we have identified with an asterisk (*) those pass-through drugs for CY 2007 OPPS that are also included in the Part B drug CAP.

TABLE 23.—LIST OF DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2007

CY 2007 final HCPCS	CY 2007 proposed rule HCPCS	APC	Short descriptor
C9232	**	9232	Injection, idursulfase.
C9233	**	9233	Injection, ranibizumab.
C9350	**	9350	Porous collagen tube per cm.
C9351	**	9351	Acellular derm tissue percm2.
J0129	C9230**	9230	Abatacept injection.
J0348	**	0760	Anadulafungin injection.
J0894	C9231**	9231	Decitabine injection.
J1740	C9229**	9229	Injection ibandronate sodium.
J2248	C9227	9227	Micafungin sodium injection.
J2278	J2278	1694	Ziconotide injection.
J2503*	J2503	1697	Pegaptanib sodium injection.
J3243	C9228	9228	Tigecycline injection.
J3473	**	0806	Hyaluronidase recombinant.
J7311	C9225	9225	Fluocinolone acetonide implt.
J8501	J8501	0868	Oral aprepitant.
J9027	J9027	1710	Clofarabine injection.
J9264*	J9264	1712	Paclitaxel protein bound.
Q4079	Q4079	9126	Natalizumab injection.

* Indicates that the drug is included in the Part B drug CAP and will be paid at this methodology in 2007.
** Pass-through status was granted after publication of the CY 2007 OPPS proposed rule.

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

1. Background

Under the CY 2006 OPPS, we currently pay for drugs, biologicals, and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment within the payment for the associated service or separate payment (individual APCs). We explained in the April 7, 2000 OPPS final rule with comment period (65 FR 18450) that we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any packaged items and supplies whose costs are recognized and paid within the national OPPS payment rate for the associated procedure or service. (Program Memorandum Transmittal A–01–133, issued on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.)

Packaging costs into a single aggregate payment for a service, procedure, or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. Notwithstanding our commitment to package as many costs as possible, we are aware that packaging payments for certain drugs, biologicals, and radiopharmaceuticals, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services.

Section 1833(t)(16)(B) of the Act, as added by section 621(a)(2) of Pub. L. 108–173, set the threshold for establishing separate APCs for drugs and biologicals at $50 per administration for CYs 2005 and 2006. Therefore, for CY 2006, we paid separately for drugs, biologicals, and radiopharmaceuticals whose per day cost exceeds $50 and packaging the costs of drugs, biologicals, and radiopharmaceuticals whose per day cost is less than $50 into the procedures with which they are billed. In addition, we extended an exception to this packaging policy for oral and injectable 5HT3 forms of anti-emetic treatments (70 FR 68635 through 68638) for CY 2006.

At the August 2006 APC Panel meeting, the Panel recommended that CMS allow providers to use all available HCPCS codes for reporting drugs in the OPPS to reduce the administrative burden associated with reporting drugs using only HCPCS codes with the lowest increments in their code descriptors. We include our response to this recommendation in the discussion below.

Comment: Several commenters recommended that CMS allow all drug, biological, and radiopharmaceutical HCPCS codes to be recognized under the OPPS, as opposed to our current policy that does not recognize some codes because they are not the lowest dosage unit HCPCS code available for an item.

Response: We appreciate these comments, as well as the efforts of the commenters to identify specific drugs where the OPPS currently recognizes only one of several HCPS codes. As is our longstanding interest, we are considerate of situations where hospitals may experience an administrative burden that could possibly be reduced with a change in OPPS policy. In general, the current practice of the HCPCS National Panel is to establish only one HCPCS code for a particular drug with a single appropriate dose descriptor for reporting all doses, whereas historically more than one HCPCS code may have been created with different dose descriptors for the same drug. Typically, under the OPPS, we have only recognized a single HCPCS code with the lowest dose descriptor, as this approach assists us in data collection for OPPS ratesetting purposes and allows hospitals to accurately reflect all doses administered by billing a variety of units in relation to the drug's dose descriptor.

Our current practice is to make a packaging determination based on historical hospital claims data for each drug, biological, and radiopharmaceutical HCPCS code that we recognize under the OPPS. Therefore, we generally determine the packaging status for the lowest dose descriptor that exists for a particular

drug, as other doses are typically assigned status indictor ''B'' (Not recognized under OPPS; alternate code may be available). If we were to recognize all the HCPCS codes that may exist for a single drug, we would need to consider the ramifications of such a substantial change on our ratesetting methodology. For example, we would need to consider whether to adjust our methodology to provide packaging decisions based upon a particular drug, rather than making a determination for each HCPCS code. If we did not adjust our methodology, we could have variable packaging determinations for multiple HCPCS codes that described the same drug, and it is not clear whether this would be appropriate. Therefore, we are not accepting the recommendation of the APC Panel and the commenters to recognize all available HCPCS codes in the CY 2007 OPPS. However, we will further explore the issues surrounding such an approach for the future, to further develop our understanding of the implications of such a change. We continue to believe that the current HCPCS codes recognized under the OPPS allow hospitals to accurately report all doses of the drugs, biologicals, and radiopharmaceuticals they administer.

2. Criteria for Packaging Payment for Drugs, Biologicals, and Radiopharmaceuticals

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. As this provision expires at the end of CY 2006, we provided a discussion in the proposed rule of four packaging level options that were considered for the CY 2007 OPPS update.

One of the packaging options we considered for the CY 2007 OPPS update was to pay separately for all drugs, biologicals, and radiopharmaceuticals with a HCPCS code. We determined that this would be a straightforward policy that would speed the creation of procedural APC medians; however, we expressed concern that this policy would be inconsistent with OPPS packaging principles, would reduce hospitals' incentives for economy and efficiency, and would increase hospitals' administrative burden related to separate billing for more drugs, biologicals, and radiopharmaceuticals.

During the August 2006 meeting of the APC Panel, the Panel endorsed this option and recommended that CMS eliminate the drug packaging threshold for all drugs and radiopharmaceuticals with HCPCS codes. We include our response to the Panel's recommendation in our discussion below.

In addition to the APC Panel's recommendation, we received several comments requesting that we pay separately for all drugs, biologicals and radiopharmaceuticals (or combination thereof) with HCPCS codes that are provided in the hospital outpatient department and payable under the OPPS.

Comment: Two commenters acknowledged that unpackaging all drugs, biologicals and radiopharmaceuticals is inconsistent with the concept of a prospective payment system. However, one of these commenters contended that packaged items may not be fully accounted for in the OPPS ratesetting process, and these costs therefore may not appear in the final payment rates established for the primary service. For this reason, the commenter believed that the OPPS should pay separately for all drugs, biologicals, and radiopharmaceuticals. The commenter further asserted that the OPPS' inability to use multiple procedure bills exacerbates the problem because multiple procedure claims are more likely to include packaged drugs, biologicals, and radiopharmaceuticals.

Response: We agree that unpackaging all drugs, biologicals and radiopharmaceuticals is inconsistent with the concept of a prospective payment system. We have not been presented with any data that support the commenter's assertion that multiple procedure claims would be more likely to include packaged drugs, biologicals, and radiopharmaceuticals. Multiple procedure claims contain a variety of services, including surgical procedures, diagnostic imaging tests, visits, and laboratory procedures that also could have significant associated packaging in addition to drugs, biologicals, and radiopharmaceuticals, such as devices, minor ancillary procedures, anesthesia, operating room time, and recovery room time. As we have previously indicated, we are unable to use these claims for ratesetting because we cannot attribute the packaging appropriately to the individual services on the claims. However, we would not expect the amount of drug, biological, and radiopharmaceutical packaging to be proportionately higher for these multiple procedure claims compared to the amount of drug packaging contained on the single drug administration claims we use for ratesetting. In fact, we might expect that the percentage of total costs related to packaged drugs on these multiple claims to be significantly less than the comparable percentage for single claims for drug administration services. In addition, much of the packaged drug costs on multiple procedure claims might be more accurately associated with services other than drug administration services. Thus, we are unsure about the appropriate methodology and the ultimate utility of studies to examine drug, biological, and radiopharmaceutical packaging on multiple claims. In section VIII.C. of this preamble, we provide a preliminary analysis of a study we performed in response to the APC Panel's March 2006 recommendation to further explore how packaged drug, biological, and radiopharmaceutical costs are accounted for within the OPPS ratesetting methodology so that their costs are incorporated into payment rates for associated drug administration procedures. The same analysis provides a preliminary response to the APC Panel's August 2006 recommendation that CMS provide claims analysis of the contributions of packaged costs (considering packaged drugs and other packaging) to the median cost of each drug administration service.

Comment: Several commenters asserted that separate payment for all drugs and biologicals under the OPPS was appropriate in the light of CMS's efforts to align payments across the physician office and hospital outpatient settings, for example, by adopting the ASP methodology in both settings. The commenters stated that continuing a policy of packaging certain items in the hospital outpatient setting would continue an inequality in payment between these settings. We also received several comments specifically against our proposal to set the packaging threshold for radiopharmaceuticals at $55. These commenters requested that we pay separately for all radiopharmaceuticals.

Response: While we believe that payment parity is appropriate for certain items in order to provide appropriate access to care without undesirable site of service shifts, the OPPS and MPFS are fundamentally different payment systems with essential differences in their payment policies. Specifically, the OPPS is a prospective payment system, based on the concept of paying for groups of services that share clinical and resource characteristics. Payment is made in the OPPS according to prospectively established payment rates that are related to the relative costs of hospital resources for services. The MPFS is a fee schedule that generally provides payment for each individual

component of a service. Differences in the degrees of packaged payment and separate payment between these two systems are only to be expected. In general, we do not believe that our packaging methodology under the OPPS creates issues that result in limiting beneficiary access to care. In those rare circumstances where we believe a situation may cause problems with beneficiary access or where our packaging methodology may unduly influence physicians' treatment decisions, in the best interest of Medicare beneficiaries, we have modified our packaging methodology, as is the case for 5HT3 anti-emetics. At this time there is neither sufficient reason, nor have we been presented with information, that leads us to consider modifying our packaging policy for radiopharmaceuticals.

Comment: Several commenters disagreed with our assertion that unpackaging all drugs and biologicals with HCPCS codes would increase the burden on hospitals, as many hospitals are following CMS' request to report charges for all drugs, biologicals, and radiopharmaceuticals with HCPCS codes, regardless of the packaging status of the particular item. However, another commenter agreed with our statement and explained that eliminating the packaging threshold for drugs, biologicals and radiopharmaceuticals would not only increase the administrative burden of hospitals, but that this change would lead to unexpected payment decreases for other services payable under the OPPS, because the OPPS is a budget neutral payment system.

Response: We appreciate these comments. We understand that the impact of increased coding responsibilities that would accompany a change in our packaging policy would likely vary from hospital to hospital. We appreciate the efforts of hospitals to include data for packaged services on their claims as it continues to provide us with a robust data set which we can use for both future ratesetting and development of OPPS payment policies.

We note that in CYs 2005 and 2006, the statutorily mandated drug packaging threshold was set at $50, and we believe it is appropriate to continue a modest drug packaging threshold for the CY 2007 OPPS, consistent with the framework provided in the law. 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 option of paying separately for all drugs, biologicals, and radiopharmaceuticals for CY 2007. Accordingly, we also are not adopting the August 2006 APC Panel recommendation presented above.

The second option we presented in the CY 2007 proposed rule was to increase the packaging threshold to a level much higher than the current $50 threshold. As we discussed, we believed that this option would be more consistent with OPPS packaging principles by packaging more drugs, biologicals, and radiopharmaceuticals. In addition, we stated that we believed this option would also provide greater administrative simplicity for hospitals. However, we expressed concern that implementation of this option might result in circumstances where drug administration payments could be less than the cost of the packaged drugs, as relatively expensive drugs, biologicals, and radiopharmaceuticals could become packaged under this option.

We received no comments on this option and we are not adopting this methodology for CY 2007.

The third option we presented in the CY 2007 proposed rule was to maintain the packaging threshold at $50. We discussed that maintaining the threshold would provide stability to the payment system, as the packaging threshold has been set at $50 since CY 2004. We also noted that this policy option would be consistent with the March 2006 APC Panel recommendation to maintain the packaging threshold at $50 in CY 2007. However we discussed our concern that this policy would not take into account price inflation and would, therefore, not be representative of real dollars in future years. We received one comment specifically on this option and a number of comments requesting this option if we decided to continue with a packaging methodology for the OPPS for CY 2007.

Comment: One commenter supported the March 2006 APC Panel recommendation to retain the $50 packaging threshold because it would help ensure adequate payments for hospitals, preserve stability in the payment policy, and continue to provide beneficiary access to care.

Response: We appreciate the commenter's support of the adequacy of the $50 threshold for drugs, biologicals, and radiopharmaceuticals. However, we have chosen to not to adopt this option, for the reasons discussed below.

The final option discussed in the CY 2007 proposed rule was a variation of the previous option, where we proposed an annual update of the packaging threshold for inflation using an inflation adjustment factor based on the Producer Price Index (PPI) for prescription preparations. As described in the proposed rule, we calculated an adjusted packaging threshold for CY 2007 by using the four quarter moving average 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 proposed to apply an annual inflation adjustment factor that would be 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 discussed our concern that in the absence of a mechanism to update the threshold, we believed that current relatively inexpensive drugs would begin to receive separate payment over time.

The PPI for prescription preparations reflects price changes at the wholesale or manufacturer stage. Because OPPS payment rates for drugs and biologicals are generally based on the average sales price (ASP) data that are reported by their manufacturers, in the proposed rule we indicated that we believed that the PPI for prescription preparations would be an appropriate price index to use to update the packaging threshold for CY 2007 and beyond.

Specifically, we proposed to adjust the packaging threshold by the PPI for prescription drugs each year, and round the adjusted dollar amount to the nearest $5 increment to identify the updated packaging threshold. We calculated the adjusted amount for CY 2007 at $55.99, rounded to $55. Therefore, for CY 2007 and beyond, we proposed to package all drugs, biologicals, and radiopharmaceuticals whose per day cost is less than or equal to $55 into the procedures with which they are billed.

We explained that we believed that this proposal was consistent with the APC Panel's March 2006 recommendation to continue the $50 packaging threshold in CY 2007, because the real dollar value would be held constant during the calendar year in which it would be in effect. Our response to this recommendation is included in the discussion presented below.

We received several comments on our proposal to provide an annual update of the packaging threshold using the four-quarter moving average PPI.

Comment: Most commenters, in general, disagreed with an increase to the packaging threshold. However, one commenter disagreed with our use of

the PPI as a basis for our annual packaging threshold update. The commenter explained that as the PPI includes information for all prescription medications, it includes information for drugs that are not covered under Part B benefits and may inaccurately represent the amount of inflation for Part B drugs. The commenter recommended that CMS calculate an inflation index using manufacturers' quarterly ASP data submissions.

Response: We appreciate the commenter's analysis of the applicability of the PPI and their proposed alternative methodology. There are a wide array of drugs that are covered under Part B of Medicare, and these drugs are used to treat a broad spectrum of clinical conditions in the hospital outpatient setting. These drugs range from monoclonal antibody agents, to complex chemotherapeutic agents, to antiemetics, to antibiotics, to narcotics, and to analgesics. The ASP system is relatively new, and we have only limited experience in following changes in manufacturers' data submissions over time. While we understand that the PPI includes drugs that may not be payable as a Part B benefit, we continue to believe that the PPI is a mature, well-established, and widely available index already used by Medicare that provides the most accurate estimate of Part B drug inflation for purposes of updating the OPPS drug packaging threshold each year. We intend to evaluate the applicability of the PPI as the drug packaging inflation adjustment factor as needed.

Because 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 a minimum $50 packaging threshold is reasonable based on its initial establishment in law 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, we are finalizing our proposal to calculate an annual update to the OPPS packaging threshold using the proposed methodology without modification. Therefore, for CY 2007 and beyond, drugs, biologicals and radiopharmaceuticals that are not new and do not have pass-through status will be packaged if their calculated per day cost is equal to or less than $55 for CY 2007 or equal to or less than the updated threshold established, rounded to the nearest $5 increment, for the relevant update year.

To determine their CY 2007 proposed packaging status, we calculated the per day cost of all drugs, biologicals, and radiopharmaceuticals that had a HCPCS code in CY 2005 and were paid (via packaged or separate payment) under the OPPS using claims data from January 1, 2005 to December 31, 2005. In CY 2005, multisource drugs and radiopharmaceuticals had two HCPCS codes that distinguished the innovator multisource (brand) drug or radiopharmaceutical from the noninnovator multisource (generic) drug or radiopharmaceutical. We aggregated claims for both the brand and generic HCPCS codes in our packaging analysis of these multisource products. In order to calculate the per day cost for drugs, biologicals, and radiopharmaceuticals to determine their packaging status in CY 2007, we proposed to use the methodology that was described in detail in the CY 2006 OPPS proposed rule (70 FR 42723 through 42724) and finalized in the CY 2006 OPPS final rule with comment period (70 FR 68636 through 68638).

In our calculation of per day costs for the CY 2007 OPPS proposed rule we used the manufacturer-submitted ASP data from the fourth quarter of CY 2005 (rates that were used for payment purposes in the physician office setting effective April 1, 2006) and a payment rate of ASP+5 percent, as our proposal was to pay for drugs and biologicals at ASP+5 percent for CY 2007. For items that did not have an ASP-based payment rate, we used their mean unit cost derived from the CY 2005 hospital claims data to determine their per day cost. For the proposed rule, we identified the items with per day cost less than or equal to $55 as packaged and identified items with per day cost greater than $55 as separately payable.

Our policy during previous cycles of the OPPS has been to use updated data to establish final determinations of the packaging status of drugs, biologicals, and radiopharmaceuticals. We note it is also our policy to make an annual packaging determination at the time of the final rule. Only items that are identified as separately payable will be subject to quarterly updates as discussed in section V.B.3. of this preamble. Items that are finalized as packaged will be eligible for consideration of separate payment only for the next update of the OPPS. We proposed to use the ASP data from the first quarter of CY 2006 (reflected in payment rates in the physician office setting effective July 1, 2006) as a basis for our annual packaging determination for CY 2007, along with updated hospital claims data from CY 2005, to determine the final per day costs of drugs, biologicals, and radiopharmaceuticals and their packaging status in CY 2007. As discussed in section V.B.3. of this preamble, for this CY 2007 final rule determination of packaging status we are also altering the payment rate used for the determination to reflect a payment rate of ASP+6 percent, based on our final CY 2007 policy, rather than the proposed rate of ASP+5 percent.

Because the data we used in the proposed rule to calculate per day costs, and the payment rates applied to that data, have been updated for the final rule packaging status determination, the packaging status of certain drugs, biologicals, and radiopharmaceuticals may have changed. Under such circumstances, we proposed to apply the following policies to these drugs, biologicals, and radiopharmaceuticals whose relationship to the $55 threshold changed based on the final updated data:

- Drugs, biologicals, and radiopharmaceuticals that were paid separately in CY 2006 (which were proposed for separate payment in CY 2007), and then have per day costs less than $55 based on the updated ASPs and hospital claims data used for the CY 2007 final rule with comment period, would continue to receive separate payment in CY 2007.
- Drugs, biologicals, and radiopharmaceuticals that were packaged in CY 2006, (which were proposed for separate payment in CY 2007), and then have per day costs less than $55 based on the updated ASPs and hospital claims data used for the CY 2007 final rule with comment period, would remain packaged in CY 2007.
- Drugs, biologicals, and radiopharmaceuticals for which we proposed packaged payment in CY 2007 but then had per day costs greater than $55 based on the updated ASPs and hospital claims data used for the CY 2007 final rule with comment period, would receive separate payment in CY 2007.

We received no comments on the methodology we proposed to use in the event that the packaging status of a drug had changed due to the data update between the proposed and final rules. Therefore, we are finalizing this proposal without modification. Table 24 below indicates those drugs, biologicals and radiopharmaceuticals that have changed packaging status between the proposed rule and the final rule, and indicates their final CY 2007 packaging status.

TABLE 24.—DRUGS, BIOLOGICALS AND RADIOPHARMACEUTICALS THAT EXPERIENCED A STATUS CHANGE BETWEEN THE PROPOSED AND FINAL CY 2007 OPPS RULES

CY 2007 HCPCS	Short description	CY 2007 proposed SI	CY 2007 final SI	CY 2007 final APC
J0580	Penicillin g benzathine inj	K	N	
J1205	Chlorothiazide sodium inj	N	K	0747
J2354	Octreotide inj, non-depot	K	N	
J3320	Spectinomycn di-hcl inj	N	K	0753
J8600	Melphalan oral 2 MG	K	N	
J9040	Bleomycin sulfate injection	N	K	0748
J9120	Dactinomycin actinomycin d	N	K	0752
J9130	Dacarbazine 100 mg inj	N	K	0746
J9230	Mechlorethamine hcl inj	N	K	0751

For CY 2007, we also included a proposal to continue exempting the oral and injectable 5HT3 anti-emetic products from packaging, thereby making separate payment for all of the 5HT3 anti-emetic products. As 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 that we believed that we should continue to ensure that Medicare payment rules do not impede a beneficiary's access to the particular anti-emetic that is most effective for him or her as determined by the beneficiary and his or her physician.

We received several supportive comments on this proposed policy for CY 2007.

Comment: Commenters commended CMS on the CY 2007 proposal to continue to pay separately for all 5HT3 antiemetics.

Response: We appreciate the support for our proposal, and we continue to believe that separate payment for these items is warranted for the reasons discussed above.

Therefore, we are finalizing our proposal to exempt the 5HT3 antiemetics from the packaging threshold. As a result, the anti-emetics listed in Table 25 will receive separate payment status under the OPPS for CY 2007.

TABLE 25.—ANTI-EMETICS EXEMPTED FROM $55 PACKAGING REQUIREMENT

HCPCS code	Short description
J1260	Dolasetron mesylate.
J1626	Granisetron HCl injection.

TABLE 25.—ANTI-EMETICS EXEMPTED FROM $55 PACKAGING REQUIREMENT—Continued

HCPCS code	Short description
J2405	Ondansetron HCl injection.
J2469	Palonosetron HCl.
Q0166	Granisetron HCl 1 mg oral.
Q0179	Ondansetron HCl 8 mg oral.
Q0180	Dolasetron mesylate oral.

3. Payment for Drugs, Biologicals, and Radiopharmaceuticals 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 exists and that either is a radiopharmaceutical agent or is a drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

Under section 1833(t)(14)(B)(ii) of the Act, certain drugs and biologicals are designated as exceptions and are not included in the definition of ''specified covered outpatient drugs.'' 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 specified covered outpatient drugs 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.

For CY 2006, we adopted a policy of paying for the acquisition and overhead costs of separately paid drugs and biologicals at a combined rate of ASP+6 percent. To calculate the ASP+6 percent payment rate, we evaluated the three data sources that were available to us for setting the CY 2006 payment rates for drugs and biologicals. As described in the CY 2006 OPPS final rule with comment period (70 FR 68639 through 68644), these data sources were the GAO reported average purchase prices for 55 specified covered outpatient drug categories for the period July 1, 2003, to June 30, 2004, collected via a survey of 1,400 acute care Medicare-certified hospitals; ASP data; and mean costs derived from CY 2004 hospital claims data. For the CY 2006 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 office setting effective October 1, 2005.

In our data analysis for the CY 2006 OPPS final rule with comment period, we compared the payment rates for

drugs and biologicals using data from all three sources described above. We estimated aggregate expenditures for all drugs and biologicals that would be separately payable in CY 2006 and for the 55 drugs and biologicals reported by the GAO using mean costs from the claims data, the GAO mean purchase prices, and the ASP-based payment amounts (ASP+6 percent in most cases), and then calculated the equivalent average ASP-based payment rate under each of the three payment methodologies. We excluded radiopharmaceuticals in our analysis because they were paid at hospital charges reduced to cost during CY 2006. The results based on updated ASP and claims data were published in Table 24 of the CY 2006 OPPS final rule with comment period. For a full discussion of our reasons for using these data, refer to section V.B.3.a. of the CY 2006 OPPS final rule with comment period (70 FR 68639 through 68644).

As we noted in the CY 2006 OPPS final rule with comment period, findings from a MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their pharmacy handling costs as well as their acquisition costs. In consideration of this information, we stated in the CY 2006 OPPS final rule that payment rates derived from hospital claims data also included acquisition and pharmacy handling costs because they are derived directly from hospital charges. Therefore, in CY 2006, we finalized a policy of providing payment to hospital outpatient departments for drugs, biologicals and associated pharmacy handling costs at a rate of ASP+6 percent.

(2) Payment Policy for CY 2007

The provision in section 1833(t)(14)(A)(iii) of the Act, as described above, continues to be applicable to determining payments for specified covered outpatient drugs for CY 2007. This provision requires that in CY 2007 payment for specified covered outpatient drugs 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. Additionally, section 1833(t)(14)(E)(ii) authorizes the Secretary to adjust APC weights for specified covered outpatient drugs to take into account the MedPAC report relating to overhead and related expenses, such as pharmacy services and handling costs.

For the CY 2007 OPPS proposed rule, we evaluated the two data sources that were available to us for ratesetting purposes for drugs and biologicals in CY 2007. The first source presented in the proposed rule was based on the ASP methodology and included data from the fourth quarter of CY 2005, which were also the data used for payments in the physician office setting effective April 1, 2006. We stated that we have prices for approximately 500 drugs and biologicals (including contrast agents) payable under the OPPS using the ASP methodology (ASP+6 percent in most cases); however, we did not have any data from this source for radiopharmaceutical products.

The second source of cost data for drugs, biologicals, and radiopharmaceuticals discussed in the OPPS proposed rule available for ratesetting purposes was CY 2005 hospital claims data, used to calculate mean and median costs for these items. As section 1833(t)(14)(A)(iii) of the Act clearly specifies that payment for specified covered outpatient drugs in CY 2007 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.

To determine our proposed payment rates for drugs and biologicals for CY 2007, we compared estimated aggregate expenditures for all drugs and biologicals (excluding radiopharmaceuticals) that would be separately payable in CY 2007 using data from both sources described above. We then used the OPPS proposed conversion factor to calculate weights for each separately payable drug and biological HCPCS code and developed an equivalent average ASP-based payment rate under both payment methodologies. The result of this analysis indicated that using mean unit cost to set the payment rates for the drugs and biologicals that would be separately payable in CY 2007 would be equivalent to basing payment rates for these drugs and biologicals, on average, at ASP+5 percent. We again stated that this payment rate was representative of both hospital acquisition costs and pharmacy handling costs, as this ASP-based rate was calculated using hospital charge data, and hospital charges are inclusive of both acquisition costs and pharmacy handling costs for the particular drug. Therefore, for CY 2007, we proposed a policy of paying for the acquisition and overhead costs of separately paid drugs and biologicals at a combined rate of ASP+5 percent.

We received several comments on our proposal to use these two data sources to calculate an average ASP-based payment rate for separately payable drugs and biologicals in the hospital outpatient department for CY 2007.

Comment: We received mixed comments about our proposal to continue to base OPPS payment rates for drugs and biologicals relative to the ASP methodology. A few commenters expressed their dissatisfaction with certain aspects of the ASP system, and as a result, our use of a payment rate relative to ASP. These commenters expressed concern that ASP rates reflect prompt pay discounts that hospitals do not experience, that the data represented by ASP reporting do not indicate hospital-specific prices, and that the inclusion of 340B prices skews ASP data because only a limited number of hospitals are eligible to receive these reduced prices. Other commenters who disagreed with our proposal to use the ASP methodology suggested that we conduct a survey to collect data on hospital acquisition costs and include factors such as size and type of hospital. However, other commenters expressed support of our continued use of the ASP-based methodology in the OPPS.

Response: We note that 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. In addition, we note that we received numerous supportive comments regarding our proposal to use ASP as the basis for hospital payments in the OPPS for CY 2006. At that time, commenters generally supported the use of ASP as a payment methodology because these rates are updated quarterly and are therefore more reflective of current market conditions that influence hospital purchasing prices than hospital claims data, and payment equity across the hospital and physician office settings offers administrative benefits and does not create a site-of-service difference. Furthermore, comparison of the ASP data to our hospital claims data serves to ensure that we are paying for drugs in the OPPS in general at rates that are reflective of hospitals costs for acquisition and overhead. For these reasons, we continue to believe that ASP is an appropriate proxy of the

average acquisition and pharmacy overhead costs for drug and biologicals administered in the hospital outpatient setting.

Comment: Several commenters also addressed our methodology for determining the specific ASP-based payment rate including acquisition costs and pharmacy handling costs for separately payable drugs and biologicals that would equate to payment of drugs and biologicals based on their mean costs from claims data. Some commenters were confused about how our methodology resulted in a proposed payment at ASP+5 percent for CY 2007, while others disagreed with our methodology to only include separately payable drugs and biologicals in our calculations. The commenters theorized that due to hospital charge compression, pharmacy overhead costs for inexpensive drugs that are typically packaged under the OPPS exhibit a higher pharmacy handling cost relative to their acquisition cost because hospitals disproportionately load their pharmacy overhead costs in their charges for less costly drugs. Therefore, while hospitals may attribute costs associated with pharmacy services across all drugs, the costs associated with a particular drug do not necessarily encompass that drug's total pharmacy handling costs. The commenters believed that this results in an inaccurate ASP-based estimate for drugs and biologicals in the OPPS, because these lower cost packaged drugs that have proportionately greater pharmacy overhead costs in their charges are not used in our calculation, which is based only on those drugs with per day costs greater than the $55 packaging threshold.

Response: We included a detailed explanation of the methodology we used to determine our proposed average CY 2007 ASP-based payment inclusive of acquisition and pharmacy handling costs in the proposed rule (71 FR 49584), and we again discussed this methodology relative to the CY 2007 final ratesetting process above. We began our analysis by identifying those drugs and biologicals that we have determined will receive separate payment in CY 2007. (See section V.B.2. of this final rule with comment period for a discussion of the methodology we used to determine the packaging status for drugs, biologicals, and radiopharmaceuticals for CY 2007.) We do not include packaged drugs and biologicals in this analysis because cost data for these items are already accounted for within the APC rates setting process through the methodology discussed in section II.A. of this preamble. To include the costs of packaged drugs in both our APC ratesetting process (for associated procedures present on the same claim) and during our ratesetting process to establish a relative ASP-based payment amount for drugs and biologicals would give this data disproportionate emphasis in the OPPS system by skewing our analyses, as the costs of these packaged items would be, in effect, counted twice. Once we determined our final CY 2007 packaging policy for drugs, biologicals, and radiopharmaceuticals at a packaging threshold of $55 or less per day, we included the costs of these packaged drugs and biologicals in the standard OPPS calculation of procedural APC median costs. Accordingly, we are not implementing the suggestion from commenters that we include all packaged and separately payable drugs and biologicals when establishing an average ASP-based rate to provide payment for the hospital acquisition and pharmacy handling costs of drugs and biologicals. However, we remind commenters that because the costs of packaged drugs, including their pharmacy overhead costs, are packaged into the payments for the procedures in which they are administered, the OPPS provides payment for both the drugs and the associated pharmacy overhead costs through the applicable procedural APC payments.

We noted that ASP data were unavailable for some drugs and biologicals at the time of the proposed rule, and some remain unavailable at the time of this final rule. For these drugs and biologicals, we proposed to use their mean unit costs from the CY 2005 hospital claims data to determine their packaging status for ratesetting. In addition, we proposed to base payment for these drugs and biologicals on their mean cost calculated from CY 2005 hospital claims data until ASP-based rates become available for these items.

Comment: One commenter requested that CMS use a drug's WAC or AWP data in order to determine an item's packaging status when ASP data are unavailable.

Response: We follow the established ASP methodology, and the ASP methodology incorporates several sources, such as WAC and AWP, as well as ASP data submitted by manufacturers. Additional information on the ASP methodology can be found at: *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp#TopOfPage.*

We noted in the proposed rule that we determine the packaging status of each drug or biological for the following year only once during the annual update process; however, those drugs and biologicals that we determine will be separately payable during the next calendar year will receive quarterly updates to their ASP-based payment rates, as is the current process in both the OPPS and physician office setting. We indicated that in CY 2007, we will continue to post these quarterly payment rate changes on our Web site.

During the March 2006 meeting of the APC Panel, the Panel recommended that CMS examine pharmacy overhead costs issues and work with appropriate associations to study how to measure pharmacy overhead costs. The Panel also recommended that CMS solicit feedback on how pharmacy overhead costs should be reimbursed in the future.

In the proposed rule, we responded to these recommendations by stating that we would continue to work on issues related to pharmacy overhead costs, and we specifically requested public comments on methodologies that could be used when considering pharmacy overhead cost issues in future years. We again note that we regularly accept requests from interested organizations to discuss their views about OPPS payment policy issues, including pharmacy handling issues. As stated in our CY 2007 OPPS proposed rule (71 FR 49585), we consider the input of any individual or organization to the extent allowed by Federal law, including the Administrative Procedure Act (APA) and the Federal Advisory Committee Act (FACA). In addition, we establish the OPPS rates through regulations, and as such 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.

The APC Panel recommended at its August 2006 meeting that CMS work with stakeholders to better understand the costs involved in the preparation of pharmaceutical agents for chemotherapy, and that CMS work to develop a new payment methodology that acknowledges and provides appropriate payment for those costs. The Panel requested a report on our findings at their next meeting. We will provide an update to the Panel on all the information that has been shared with us at their next meeting.

We received many comments in response to our request for information related to hospital outpatient department pharmacy overhead costs.

Comment: A number of commenters expressed dissatisfaction with the

amount of pharmacy handling costs represented in the methodology that resulted in an aggregate payment for drug acquisition and pharmacy handling costs at ASP+6 percent in CY 2006. The commenters noted increased pharmacy costs, such as unfunded mandates, increased staff training in order to handle complex drugs, and multiple demands on the time of pharmacists, including quality verification requirements and patient or physician consultations, that contribute to pharmacy handling costs that are above the amount represented by the ASP+6 methodology after subtracting drug acquisition costs. Several of these commenters expressed disappointment that CMS had not implemented an administratively simple methodology for collecting hospital pharmacy overhead cost data that could be used as the basis for providing additional payments for pharmacy handling costs.

Several commenters also expressed concern that the proposed payment of ASP+5 percent for CY 2007 would not be adequate to cover both the acquisition costs and pharmacy handling costs associated with drug services provided in a hospital outpatient department setting. One commenter suggested that CMS should, at a minimum, implement the two percent add-on payment that was discussed in the CY 2006 OPPS proposed rule. Others suggested various add-on payments, with amounts ranging from $10 for every billed drug, to inflating OPPS payment rates for separately payable drugs and biologicals to ASP+39 percent.

MedPAC expressed concern that our proposal to pay for drugs and biologicals at ASP+5 percent, a proportional payment methodology, could result in inaccurate payments for individual drugs because it does not effectively account for large differences in pharmacy overhead costs among drugs. MedPAC recommended that payment for pharmacy overhead costs should reflect methods recommended in their June 2005 Report to Congress to collect drugs into APC groups based on attributes that affect overhead costs and establish payment rates for the APCs based on hospital claims data. MedPAC encouraged us to revisit this issue and develop a method that recognizes and pays more specifically for the pharmacy overhead costs of different classes of drugs.

Response: We appreciate these comments and recognize the concerns that were expressed related to identifying and providing accurate payments for hospital outpatient department costs for pharmacy handling services. We understand that not every hospital will be able to acquire all drugs for the same price, and to that end, we use aggregate amounts when determining the average ASP-based amount that applies across all drugs. We also acknowledge that different types of drugs likely have very disparate pharmacy handling costs.

In the CY 2006 proposed rule, we proposed creating a set of HCPCS codes that hospitals would be able to use to indicate the relative resource levels of pharmacy handling involved in preparing a reported drug, biological, or radiopharmaceutical for administration. This methodology would have allowed us to begin collecting data on pharmacy overhead costs for possible use in future ratesetting calculations. We did not finalize this proposal for CY 2006 due to the overwhelming response from the hospital community citing the tremendous administrative burden reporting these pharmacy handling codes would have placed on hospital resources. Hospitals have now had 1 year to fully consider this proposal and it appears that there may be greater support for the creation of these pharmacy HCPCS codes, or another methodology to collect this data. We are reluctant to proceed with the implementation of our CY 2006 proposal until we are confident that there is not another feasible, less burdensome alternative or there is much broader support in the hospital community for this proposal. Therefore, we are not adopting this methodology for CY 2007. However, we again specifically request comments regarding hospital outpatient department pharmacy costs and request ideas and methodologies that we may consider for future data collection purposes under the OPPS.

As we stated in our discussion of the average ASP-based methodology in CY 2006, and as we have reiterated above, it is our understanding that pharmacy handling costs are included in hospital charges for drugs and biologicals. Therefore, we continue to believe that without more information regarding the specific required resources and their associated costs for providing hospital outpatient department pharmacy handling services associated with particular groups of drugs, it is not reasonable to provide differential, identifiable payments for pharmacy handling services that are separate from our payments for the average acquisition costs of drugs. We believe that generally our methodology of providing a single payment level for drug acquisition and pharmacy overhead costs provides, in aggregate, appropriate payment to hospitals for both types of costs. This averaging methodology is fully consistent with the principles of a prospective payment system like the OPPS.

Comment: One commenter suggested that CMS develop a survey for hospitals and instruct fiscal intermediaries to administer, collate, and transmit this data back to CMS where this information could then be used as the basis for an additional pharmacy add-on or separate APC payments for pharmacy services.

Response: We appreciate the commenter's suggestions for gathering information regarding pharmacy overhead costs. We are not sure, however, that it would be administratively feasible and reasonable from a resource perspective to develop and update information regarding pharmacy overhead costs through a hospital survey administered by fiscal intermediaries. We are also concerned that such a survey could be quite burdensome for hospitals. We will continue to work with the hospital industry to better understand the costs associated with pharmacy overhead and drug handling, and we welcome additional suggestions for alternative approaches to gathering cost information to inform our policy development.

Comment: One commenter requested that CMS convene an APC Panel meeting specific to the topics of pharmacy handling issues and charge compression.

Response: We appreciate the commenter's suggestion. However, at this time, we do not believe that a special meeting of the APC panel on pharmacy overhead costs is necessary, since the topic has been included on the agenda of several recent Panel meetings, and has been the subject of extended discussions in the course of these meetings. Furthermore, the APC Panel's 2004 charter specifically states that the issue of cost compression is outside of the scope of the Panel. Additional information on the purpose and scope of the APC Panel is available at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp.*

In its final report on the hospital acquisition cost survey of specified covered outpatient drugs entitled ''Medicare Hospital Pharmaceuticals: Survey Shows Price Variation and Highlights Data Collection Lessons and Outpatient Rate-Setting Challenges for CMS,'' the GAO recommended that the Secretary validate, on an occasional basis, manufacturers' reported drug ASPs as a measure of hospitals'

acquisition costs using a survey of hospitals or other method that CMS determines to be similarly accurate and efficient. As we indicated in our written comments to the GAO on its draft report, we will continue to consider the best approach for setting payment rates for drugs and biologicals in light of this recommendation. We also indicated that we would continue to analyze the adequacy of ASP-based pricing in light of our hospital claims data.

In its October 31, 2005 letter of comment on proposed 2006 SCOD rates titled ''Comments on Proposed 2006 SCOD Rates,'' the GAO recommended that in order to approximate hospitals' acquisition costs of SCODs better, the Secretary should reconsider the level of proposed payment rates for drug SCODs, in relation to survey data on average purchase price, the role of rebates in determining acquisition costs, and the desirability of setting payment rates for SCODs at average acquisition costs. In the CY 2006 OPPS proposed rule (70 FR 42726), we noted that the comparison between the GAO purchase price data and the ASP data indicated that the GAO data on average were equivalent to ASP+3 percent. For the CY 2006 OPPS final rule with comment period, we found that the comparison between the GAO purchase price data and the ASP data indicated that the GAO data on average were equivalent to ASP+4 percent, and using mean unit cost from hospital claims to set the payment rates for the drugs and biologicals that would be separately payable in CY 2006 would be equivalent to basing their payment rates, on average, at ASP+6 percent. Because pharmacy overhead costs are already built into the charges for drugs, biologicals, and radiopharmaceuticals, we noted in the CY 2006 OPPS final rule with comment period that our claims data indicated that payment for drugs and biologicals and their pharmacy overhead at a combined ASP+6 percent rate served as the best proxy for the combined acquisition and overhead costs of each of these products.

During the August meeting of the APC Panel, the Panel recommended that CMS maintain the payment rate for drugs and biologicals at ASP+6 percent in the hospital outpatient setting for CY 2007. We discuss our responses to these recommendations below.

We received a number of comments on our proposal to set the ASP-based payment for separately payable drugs and biologicals provided in CY 2007 in the hospital outpatient setting at ASP+5 percent.

Comment: The majority of comments we received regarding our CY 2007 OPPS payment policy for drugs and biologicals expressed concern over the proposed rate of ASP+5 percent. Most commenters requested that we continue the ASP+6 percent methodology, or increase the ASP-based payment amount for separately payable drugs and biologicals under the OPPS for CY 2007. The commenters stated that the proposed ASP-based rate of ASP+5 percent was inadequate, citing difficulties obtaining drugs at this price and challenges identifying the portion of payment that was to account for pharmacy handling costs associated with these items. In addition, several commenters expressed that a difference in payment rates for drugs and biologicals across the hospital outpatient and physician office settings may result in an unexpected site of service shift that may be problematic for beneficiaries.

The vast majority of commenters recommended that CMS retain the CY 2006 rate of ASP+6 percent for drugs, biologicals and their associated pharmacy handling costs for CY 2007.

Response: We appreciate these comments. In analyzing data for the CY 2007 final rule, we again performed the analysis described in the CY 2007 proposed rule 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 ASP-based average payment rate for drugs and biologicals provided in hospital outpatient departments for CY 2007. As we did for our final rule analysis to determine the final packaging status for each drug, we used updated CY 2005 hospital claims data, including updated CCRs and complete year CY 2005 mean unit costs and drug volumes. The result of our final analysis using updated hospital claims data for the full CY 2005 year and updated CCRs indicates that the ASP-based average payment rate for separately payable drugs and biologicals, including pharmacy handling costs, would be the equivalent of ASP+4 percent for CY 2007. Thus, if we were to follow the methodology that we employed for establishing the payment rate for drugs and biologicals under the OPPS in the CY 2006 final rule and the CY 2007 proposed rule, we would set the CY 2007 payment rate for these items at ASP+4 percent.

However, we have decided to accept the recommendation of the APC Panel and the recommendation of many commenters to continue to pay for the acquisition costs of separately payable drugs and biologicals and their associated pharmacy handling costs in the hospital outpatient department at a combined rate of ASP+6 percent for CY 2007. In addition, we are also finalizing our proposal to pay for separately payable drugs and biologicals without ASP-based data at their mean cost calculated from CY 2005 hospital claims data. We have adopted this final policy for CY 2007 for the reasons noted below. We continue to believe the MedPAC finding that pharmacy overhead costs are included in the hospital's charge for a drug, whether we treat the payment for the drug and its handling as packaged or separately payable. While our final rule analysis indicated an average ASP-based payment of ASP+4 percent, we note that this is the same relative ASP-based amount that was comparable to the GAO purchase price data for a subset of drugs reviewed in our CY 2006 final rule with comment period, which did not include pharmacy overhead costs. This factor furthered our conclusion that a final payment determination of ASP+6 percent was a reasonable level of payment for both the hospital acquisition and pharmacy overhead costs of drugs and biologicals in CY 2007. We further believe maintaining stability in the payment levels for drug and biologicals should be considered in light of the inherent complexity in determining how to best account for pharmacy overhead costs.

We also understand the commenters' concerns about providing appropriate OPPS payment for the costs of pharmacy overhead and drug handling, but believe a better understanding of the full nature and magnitude of hospitals costs related to these important activities is needed. Therefore, we will continue to work with the hospital industry to examine the difficult and complex issues concerning pharmacy overhead in the hospital outpatient department.

Therefore, for these reasons, we are not finalizing our proposal to pay for drugs and biologicals at ASP+5 percent. Instead, after carefully considering all comments and the recommendations of the APC Panel, we are accepting the Panel's recommendation to continue to pay for separately payable drugs, biologicals and their associated pharmacy handling in the hospital outpatient department for CY 2007 at a combined rate of ASP+6 percent to maintain the stability of our payments. We believe that this rate will ensure suitable payment for the hospital pharmacy overhead costs associated with drugs and biologicals, while we continue to work with the hospital industry to understand the complex

issues related to capturing and evaluating these overhead costs. Full consideration of the potential benefits and challenges associated with alternative OPPS payment methodologies for hospitals' pharmacy overhead and drug handling costs that are associated with administering drugs and biologicals in the hospital outpatient department is an important part of this ongoing work.

During the March 2006 meeting of the APC Panel, the Panel included several recommendations regarding intravenous immune globulin (IVIG) including: that CMS work with the Plasma Protein Therapeutics Association and other stakeholders to develop appropriate payments for IVIG; that CMS maintain separate payment for IVIG preadministration-related services as long as it remains appropriate, and that CMS reevaluate payments for IVIG administration, especially considering the resource intensity of IVIG infusions. Our responses to these recommendations are included in our discussion below.

Comment: Several commenters urged the continuation of the one-year temporary preadministration-related services fee for IVIG that we established for CY 2006. The commenters stated that there continue to be concerns with IVIG access and availability and that eliminating the fee will have an adverse impact on beneficiary access to care. Furthermore, some indicated that CMS provided little rationale in the proposed rule for why the fee was no longer needed.

A number of commenters expressed concerns about the adequacy of Medicare's drug and drug administration payment rates for IVIG, and made some suggestions for changes to these payment rates that they have previously expressed to us. For example, some urged CMS to take actions such as establishing separate HCPCS codes for each IVIG product, increasing payment for IVIG administration and instituting a payment adjustment to the ASP-based payment rates for IVIG.

One commenter provided information from a survey conducted of 800 patients with primary immune deficiency syndrome. The commenter, a patient advocacy group, stated that since the beginning of 2005, Medicare patients receiving IVIG have been more likely than patients with other types of insurance to report a shift in site of care, increased intervals between infusions, reduced IVIG dosages, and adverse health effects, and they believe that this is the result of Medicare reimbursement issues.

Response: We recognize the importance of IVIG to patients who need it, and we are concerned about reports of problems with IVIG access and availability. Since 2005, CMS has taken several specific actions that are within our statutory authority in response to the IVIG concerns that have been raised, including creating separate HCPCS codes to report lyophilized and non-lyophilized IVIG in April 2005, having discussions with manufacturers about their ASP data to confirm that their ASPs have been developed in accordance with applicable guidance, and for CY 2006 establishing a temporary additional payment for IVIG preadministration-related services to compensate physicians and hospital outpatient departments for extra resources expended on locating and obtaining appropriate IVIG products and on scheduling patients' infusions during a period where there may be temporary market instability. In addition, we continue to work with manufacturers, patient groups, and stakeholders to understand the present situation and to assess potential actions that could help ensure an adequate supply of IVIG and patients receiving appropriate, high quality care. We believe that these ongoing efforts will continue to assist us in developing future payment policies that continue to adapt to the IVIG marketplace. Therefore, we accept the Panel's recommendation to work with external stakeholders to develop appropriate payments for IVIG and related services.

As these efforts are ongoing, we do not believe that specific adjustments to the ASP-based payment rates for IVIG are appropriate or necessary at this time. We remain confident that our ASP data reflect current market pricing for all of the brands of IVIG, and that our CY 2007 final payment rates are appropriate for these therapies. Furthermore, there are currently two studies underway in the Department of Health and Human Services (HHS) concerning IVIG. The HHS Assistant Secretary for Planning and Evaluation has commissioned a study to better understand the market for IVIG and evaluate the demand, supply, and access to IVIG. The HHS Office of Inspector General is also conducting a study on availability and pricing of IVIG. We anticipate that these studies will provide more information on IVIG supply, demand, and pricing.

With several studies on IVIG not yet completed and with comments from stakeholders suggesting that some beneficiaries are experiencing IVIG access issues such as delayed treatments and site of service shifts, we believe it is appropriate to continue the temporary IVIG preadministration-related services payment into CY 2007 to help ensure continued patient access to IVIG. We will continue to review IVIG access during CY 2007 as additional information becomes available, and we will discontinue this temporary preadministration-related services payment during CY 2007 through rulemaking if we determine it is no longer warranted.

Therefore, after our assessment of the comments, we are also accepting the March 2006 recommendation of the APC Panel and the suggestion of several commenters to continue the IVIG preadministration-related services payment as long as it remains appropriate in CY 2007. Consequently, Medicare will temporarily allow a separate payment in CY 2007 for each day of IVIG administration to physicians and hospital outpatient departments that administer IVIG to Medicare beneficiaries. This payment is for the extra resources expended on locating and obtaining appropriate IVIG products and on scheduling patients' infusions during this time when there may continue to be transient disruptions in the marketplace. This preadministration-related service payment will continue to be billed under the same HCPCS code as CY 2006: G0332 (Preadministration-related services for intravenous infusion of immunoglobulin, per infusion encounter). We are continuing our CY 2006 placement of HCPCS code G0332 in New Technology APC 1502 (status indicator ''S'') with a payment rate of $75 at this time. The payment for preadministration-related services is in addition to the separate payments Medicare makes for the IVIG product itself and its administration.

We believe that continuation of this temporary separate payment provided through G0332 for the physician office and hospital outpatient resources associated with additional IVIG preadministration-related services will help facilitate beneficiary access to care in this current period where there may be continuing market fluctuations for IVIG products. At the same time, we will continue to work with the IVIG community, manufacturers, providers, and other stakeholders, and will be monitoring IVIG market developments and access to care closely.

Additionally, regarding comments requesting the establishment of brand-specific HCPCS codes for IVIG products, we again remind the commenters that Level II HCPCS codes describe categories of similar items. The code set is not intended to be an exhaustive listing of all brands on the market. In CY

2006, we stated that we do not see a compelling reason to override that standard; this conclusion also holds true for CY 2007. (For further discussion of HCPCS coding procedures, see *http://www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp*.)

Commenters expressed concern regarding OPPS payment for both IVIG drugs and their administration. Typically, IVIG administration requires a multiple hour infusion and frequent monitoring by qualified hospital staff. As discussed above, the APC Panel recommended that we reevaluate IVIG administration payments, taking into consideration the additional resources associated with this type of therapy. We accepted this APC Panel recommendation and reevaluated the IVIG administration payments, along with our general review of drug administration methodology. We believe that our final drug administration payment policy for CY 2007, as discussed in section VIII. of this final rule with comment period, will provide more accurate payments for extended infusions, including IVIG infusions.

Finally, we received several comments requesting that we classify IVIG therapy as a biological response modifier. We note that the term ''biological response modifier'' is used in the text preceding CY 2006 CPT codes, and as such, we refer commenters to the AMA CPT Editorial Panel, as they are the creators and maintainers of CPT codes and CPT code instructions.

In CY 2005, we applied an equitable adjustment to determine the payment rate for darbepoetin alfa (HCPCS code Q0137) pursuant to section 1833(t)(2)(E) of the Act. However, for CY 2006 we transitioned to ASP-based payment rates for OPPS drugs and biologicals and stated that it was our intent to permit market forces to determine the appropriate payment rate for this biological. We received a few comments on our proposal to continue with an ASP-based payment rate for this biological.

Comment: Commenters commended CMS on our decision to not exercise our equitable adjustment authority for any drug or biological in CY 2007.

Response: We appreciate the support of these commenters. As we discussed in CY 2006, we believe that as long as the market price for darbepoetin alfa is consistent with a payment rate derived using a clinically appropriate conversion ratio, invoking our equitable adjustment authority would not lead to a different result.

During CY 2006, we provided payment for blood clotting factors under the OPPS at ASP+6 percent and included payment for the furnishing fee that is also a part of the payment for blood clotting factors furnished in physician offices under Medicare Part B. In the CY 2006 OPPS final rule with comment period (70 FR 68661), we indicated that we would update the furnishing fee (based on the consumer price index) and the payment amount for this furnishing fee each calendar year so that the furnishing fee is equal to the amount noted in the MPFS final rule.

Comment: One commenter requested that CMS establish brand-specific HCPCS codes for each available sodium hyaluronate product. In addition, they requested that each brand-specific HCPCS code be assigned to an individual APC, with assigned APC payment rates based on product-specific ASP data. The commenter concluded that they believe that there is no scientific justification for the current three HCPCS code structure that assigns two products to individual HCPCS codes while other products are grouped together in a single HCPCS code.

Response: We appreciate this comment, and the National HCPCS Panel agreed that a reconfiguration of these codes was warranted. The National HCPCS Panel has examined the sodium hyaluronate codes referenced by this comment and has concluded that all sodium hyaluronate products will be reported in CY 2007 with the single HCPCS code J7319 (Hyaluronan (Sodium hyaluronate) or derivative, intra-articular injection, per injection). As we discuss in reference to pass-through drugs and biologicals in section V.A.3. of this final rule with comment period, it is our practice to adopt a national HCPCS code for reporting drugs when available, with the exception of certain pass-through drug situations. Therefore, for services furnished on or after January 1, 2007, hospitals are to use the single HCPCS code for sodium hyaluronate products, J7319, status indicator ''K,'' to report all sodium hyaluronate intra-articular injections provided in hospital outpatient departments.

As there is a single national HCPCS code, and there are no sodium hyaluronate products with pass-through status in CY 2007, this single HCPCS code will be assigned to a single APC for OPPS payment purposes. Therefore, for CY 2007, HCPCS code J7319 is assigned to APC 0896 (Sodium Hyaluronate Injection). We have calculated a reference October 2006 ASP-based payment rate for this single code at $124.68, as shown in Addenda A and B of this final rule with comment period.

In the CY 2007 OPPS, we proposed to continue our CY 2006 policy of providing payment for blood clotting factors at a rate of ASP+5 percent plus an additional furnishing fee.

We received four comments on our proposal regarding blood clotting factors.

Comment: All commenters commended us on proposing to continue to pay the furnishing fee and urged us to continue providing payment for blood clotting factors under the OPPS at a rate equal to ASP+6 in CY 2007.

Three of these commenters additionally expressed concern that the proposed ASP-based rate for blood clotting factors would also be applied to the inpatient hospital setting. These commenters requested that if payment rates were adjusted in the outpatient setting that we not apply these rates to the inpatient hospital setting as well.

Response: We appreciate these comments. As we proposed an ASP-based payment rate for CY 2007 of ASP+5 percent for separately payable drugs, biologicals and blood clotting factors in CY 2007, and we have since finalized a payment rate of ASP+6 percent for separately payable drugs and biologicals in this final rule, we are taking this opportunity to finalize a payment rate for separately payable blood clotting factors in the outpatient setting at ASP+6 percent plus the updated CY 2007 furnishing fee of $0.15. Issues concerning inpatient hospital rates are outside the scope of this final rule with comment period, and we refer the commenters to the annual IPPS rulemaking process to note these concerns.

(3) CY 2007 Payment Policy for Radiopharmaceuticals

(a) Background and Proposed CY 2007 Radiopharmaceutical Payment Policy

Section 303(h) of Public Law 108–173 exempted radiopharmaceuticals from ASP pricing in the physician office setting. In both the CY 2005 and CY 2006 OPPS final rules with comment period, the OPPS exempted radiopharmaceutical manufacturers from reporting ASP data for payment purposes under the OPPS for reasons discussed in those rules (69 FR 65811 and 70 FR 68655, respectively). Consequently, we did not have ASP data for radiopharmaceuticals for consideration for CY 2007 ratesetting in the OPPS.

Pursuant to section 1833(t)(14)(B)(i)(I) of the Act, radiopharmaceuticals are classified under the OPPS as specified covered outpatient drugs (SCODs).

Accordingly, payments for radiopharmaceuticals are to be made at average acquisition cost as determined by the Secretary and subject to any adjustment for overhead costs. Radiopharmaceuticals are also subject to the policies affecting all similarly classified OPPS drugs and biologicals, such as pass-through payments and packaging determinations, as discussed earlier in this final rule with comment period.

For CY 2006, we used CY 2004 mean unit cost data from hospital claims to determine each items' packaging status, and we implemented a 1-year 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 cost-to-charge ratio. This temporary methodology was finalized as an interim proxy for average acquisition cost because of the unique circumstances associated with providing radiopharmaceutical products to Medicare beneficiaries. We clearly stated in the CY 2006 OPPS final rule with comment period that we did not intend to maintain the CY 2006 methodology permanently (70 FR 68656), and that we would actively seek other methodologies for setting payments for radiopharmaceuticals in CY 2007.

In the CY 2006 final rule, we also discussed the various data sources available to us, as well as the challenges associated with developing an acceptable mechanism to identify average costs for radiopharmaceutical products. In addition, we stated that we agreed with MedPAC's assessment that hospitals include associated preparation and handling costs in their charges for the radiopharmaceutical. We strongly encouraged hospitals and the radiopharmaceutical community to assist us as we began developing a viable long-term prospective payment methodology for these products under OPPS.

During the March 2006 meeting of the APC Panel, the Panel recommended that CMS work with stakeholders to continue to develop a methodology to pay for radiopharmaceuticals. While Federal law, including the Administrative Procedure Act (APA) and the Federal Advisory Committee Act (FACA), govern the forum by which we receive input of stakeholders, we have met with interested organizations to discuss the numerous complexities associated with developing radiopharmaceutical payments under the OPPS, and in the CY 2007 OPPS proposed rule, we again invited comment and feedback on how we may be able to improve on our methodology in future years. We note that we received relatively little feedback in response to our CY 2006 requests for comments on methodologies we could consider during the development of a methodology for radiopharmaceutical payments in the hospital outpatient setting in preparation for the CY 2007 proposed rule. We again specifically invite feedback on this issue and request comments for our consideration during the development of our proposal for CY 2008 radiopharmaceutical payments.

We considered a number of alternative methodologies for radiopharmaceutical payment policy under the OPPS in CY 2007. One of the options we considered for CY 2007 (71 FR 49587) was to package additional radiopharmaceuticals, either through increasing the packaging threshold for radiopharmaceuticals from a cost of $55 per day to a higher amount or through a policy that would package payments for all radiopharmaceuticals with payments for the services with which they are reported. All nuclear medicine procedures require the use of at least one radiopharmaceutical, and while many separately payable drugs may share the same drug administration HCPCS code, there are only a few radiopharmaceuticals that may be appropriately billed with the same nuclear medicine procedure. A policy to package additional radiopharmaceuticals would be consistent with OPPS packaging principles and would provide greater administrative simplicity for hospitals. We noted that while examining CY 2005 hospital claims data, we identified a significant number of nuclear medicine procedure claims that were missing HCPCS codes for the associated radiopharmaceutical. We believed that there could be two reasons for the presence of these claims in the data. One reason could be that the radiopharmaceutical used for the procedure was packaged under the OPPS and therefore would not be billed on the claim with a HCPCS code and an associated charge. The second reason could be that the hospitals may have incorporated the costs of the radiopharmaceutical into their charges for these nuclear medicine procedures. We did not propose this methodology for CY 2007 because we were concerned that payments for certain nuclear medicine procedures could potentially be less than the costs of some of the packaged radiopharmaceuticals, and that relatively expensive and high volume radiopharmaceuticals could become packaged. At the same time, we also note the GAO's comment in reference to the CY 2006 OPPS proposed rule that 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 as there may be more than one radiopharmaceutical that may be used for one particular procedure. We were also concerned that with such divergent outcomes, this payment policy could provoke a treatment decision that may not reflect the most clinically appropriate radiopharmaceutical for a particular nuclear medicine procedure. We also considered maintaining the CY 2006 policy of paying for radiopharmaceuticals at charges converted to cost.

For CY 2007, our proposed methodology included a packaging threshold equal to that of other drugs and biologicals proposed for CY 2007 and established prospective payment rates for separately payable radiopharmaceuticals using mean costs derived from the CY 2005 claims data, where the costs were 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 were unavailable. This proposed payment methodology included both the acquisition and pharmacy handling costs of radiopharmaceuticals determined to be separately payable for CY 2007. As we have noted previously, we agree with the MedPAC finding that hospitals include overhead costs in their charges for the associated radiopharmaceutical. We believe this methodology provides for an appropriate proxy for the average acquisition cost of the radiopharmaceutical along with its handling cost. We noted that this proposed methodology would be an appropriate long-term radiopharmaceutical payment policy that would allow us to consistently establish prospective OPPS payment rates for the acquisition and overhead costs of separately payable radiopharmaceuticals. We also proposed to update the packaging threshold consistent with the methodology discussed above.

We noted in the proposed rule that the National HCPCS Panel implemented changes to many radiopharmaceutical codes and their descriptors effective January 1, 2006. In some instances, these changes were relatively minor; in

others, code descriptors changed from ''per unit'' to ''per study dose.'' The hospital claims data used for our proposed rule included radiopharmaceutical HCPCS codes that were in effect during CY 2005. Because there were significant changes in HCPCS code descriptors for several radiopharmaceuticals from CY 2005 to CY 2006, implementation of the proposed payment methodology for radiopharmaceuticals required us to propose a crosswalk to map the CY 2005 hospital claims data to updated CY 2006 codes that we expected to be in effect during CY 2007. Out of the 39 radiopharmaceutical HCPCS codes that we proposed to pay separately for in CY 2007, we were able to directly crosswalk the CY 2005 cost data to 31 of these codes. The descriptors for the remaining eight codes changed from per unit of radioactivity in CY 2005 to new descriptors based on per study doses in CY 2006. Therefore, we proposed to use the per day costs based on the CY 2005 claims data as proxies for the per study dose costs for this subset of radiopharmaceutical HCPCS codes to be reported in CY 2007. (We refer readers to the CY 2007 proposed rule for a more detailed description of our proposed crosswalk methodology.)

We also noted in the proposed rule that there were three cases where two CY 2005 HCPCS codes were mapped to the same new CY 2006 HCPCS code that would be reported in CY 2007. These three CY 2006 HCPCS codes were A9550 (Tc99m gluceptate), A9553 (Cr51 chromate), and A9559 (Co57 cyano). Because of the complicated nature of crosswalking the cost data for two predecessor HCPCS codes with different units in their descriptors to each of these new HCPCS codes, we proposed to crosswalk the cost data only from the predecessor HCPCS codes with the most claims volume in CY 2005 to each of these three HCPCS codes to be used for CY 2007 ratesetting purposes.

Table 26 of the CY 2007 proposed rule (71 FR 49589) listed all of the CY 2007 separately payable radiopharmaceuticals and the predecessor HCPCS codes whose claims data were used to set the CY 2007 proposed payment rates and noted the crosswalk methodology used for the proposed rates.

(b) CY 2007 Final Radiopharmaceutical Payment Policy

During the August 2006 meeting of the APC Panel, the Panel recommended that CMS continue the 1-year temporary policy of paying for radiopharmaceuticals at charges reduced to cost, using the overall hospital CCR. In addition, the Panel recommended that we consider using external data to evaluate the proposed payment rate for HCPCS code A9600 (Sr89 strontium) because of concerns about hospital miscoding of this radiopharmaceutical. We include our responses to these Panel recommendations in the discussion presented below.

In addition to these Panel recommendations, we received many comments on our proposed payment methodology for radiopharmaceuticals in CY 2007.

Comment: Several commenters supported our proposal to establish a prospective payment methodology for radiopharmaceuticals, but noted that, prior to the CY 2006 final rule with comment period, many hospitals were unaware that charges for the preparation and handling should be included in the charge for the associated radiopharmaceutical. Therefore, these commenters claimed that the CY 2005 data used to establish proposed mean-based payment rates for CY 2007 are inaccurate. In addition, commenters noted that several radiopharmaceutical HCPCS codes were updated in CY 2006 to standardize hospital coding for radiopharmaceuticals, and that CY 2005 data are unreliable because hospitals were not using the CY 2005 radiopharmaceutical HCPCS codes uniformly. Other commenters noted that using a methodology that incorporates a departmental CCR is not appropriate for radiopharmaceuticals because the unique costs associated with radiopharmaceuticals are not properly accounted for within any department. For these reasons, commenters requested that CMS extend the temporary CY 2006 methodology of paying for separately payable radiopharmaceuticals at charges reduced to cost, where payment is determined using each hospital's overall CCR.

Response: We understand the commenters' concerns regarding the data that are represented in the CY 2005 hospital claims, especially in light of the reports of confusion resulting from coding changes. We also acknowledge that the preparation and handling costs associated with administering radiopharmaceuticals are significant and should be fully captured in claims data used to establish prospective payments rates. At this time, we believe that there is sufficient reason to extend the temporary policy of paying for radiopharmaceuticals at charges reduced to cost for one additional year as the best proxy for radiopharmaceutical acquisition and overhead costs, consistent with the August 2006 recommendation of the APC Panel. Although we do believe that the costs unique to radiopharmaceuticals are recognized in several departmental cost-to-charge ratios, similar to the costs of many other items and services paid prospectively under the OPPS, consistent with the CY 2006 methodology, we will again calculate payment using each hospital's overall cost-to-charge ratio in CY 2007. As stated in the CY 2006 final rule, we believe that using hospitals' overall CCRs to determine payments could result in an overstatement of radiopharmaceutical costs, which are likely reported in several cost centers such as diagnostic radiology that have lower CCRs than hospitals' overall CCRs. We note that it is still our intention to move toward a prospective payment methodology for radiopharmaceuticals in the OPPS, and that we generally employ departmental CCRs in setting payment rates for most items and services that are paid separately in the OPPS. We expect that for the CY 2008 OPPS update, hospitals will have adapted to the CY 2006 coding changes and responded to our instructions to include their charges for radiopharmaceutical handling in their charges for the radiopharmaceutical products. We anticipate, as do our commenters, that our CY 2006 claims data should be much more comprehensive and accurate in reflecting the full hospital costs for radiopharmaceutical products and their overhead. Because of the coding changes for CY 2006 to simplify radiopharmaceutical reporting, hospital data from that time should also reflect more consistent and correct coding because the HCPCS code units for reporting have been aligned with the clinical uses of the radiopharmaceuticals.

Comment: One commenter suggested that CMS require ASP reporting for radioimmunotherapy radiopharmaceutical manufacturers. The commenter suggested that this data could be used in conjunction with a new HCPCS code for compounding services related to these radiopharmaceuticals. The commenter suggested that CMS assign the compounding HCPCS code to its own APC and set the payment rate between $2,000 and $3,000.

Response: We appreciate these comments, but we do not believe that the complex issues relating to the collection of ASP data for radiopharmaceuticals, as discussed at length in the CY 2006 OPPS final rule with comment period (70 FR 68655),

have been resolved. Therefore, we believe that implementation of the collection of ASP data for these products remains premature. However, we will consider this comment during the development of future updates to the OPPS.

Comment: One commenter requested that CMS instruct hospitals to include radiopharmaceutical handling costs in the charge for the associated nuclear medicine procedure.

Response: We appreciate this comment. However, we believe that hospitals appropriately include these handling charges in their charges for drugs, biologicals, and radiopharmaceuticals. As such, we believe that these costs are already being captured through hospital charges for these items, which require preparation and handling for their administration. In addition, for hospitals that were not clear where these handling costs should be represented on a claim, we provided specific instructions in the CY 2006 final rule with comment period (70 FR 68654). As we stated for CY 2006, and reiterate here for CY 2007, it is appropriate for hospitals to set charges for radiopharmaceuticals based on all costs associated with the acquisition, preparation, and handling of these products so that their payments under the OPPS can accurately reflect all of the actual costs associated with providing these products to hospital outpatients. If necessary, we believe that hospitals can appropriately adjust their charges for radiopharmaceuticals so that the calculated costs from applying hospitals' overall CCRs to radiopharmaceutical charges on claims properly reflect their actual costs. We do not believe it is appropriate to provide different instructions in this final rule with comment period, when we have many comments reflecting hospitals' efforts to respond to our CY 2006 instruction.

We received a few comments that included specific suggestions for consideration during the future development of our proposed CY 2008 radiopharmaceutical payment policy.

Comment: Commenters suggested that CMS consider establishing a buffering mechanism when radiopharmaceuticals are transitioned to a prospective payment methodology; that we continue to use the overall hospital CCR to calculate costs, regardless of any future radiopharmaceutical payment methodology; that we consider a unique data trimming methodology for radiopharmaceuticals; and that we consider using the PPI as a basis for annual radiopharmaceutical payment updates.

Response: We appreciate these comments, and we continue to encourage comments and suggestions on methodologies we may consider during the development of our CY 2008 proposed radiopharmaceutical payment policy.

We also received several comments on the amount of pharmacy handling involved with compounding radiopharmaceuticals and preparing them for administration.

Comment: Commenters proposed several methodologies for implementation in the OPPS to provide additional payment for radiopharmaceutical pharmacy handling costs. Additional payments are warranted, commenters noted, because radiopharmaceutical products require substantial preparation and handling prior to administration, and these services are unique to radiopharmaceuticals. In addition, commenters cite concerns regarding the effects of charge compression for these high cost items with substantially higher pharmacy handling costs (see section V.B.III.a.2. of this preamble for additional discussion on the issue of charge compression). Commenters included suggestions ranging from inflating proposed payment amounts to providing a fixed add-on payment amount.

Response: As we noted in the CY 2006 final rule with comment period (70 FR 68654), we believe that hospitals have the ability to set charges for items properly so that charges converted to costs can appropriately account fully for their acquisition and overhead costs. As noted previously, commenters urged us to delay implementation of our proposed CY 2007 radiopharmaceutical payment methodology based on CY 2005 mean unit costs calculated from hospital claims data because, they claimed, hospitals had only begun including associated overhead charges in response to our CY 2006 final rule, and these preparation and handling costs were not included in the CY 2005 claims data. As we are continuing our CY 2006 methodology of paying for radiopharmaceuticals at a hospital's charges for the radiopharmaceutical reduced to costs, based upon the hospital's overall CCR, we do not believe that an additional payment specific to overhead costs for radiopharmaceutical products is warranted at this time.

Therefore, for CY 2007, we have concluded that our final payment methodology provides an acceptable proxy for the average acquisition cost of the radiopharmaceutical along with its handling cost. In addition, we believe that this final payment policy addresses the concerns of the APC Panel regarding HCPCS code A9500. Therefore, we are accepting this Panel recommendation and we have applied the packaging methodology for radiopharmaceuticals, as described above, and determined that HCPCS code A9500 will be separately payable in the OPPS in CY 2007. As such, payment will be at a hospital's charge for the radiopharmaceutical reduced to cost, using the overall hospital CCR. We again reiterate our intent to develop a suitable prospective payment methodology for radiopharmaceutical products paid under the OPPS in future years, beginning in CY 2008. We generally do not make payments under the OPPS for items and services at cost, particularly if we do not expect the costs of the services to vary substantially and unpredictably over time and if we have hospital claims data available. Paying for radiopharmaceuticals at cost provides hospitals with no incentive to supply radiopharmaceuticals in the most efficient manner. However, we are encouraged by recent reports of ongoing discussions within the radiopharmaceutical community to develop a viable, ongoing methodology for OPPS radiopharmaceutical ratesetting and recent meetings with members of the radiopharmaceutical community. We again specifically solicit comments on alternative methodologies and data sources that may be used to set radiopharmaceutical payment rates in the OPPS.

While payments for drugs, biologicals and radiopharmaceuticals are taken into account when calculating budget neutrality, we proposed to make payments for drugs, biologicals, and radiopharmaceuticals without scaling these payment amounts. Section 1833(t)(14)(A)(iii)(I) requires that, beginning in CY 2006, we pay for a separately payable drug on the basis of ''the average acquisition cost of the drug.'' As we stated in the CY 2006 OPPS final rule with comment period (70 FR 42728), we believe that the best interpretation of the specific requirement that we pay for such drugs on the basis of average acquisition cost is that these payments themselves should not be adjusted as part of meeting the statutory budget neutrality requirement. If we were to apply a budget neutrality scalar to these payments, we would no longer be paying the average acquisition cost, but rather an adjusted average acquisition cost for separately payable drugs, biologicals, and radiopharmaceuticals. We believe that these amounts, without

a budget neutrality scalar applied, are the best proxies we have for the aggregate average acquisition and pharmacy overhead and handling costs of drugs, biologicals, and radiopharmaceuticals.

Comment: A few commenters requested the implementation of edits similar to procedure to device edits that would require hospitals to include a radiopharmaceutical HCPCS code whenever a nuclear medicine procedure is billed.

Response: We understand that coding accurately for the variety of services provided across a hospital setting can be challenging, as can be keeping current on changes to codes, modifiers and updated billing instructions. However, we do not believe that the appropriate solution to complex billing is the implementation of edits for a large number of services. As discussed above, during our review of claims for the CY 2007 ratesetting process we identified a large number of claims without associated radiopharmaceuticals reported with nuclear medicine procedures. We believe that this may be due to hospitals using packaged radiopharmaceuticals, or because hospitals have already packaged the costs of the associated radiopharmaceutical into the cost of the nuclear medicine procedure. If this is the case, we do not believe that implementing procedure to radiopharmaceutical edits would be an appropriate mechanism for us to use in order to get additional data for radiopharmaceutical products. We do not mandate hospital charging practices for specific items, and implementing edits would be contrary to our general concept of encouraging hospitals to develop their charges, revenue centers and internal practices as they find appropriate. In addition, edits do not necessarily ensure quality data. Most importantly, we generally implement edits to ensure that high cost items with packaged payment are reported on appropriate claims, so that the procedural payment rates fully incorporate the costs of these items that are required for the procedures. We have no need to edit for the presence of radiopharmaceutical HCPCS codes on claims for nuclear medicine procedures when we will be paying separately in CY 2007 for all radiopharmaceuticals with per day costs greater than $55. Therefore, we are not accepting this commenter's proposal to implement procedure to radiopharmaceutical edits at this time.

Comment: The manufacturer of a radiopharmaceutical product stated that HCPCS codes A9500 (Tc99m sestamibi) and A9502 (Tc99m tetrofosmin) are comparable in terms of safety and efficacy, and as such, there should be no difference in OPPS payment rates. It suggested that factors such as manufacturer rebates and incomplete hospital reporting may have contributed to inaccurate CY 2005 claims data. It suggested that the payment rates for these products be averaged and that the resulting rate be used for both products.

Response: We believe the concerns expressed by this commenter are no longer applicable in light of the finalized payment methodology for radiopharmaceutical products in CY 2007 discussed above.

b. CY 2007 Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without OPPS Hospital Claims Data

(1) Background

Pub. L. 108–173 does not address the OPPS payment in CY 2005 and after for new 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 and 2006, 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 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. Therefore, we developed our proposed CY 2007 payment methodologies for drugs, biologicals, and radiopharmaceuticals with HCPCS codes but without OPPS hospital claims data in line with our payment methodologies for newly established HCPCS codes that are granted pass-through status under the OPPS. (Section V.A. of this final rule with comment period provides additional details on our final policies for CY 2007 pass-through drugs, biologicals, and radiopharmaceuticals.) In Addendum B of the CY 2007 proposed rule, we assigned status indicator ''K'' to these new CY 2007 HCPCS codes for drug, biological, and radiopharmaceutical items without pass-through status.

(2) CY 2007 Proposed and Final Payment Policy for Radiopharmaceuticals With HCPCS Codes, But Without OPPS Hospital Claims Data

In section V.B.3.a.(3) of this final rule with comment period, we discuss our proposed methodology to base payment rates for radiopharmaceuticals with CY 2005 hospital claims data at their mean costs for CY 2007. We also proposed to use WAC as a basis for ratesetting for new radiopharmaceuticals without hospital claims data that have been assigned HCPCS codes as of January 1, 2007, without regard to their pass-through status. If WAC data were unavailable, we proposed to use 95 percent of the most recent AWP, and to implement payment rate adjustments resulting from the quarterly update process accordingly.

We received numerous comments on our proposed payment methodologies for radiopharmaceutical products, and one comment specific to HCPCS code A9567 (Technetium TC–99m aerosol).

Comment: One commenter objected to our proposed packaged status for HCPCS code A9567. The commenter recommended that in the absence of data providing payment information, we assign HCPCS code A9567 status indicator ''H'' and provide payment in CY 2007 at charges reduced to cost.

In addition, other commenters remarking on our proposed radiopharmaceutical policies requested that we continue our CY 2006 payment methodology for separately payable radiopharmaceuticals (see section V.B.3.a.(3) of this preamble). That is, commenters requested that we continue to pay for radiopharmaceuticals at the hospital's charge for the radiopharmaceutical adjusted to the cost, using the hospital's overall CCR.

Response: We believe it is appropriate to align our payment methodologies, whenever possible, within the OPPS. Therefore, for CY 2007, we are finalizing our payment policy for nonpass-through radiopharmaceuticals without hospital claims data that have been assigned

HCPCS codes as of January 1, 2007, as follows: For CY 2007, hospitals will receive payment for nonpass-through radiopharmaceuticals without hospital claims data that have been assigned HCPCS codes as of January 1, 2007, at the hospital's charge for the radiopharmaceutical adjusted to cost, using the hospital's overall cost-to-charge ratio. This methodology will provide payment for nonpass-through radiopharmaceuticals using the same payment methodology that we have finalized for pass-through radiopharmaceuticals in CY 2007, as discussed in section V.B.3.a.(3) of this final rule with comment period. As we discuss above, we are aware that due to the additional costs associated with new radiopharmaceuticals that a decision to package these items may affect beneficiary access. Therefore, when we are unable to determine the appropriate packaging status (as outlined in section V.B.2. of this preamble) for a radiopharmaceutical in CY 2007 due to the lack of hospital claims data, we are finalizing a policy to provide payment for these items at the hospital's charge for the radiopharmaceutical adjusted to cost, using the hospital's overall CCR.

(3) CY 2007 Proposed and Final Payment Policy for Drugs and Biologicals With HCPCS Codes, But Without OPPS Hospital Claims Data

(a) New Drugs Without Hospital Claims Data

For CY 2007, we proposed to continue payment for new drugs and biologicals with HCPCS codes as of January 1, 2007, but without pass-through status, at a rate that is equivalent to the payment they would receive in the physician office setting, unless the drug or biological was also covered under the Part B drug CAP. If the drug or biological was covered under the Part B drug CAP, then we proposed to set the OPPS rate equal to the Part B drug CAP rate. If not, then we proposed to set the OPPS payment rate at a rate equal to the payment rate established in accordance with the ASP methodology described in the CY 2006 MPFS final rule, where payment will generally be equal to ASP+6 percent. Additional information on the ASP methodology can be found at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp#TopOfPage.*

In the rare circumstance that a drug does not have a Part B drug CAP rate or data available for use for the ASP methodology, we proposed to make payment at 95 percent of the product's most recent AWP in order to be consistent with how we pay for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes, as discussed in the CY 2006 OPPS final rule with comment period (70 FR 68669). We noted in our proposal that it was our intent to adjust payment rates through the quarterly update process for items paid under a methodology other than ASP once ASP data became available and to make appropriate adjustments to the payment rates for new drugs and biologicals in the event that they become covered under the Part B drug CAP in the future.

Table 26 below lists the new CY 2007 HCPCS codes for drugs, biologicals, and radiopharmaceuticals that were not available during development of the proposed rule. In addition, we note that these codes are included in Addendum B this final rule with comment period and are identified with comment indicator ''NI.''.

TABLE 26.—CY 2007 HCPCS CODES WITHOUT OPPS CLAIMS DATA AND WITHOUT PASS-THROUGH STATUS

HCPCS code	Short description	CY 2007 SI	CY 2007 APC
C9234	Inj, alglucosidase alfa	K	9234
C9235	Injection, panitumumab	K	9235
J0364	Apomorphine hydrochloride	K	0766
J1324	Enfuvirtide injection	K	0767
J1562	Immune globulin subcutaneous	K	0804
J2170	Mecasermin injection	K	0805
J2315	Naltrexone, depot form	K	0759
J8650	Nabilone oral	K	0808
J9261	Nelarabine injection	K	0825

(b) Established Drugs Without Hospital Claims Data

As we discussed in the CY 2007 proposed rule, there are several drugs, biologicals, and radiopharmaceuticals which are not new for CY 2007, but for which we do not have CY 2005 hospital claims data. In order to determine the packaging status of these items for the CY 2007 proposed rule, we estimated the per day cost of each item by multiplying the proposed payment rate of ASP+5 for each product by an estimated average number of units typically furnished to a patient during one administration in the hospital outpatient setting. We included our estimated average number of units in Table 27 of the CY 2007 OPPS proposed rule (71 FR 49595).

We proposed to use the same CY 2007 packaging methodology as was proposed for other drugs, biologicals, and radiopharmaceuticals. Specifically, we proposed that items with a per administration cost of less than or equal to $55 would be packaged and items with an estimated per administration cost greater than $55 would receive separate payment at a proposed rate of ASP+5 percent, using the ASP methodology, subject to adjustments as updates became available through the quarterly process. As we discussed in the proposed rule, we used the most recent data available at the time of the proposed rule to determine both the packaging status and payment rates for these drugs. We update these rates and reevaluate our proposed status indicators and payment rates for the final rule, as is the process for all other drugs, biologicals, and radiopharmaceuticals.

We specifically requested comments on our proposed payment policies for drugs and biologicals with HCPCS codes but without hospital claims data that do not have pass-through status as of January 1, 2007.

We received one comment specific to our packaging determination for HCPCS code J2805 (Sincalide injection) as a result of our proposal.

Comment: One commenter objected to our proposed packaging determination for HCPCS code J2805. This commenter stated that in absence of data, codes should not automatically be packaged; rather, J2805 should be assigned status indicator ''K'' with a payment rate at ASP+6 percent for CY 2007.

Response: As we noted in the CY 2007 proposed rule, we have an ASP-based amount for HCPCS code J2805, however we do not have CY 2005 hospital claims data available. Therefore, in absence of aggregate totals for the number of units and the number of days this code was billed on hospital claims in CY 2005, we estimated an average number of units that would be clinically appropriate for one administration of this drug to a typical hospital outpatient. Our estimate was included in Table 27 of the OPPS proposed rule (70 FR 49595). In order to determine the packaging status of this drug, we multiplied the ASP-based payment rate by our estimated number of units per administration. We proposed to package HCPCS code J2805 because its cost per administration was below our proposed packaging threshold. The final packaging determination for CY 2007 for this code can be found in Table 27.

In addition to this code-specific comment, we believe that the general comments received regarding our proposed packaging methodology and the comments received regarding our proposed payment rate of ASP+5 for nonpass-through drugs and biologicals also apply to this group of drugs with HCPCS codes but without CY 2005 hospital claims data and without pass-through status. (For a discussion of the comments and our responses to these issues, see sections V.B.2. and V.B.3. of this final rule with comment period.) For the reasons cited in sections V.B.2. and V.B.3. of this final rule with comment period, and because we believe it is appropriate to align our payment methodologies whenever possible within the OPPS, we are finalizing our policy for drugs and biologicals that have HCPCS codes but do not have pass-through status, and those that also do not have CY 2005 hospital claims data as follows: Packaging status will be determined using the threshold finalized in section V.B.2. of this final rule with comment period. That is, for CY 2007, items with a per administration cost of less than or equal to $55 would be packaged and items with an estimated per administration cost greater than $55 would receive separate payment. Estimating the per day costs for each item will be determined by multiplying the final payment rate (described in section V.B.3. of this final rule with comment period) for each product by the estimated average number of units typically furnished to a patient during one administration in the hospital outpatient setting as published in Table 27 of the proposed rule (71 FR 49595). For those drugs and biologicals that have been classified as separately payable using this final methodology, payment will be determined using the methodology finalized in section V.B.3. of this final rule with comment period. Therefore, drugs that have been identified as separately payable in CY 2007 will be paid under the ASP-based methodology at a rate of ASP+6 percent, and will be subject to adjustments through the quarterly update process.

Table 27 below shows our final determinations using the methodology finalized above for drugs and biologicals that do not have CY 2005 hospital claims data and are not new for CY 2007. We note that since the time of the proposed rule, we have received claims data for two codes that were previously listed in Table 27 of the proposed rule. These codes are J0200 (Alatrofloxacin mesylate) and J0288 (Ampho b cholesteryl sulfate). Accordingly, these codes have been removed from the table and their packaging and payment rates determined under our final OPPS policy as noted in section V.B.1. of this final rule with comment period.

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Table 27.--Drugs and Biologicals Without CY 2005 Claims Data

HCPCS Code	Description	ASP-based payment rate	Estimated average number of units per administration	CY 2007 final SI	CY 2007 final APC
90714	Td vaccine no prsrv >/= 7 im	$18.78	1	N	
90727	Plague vaccine, im	$150.00	1	K	0744
A9535	Injection, methylene blue	$4.78	10	N	
J0132	Acetylcysteine injection	$1.94	210	K	1680
J0278	Amikacin sulfate injection	$1.21	5.25	N	
J0350	Injection anistreplase 30 u	$2,268.46	1	K	1606
J0395	Arbutamine HCl injection	$160.00	1	K	9031
J1452	Intraocular Fomivirsen na	$212.00	1	K	9040
J2425	Palifermin injection	$11.43	84	K	1696
J2805	Sincalide injection	$52.08	1	N	
J2850	Inj secretin synthetic human	$20.31	14	K	1700
J3355	Urofollitropin, 75 iu	$49.35	2	K	1741
J3471	Ovine, up to 999 USP units	$0.11	150	N	
J3472	Ovine, 1000 USP units	$137.43	1	K	1703
J7341	Non-human, metabolic tissue	$1.78	50	K	1707
J8540	Oral dexamethasone	$0.25	80	N	
J9225	Histrelin implant	$1,741.71	1	K	1711
Q9958	HOCM <=149 mg/ml iodine, 1ml	$0.08	100	N	
Q9959	HOCM 150-199mg/ml iodine,1ml	$0.08	100	N	
Q9960	HOCM 200-249mg/ml iodine,1ml	$0.10	100	N	
Q9961	HOCM 250-299mg/ml iodine,1ml	$0.25	100	N	
Q9962	HOCM 300-349mg/ml iodine,1ml	$0.13	100	N	
Q9963	HOCM 350-399mg/ml iodine,1ml	$0.33	100	N	
Q9964	HOCM>= 400mg/ml iodine, 1ml	$0.19	100	N	

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In addition, we note that HCPCS codes Q9945-Q9954 for low osmolar contrast material of various iodine concentrations were activated in the OPPS in CY 2006 and replaced several CY 2005 HCPCS A-codes that defined different sets of units in their descriptors. As we have no CY 2005 hospital claims data for the Q-codes, we used the CY 2005 data from the HCPCS A-codes (HCPCS mean, number of units, and days) to determine the packaging status of the corresponding set of HCPCS Q-codes for CY 2007. All of our estimated per-day administration rate determinations for the HCPCS A-codes were above the final OPPS CY 2007 packaging threshold of $55, as discussed in section V.B.2. of this final rule with comment period. Therefore, we are determining that the corresponding set of CY 2007 HCPCS Q-codes will be paid separately in CY 2007. As there are ASP data available for these HCPCS Q-codes, they will be paid at the same rate as other separately payable drugs and biologicals in the OPPS for CY 2007, which in general will be equal to ASP+6 percent, subject to adjustments based on the quarterly update process. This final CY 2007 methodology for separately payable drugs and biologicals is discussed further in section V.B.3 of this final rule with comment period.

(4) CY 2007 Proposed and Final Payment Policy for Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without OPPS Hospital Claims Data and Without ASP-Related Data

In addition to the drugs, biologicals, and radiopharmaceuticals without CY 2005 claims data identified in Table 27 of the proposed rule (71 FR 49595), we identified three HCPCS codes for which there were no available data to support the ASP methodology and no available hospital claims data from CY 2005. As we were unable to estimate the per administration cost of these three HCPCS codes (90393,Vaccina ig, im; 90693, Typhoid vaccine, akd, sc; A9567, Technetium TC–99m aerosol), we proposed to package them in CY 2007. We specifically invited comments on our proposed policies for determining the per administration cost of the drugs, biologicals, and radiopharmaceuticals that are payable under the OPPS, but do not have any CY 2005 claims data.

We received a few public comments concerning our proposed CY 2007 policies for drugs, biologicals, and radiopharmaceuticals with HCPCS codes, but without OPPS hospital claims data and without ASP-related data.

Comment: Commenters suggested that ASP pricing data are available for one or more of these items. Another commenter requested that we use alternative data sources, such as WAC or AWP, to determine the CY 2007 packaging status of the three items listed above as ASP information is not available.

Response: We appreciate these comments. During the data update process we perform between the CY

2007 proposed and final rules, we again queried for ASP-related data for these three items, including other sources such as WAC and AWP. Again, we were unsuccessful in identifying this information. However, in the course of our research for updated pricing data, we discovered that HCPCS code 90693 (Typhoid vaccine, akd, sc) is not available for purchase by hospitals. Therefore, we are assigning status indicator ''B'' (Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x)).

After carefully considering the comments received, we are finalizing our CY 2007 proposed policy to package HCPCS code 90393 (Vaccina ig, im), as we remain unable to determine pricing information for this item. Finally, HCPCS code A9567 (Technitium TC–99m aerosol) is a radiopharmaceutical, and as such, we are finalizing a policy to pay for this item in CY 2007 as we will pay for all new radiopharmaceuticals without claims data, regardless of pass-through status. Therefore, for CY 2007, we will pay for HCPCS code A9567 at the hospital's charge for the radiopharmaceutical adjusted to cost, using the hospital's overall CCR.

In addition, HCPCS code J0190 (Inj biperiden lactate/5 mg) was packaged for CYs 2005 and 2006. As discussed in section V.B.2. of this final rule with comment period, to determine the CY 2007 final packaging status of drugs, biologicals, and radiopharmaceuticals we used ASP data from the first quarter of CY 2006 (reflected in payment rates in the physician office setting effective July 1, 2006), along with updated hospital claims data from CY 2005. Under this methodology, we determined that for CY 2007, HCPCS code J0190 will be separately payable. We note that for impact estimates and for purposes of publication of Addenda A and B of this final rule with comment period, we use payment rates for drugs, biologicals, and radiopharmaceuticals that are effective in the OPPS for October 2006. These rates are developed through the methodologies discussed in the CY 2006 final rule with comment period (70 FR 68631), and generally reflect ASP data from the second quarter of CY 2006, hospital claims data from CY 2004, or rates paid under the Part B drug CAP. This methodology essentially provides comparable payment rates across HCPCS codes at a specific point in time, and therefore enables consistency when calculating impact estimates. Under this methodology, we do not have ASP based data or CY 2004 claims-based mean unit cost data for HCPCS code J0190. Therefore, for purposes of impact estimates and for publication of Addenda A and B of this final rule with comment period, we have used the CY 2005 mean as it is the only pricing source available to us at this time.

Also, based upon CY 2005 hospital claims mean unit cost data and the methodology described in section V.B.2. of this final rule with comment period, we have determined that HCPCS code A9566 (Tc99m fanolesomab) is separately payable in CY 2007. However, we do not have CY 2004 hospital claims data available for this code as its predecessor code, C1093, was not reported under the OPPS until January 1, 2005. Therefore, similar to HCPCS code J0190 described above, we are using the CY 2005 mean unit cost for this code for purposes of impact estimates. We note that there will be no payment rate information for this code included in Addenda A or B of this final rule with comment period because this code is a radiopharmaceutical and will be paid according to the methodology described in section V.B.3.a.(3) of the preamble of this final rule with comment period.

VI. Estimate of OPPS Transitional Pass-Through Spending in CY 2007 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 2007 entails estimating spending for two groups of items. The first group consists of those items for devices that were eligible for pass-through payment in CY 2005 and/or CY 2006 and that would continue to be eligible for pass-through payment in CY 2007. The second group contains items that we know are newly eligible, or project would be newly eligible, for pass-through payment beginning in CY 2007.

B. Estimate of Pass-Through Spending for CY 2007

As we proposed, in this final rule with comment period, we are setting the applicable percentage cap at 2.0 percent of the total OPPS projected payments for CY 2007. As we discuss in section IV.B. of this preamble, there is one device category receiving pass-through payment in CY 2006 that will continue for payment during CY 2007. In cases where we have relevant claims data for the procedures associated with a device category, we often 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 proposed rule (71 FR 49596), 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. Based on our historical claims data for the procedures associated with the current device category continuing for pass-through payment into CY 2007 and the device's clinical characteristics, we estimate pass-through spending attributable to the first group (that is, one category for CY 2007) described above to be $44.0 million for CY 2007.

To estimate CY 2007 pass-through spending for device categories in the second group, that is, items that we know at the time of development of this final rule with comment period would be newly eligible for pass-through payment in CY 2007 or contingent projections for new categories in the second through fourth quarters of CY 2007, we used the following approach. In general, as described for the first group of device categories above, if we have relevant claims data we may project these data forward using OACT inflation and utilization factors based on total growth in OPPS services, or we may use an alternate growth factor for any specific new device category based on our claims data or the device's clinical characteristics, or both. As we indicated in the proposed rule (71 FR 49596), we anticipated that any new

categories for January 1, 2007 would be determined after the publication of the proposed rule, but before publication of this final rule with comment period. For the two additional device categories that have now been approved for pass-through status as of January 1, 2007, we used price information and utilization estimates from manufacturers, because we did not have any relevant CY 2005 claims data upon which to base a spending estimate for CY 2007. To account for the contingency of new device categories that we project could become eligible for pass-through status in the second, third, or fourth quarters of CY 2007, we used the general methodology as described above, while also considering the most recent OPPS experience in approving new pass-through device categories. Therefore, as indicated in our proposed rule (71 FR 49596), the estimate of pass-through spending in this CY 2007 OPPS final rule with comment period incorporates both CY 2007 estimates of pass-through spending for device categories made effective January 1, 2007, and estimates for those projected to be approved during subsequent quarters of CY 2007.

With respect to CY 2007 pass-through spending for drugs and biologicals, as noted in the proposed rule (71 FR 49596) and explained in section V.A.3. of this final rule with comment period, the pass-through payment amount for new drugs and biologicals that we determine to have pass-through status will equal zero. Therefore, in this final rule with comment period, our estimate of pass-through spending for drugs and biologicals with pass-through status in CY 2007 equals zero.

In the CY 2005 OPPS final rule with comment period (69 FR 65810), we indicated that we are accepting pass-through applications for new radiopharmaceuticals that are assigned a HCPCS code on or after January 1, 2005. (Prior to this date, radiopharmaceuticals were not included in the category of drugs paid under the OPPS, and therefore, were not eligible for pass-through status.) There are no radiopharmaceuticals that were eligible for pass-through payment in CY 2005 or at the time of publication of this final rule with comment period in CY 2006. In addition, we have no information identifying new radiopharmaceuticals to which a HCPCS code might be assigned on or after January 1, 2007, for which pass-through payment status would be sought. We also have no data regarding payment for new radiopharmaceuticals with pass-through status under the methodology that we specified in the CY 2005 OPPS final rule with comment period. However, we do not believe that pass-through spending for new radiopharmaceuticals in CY 2007 will be significant enough to materially affect our estimate of total pass-through spending in CY 2007. Therefore, we are not including radiopharmaceuticals in our final estimate of pass-through spending for CY 2007. We discuss the methodology for determining the CY 2007 payment amount for radiopharmaceuticals with pass-through status in section V.B.3.b. of this preamble.

In accordance with the methodology described above, we estimate that total pass-through spending for both device categories that are continuing into CY 2007 and those that first become eligible for pass-through status during CY 2007 will equal approximately $65.6 million, which represents 0.21 percent of total OPPS projected payments for CY 2007. This figure includes an estimate for the current device category continuing into CY 2007, which equals approximately $44.0 million, in addition to projections for both categories that were approved after publication of the OPPS proposed rule effective January 1, 2007, and discussed in section IV.B. of the preamble of this final rule with comment period, and new categories that may become eligible during the subsequent quarters of CY 2007.

TABLE 28.—ESTIMATE OF CY 2007 TRANSITIONAL PASS-THROUGH SPENDING FOR CURRENT PASS-THROUGH CATEGORY CONTINUING INTO CY 2007

HCPCS	APC	Existing pass-through device category	CY 2007 estimated utilization	CY 2007 estimated pass-through payments
C1820	1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	5,483	$43,974,519

Because we estimate that pass-through spending in CY 2007 will not amount to 2.0 percent of total projected OPPS CY 2007 spending, we will return 1.79 percent of the pass-through pool to adjust the conversion factor, as we discuss in section II.C. of this preamble.

Accordingly, we are finalizing our proposed methodology for estimating CY 2007 OPPS pass-through spending for drugs, biologicals, and categories of devices. Our final total pass-through estimate for CY 2007 is $65.6 million.

VII. Brachytherapy Source Payment Changes

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. In accordance with this provision, since CY 2004 we have established four new brachytherapy source codes and descriptors.

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 have been 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 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.

B. Government Accountability Office's Final Report on Devices of Brachytherapy

Section 621(b)(3) of Pub. L. 108–173 required the Government Accountability Office (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. 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), which was published on July 24, 2006, was not available in time for review and discussion in the CY 2007 OPPS proposed rule. Therefore, we are summarizing and discussing the report's findings and recommendations in this final rule with comment period. The GAO report principally recommends 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 recommends that we consider using claims data for the third source studied, high dose rate (HDR) iridium-192. During the GAO hospital purchase price study period, separate device codes were not available to specifically distinguish high activity and low activity iodine and palladium sources. Therefore, in addition to establishing prospective payment rates for iodine-125 (C1718) and palladium-103 (C1720) based on claims data, the GAO states that it expects CMS to have data available to set prospective payment rates for high activity iodine-125 (C2634) and palladium-103 (C2635) sources in CY 2007 as well. These two codes were created in CY 2005 as a result of the Medicare Modernization Act (MMA) requirement that the OPPS establish brachytherapy device payments that account for the radioactive intensity of the sources.

The GAO studied 3 of the 12 specific sources currently paid separately under the OPPS: palladium-103, iodine-125, and HDR iridium-192. The GAO conducted a survey of purchase prices paid by 121 hospitals, from July 1, 2003, through June 30, 2004. These hospitals were carefully selected to be representative of all hospitals providing these sources in CY 2002. The GAO used a regression model to identify stratification factors that would maximize the difference in mean purchase price among strata of the sample. It grouped hospitals into major teaching hospitals, nonmajor teaching hospitals, urban nonteaching hospitals, and rural nonteaching hospitals. The GAO placed small hospitals into a separate stratum to ensure that they were appropriately represented.

For iodine and palladium sources, the survey requested reporting of the name of the manufacturer, the number of sources, the price per source, and certain characteristics of the sources purchased, such as radioactivity level and configuration. For iridium, it requested reporting of the name of the manufacturer, the number of treatments delivered, the source price, and its rebate eligibility. The GAO survey had an overall response rate of 51 percent, and the GAO was able to calculate the mean and median purchase prices for iodine and palladium. Few hospitals reported receiving rebates.

To estimate the hospitals' mean and median purchase prices for iodine and palladium sources, the sample hospitals' purchase price data were weighted to make them representative of the sample frame of hospitals from which the sample was drawn. The GAO used standard statistical trimming principles, which resulted in the exclusion of only 2 percent of the reported purchase prices of iodine and exclusion of none of the reported purchase prices of palladium. It estimated the mean price per source as $29.54 (median $25.37) for iodine from data submitted by 52 hospitals and $45.35 (median $45.46) for palladium from data submitted by 40 hospitals, with very low price variability across hospitals. Specifically, the coefficients of variation for the mean estimates were 1.59 percent for the iodine purchase price data and 0.68 percent for the palladium purchase price data. This shows a remarkably low degree of variability within the data for the purchase prices of iodine and palladium brachytherapy sources during the survey period.

The GAO found this price information to be reasonably consistent with cost data calculated from historical OPPS claims for the sources. It speculated that, to the extent that price variation in the survey data existed across either palladium or iodine sources, this variation could be attributed to differential pricing by source characteristics, such as configuration or radioactivity level. While the GAO stated that its survey data were insufficient to reliably identify any price differences by source characteristics, it concluded that any price variation should be reflected in its survey data because hospitals were to report all their purchases during the survey period. The GAO indicated that its results could be appropriately generalized to the approximately 950 hospitals providing these sources in the outpatient department that met the sampling criteria, and stated that the sampling frame contained 98 percent of the hospitals submitting OPPS claims for the three brachytherapy sources in CY 2002.

Only 19 hospitals responded to the survey with iridium information, but 11 did not provide the number of treatments and/or reported questionable source prices, resulting in the GAO's inability to estimate the cost per treatment in these cases. For the other eight hospitals, there were also data inconsistencies. Because the GAO could not establish a unit cost for iridium, it could not assess if the unit cost of iridium varied substantially and unpredictably over time in a way that would make establishing a prospective payment rate inappropriate.

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.

C. Payments for Brachytherapy Sources in CY 2007

As indicated above, the provision to pay for brachytherapy sources at charges reduced to cost expires after December 31, 2006, in accordance with section 1833(t)(16)(C) of the Act. However, under section 1833(t)(2)(H) of the Act,

CMS is 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 the CY 2007 OPPS proposed rule, we proposed to pay separately for each of the sources listed in Table 29 of that rule (71 FR 49597) on a prospective basis for CY 2007, with payment rates to be determined using the CY 2005 claims-based median unit cost per source for each brachytherapy device (with the exception of Ytterbium-169, as discussed below). 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 provisions of section 1833(t)(5) of the Act. As indicated in section II.A.2. of this preamble, for CY 2007 we proposed specific payment rates for brachytherapy sources, which would be subject to scaling for budget neutrality.

Table 29 of the proposed rule included a complete listing of the HCPCS codes, long descriptors, APC assignments, APC titles, and status indicators that we currently use for brachytherapy sources paid under the OPPS in CY 2006, and that we proposed to use for CY 2007. The brachytherapy sources and related information in Table 29 were the same sources and information as those listed in Table 28 of the OPPS CY 2006 final rule with comment period (70 FR 68676). No additional brachytherapy sources have been added since the CY 2006 final rule with comment period.

As indicated in the CY 2007 OPPS proposed rule (71 FR 49597), we believed there were a number of advantages to this proposed payment method. The OPPS is a prospective payment system under which payment rates are generally established based on median costs from historical hospital claims. Under our proposal, brachytherapy sources would be paid using the same basic median cost methodology as the overall OPPS. We believed that the payment of sources based on this approach would thus be an integral part of the OPPS, rather than a separate cost-based payment methodology within the OPPS. In addition, we proposed this option because we believed that consistent and predictable prospectively established payment rates under the OPPS for brachytherapy sources would be appropriate. We doubted 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 sources utilized, which would be accounted for in our proposed per source payment methodology. We also believed that the proposed prospective payment methodology would promote efficiency in the provision of sources, while continuing to provide payments that reflect the wide clinical variation in the use of brachytherapy sources related to many factors, including tumor type and stage, patient anatomy, and planned brachytherapy dose. In addition, under the proposal we would continue to pay for brachytherapy sources separately using the same C-codes and descriptors that hospitals have reported for the last several years.

We received numerous comments regarding our CY 2007 proposed payment methodology for brachytherapy sources.

Comment: A number of commenters objected to CMS' proposal to set prospective payment rates based on median unit costs of sources because they believed that there was no valid, useful source of data for brachytherapy sources upon which to base prospective payment rates for CY 2007. The commenters stated that the GAO survey data were fundamentally flawed and should be disregarded by CMS, and that CMS' claims data also did not reflect the true hospital costs of brachytherapy sources. Specifically with regard to the GAO survey, they believed that the data collected by the GAO were outdated, and that the survey response rate was inadequate as the basis for conclusions regarding the costs of sources. They stated that the GAO survey failed to provide data sufficient for analyses by source configuration (specifically, loose sources versus stranded sources) and type of hospital (specifically, rural versus urban), both of which they believed should be taken into account in setting prospective payment rates for brachytherapy sources.

The commenters also stated that the CMS claims data were not valid because they were not available by source configuration (that is, loose sources versus stranded sources), which commenters viewed as an important distinction with respect to clinically meaningful characteristics and costs. They observed that the CMS cost data showed significant variation in unit costs across hospitals, and that the number of claims containing source charges was inadequate. They objected to reliance on CMS' cost data because they stated that two-thirds of the source APCs have fewer than 50 hospitals reporting cost data for sources. They concluded that the CMS data must be erroneous, because it showed the costs of low activity iodine and palladium sources to be higher than the costs of high activity sources of iodine and palladium, a result that contradicted their expectations. The commenters believed that the use of median costs was not valid because median costs can result in a single claim or hospital being the determinant of the median cost. Therefore, they concluded that basing brachytherapy source payment on a median cost did not fully represent the costs of all hospitals.

Response: In contrast to the commenters' opinions, we believe that both the GAO survey information and CMS' claims data provide sufficient valid information on which to base prospectively established payment rates for brachytherapy sources. The findings of the GAO survey and CMS' claims data are sufficiently similar and stable to justify the use of claims data in setting prospective payment rates for brachytherapy sources. We do not view the delay in the publication of the GAO report as causing its contents to be outdated. In fact, the law that required the survey was passed on December 23, 2003. Instead of choosing to survey hospital costs only from CY 2003 or before, GAO, after seeking the views of stakeholders, chose to survey for the period, July 1, 2003, through June 30, 2004, in order to acquire the most current information available at the time that the survey was performed.

We found the GAO survey to provide credible information based on a stratified sample of all relevant categories of hospitals furnishing brachytherapy sources. We noted that there was remarkably little variation within the cost data elements for the iodine and palladium sources, the two most commonly billed sources under the OPPS. The GAO survey was performed using standard survey techniques, and the statistics were calculated using standard statistical methods. The coefficients of variation demonstrated a remarkable amount of stability for the data which were gathered from a wide range of provider types. We agree with the GAO that the response to the survey, while not sufficiently robust to provide information by source configuration or other characteristics of sources, is sufficient to provide a valid measure of the purchase price for iodine and palladium sources. We do not believe that the information from the survey was insufficient to yield valid estimates of hospital costs. Moreover, the median costs provided by the GAO survey are remarkably consistent with the median costs derived from Medicare claims data

over the years as discussed below and shown in Table 29.

The GAO report recommended that we use OPPS claims data to determine prospective payment rates for two of the most frequently utilized brachytherapy sources, iodine-125 and palladium-103. In addition, the GAO report stated that it was unable to determine a suitable methodology for paying separately for HDR iridium because the survey provided insufficient data to identify and evaluate iridium's average unit cost across hospitals. However, the GAO observed that CMS has historical outpatient claims data from all hospitals that have provided iridium sources. The GAO concluded that CMS should be able to use its data to establish an average unit cost for HDR iridium, which could then be evaluated for suitability as the basis for separate payment, specifically considering whether the source cost varies substantially and unpredictably.

We do not believe the absence of data by configuration or type of hospital is relevant to the validity of the median costs of iodine and palladium sources that resulted from the survey. We discuss the issue of changes in source configuration in more detail below in the context of the CMS data. With respect to the absence of statistics by type of facility, we believe that the consistency between the GAO survey purchase prices and the CMS data (which are based on billing by all hospitals regardless of type) shows that the lack of response by rural hospitals to the GAO survey is not meaningful.

We believe that there are sufficient and valid CMS claims data upon which to base prospective payment rates per source for each of the brachytherapy sources with available historical claims information. Sources of brachytherapy have been separately paid for virtually all of the history of the OPPS, with packaging of iodine and palladium sources only for prostate brachytherapy in CY 2003, when there was separate payment in that year for these sources for other uses. Moreover, before CY 2003 the sources were paid separately under the transitional pass-through payment methodology as pass-through devices. Therefore, hospitals have now had 6 years of experience in billing the sources separately to receive payment for these relatively costly items. Due to their pass-through payments in CYs 2000 through 2002 and payments at charges reduced to costs for CYs 2004 through 2006, hospitals have historically had a strong incentive to bill for sources at charges that reflected the costs of the sources. Therefore, to the extent that the commenters believed that our data show rank order anomalies or inadequate charges or wide variations in charges, we must assume that the charges reflect the hospitals' perceptions of the relative costs of the sources, and hospitals alone choose the charges they submit to Medicare and to all other payers.

With regard to the use of the median cost, we note that the use of median costs for sources of brachytherapy is identical to the basis of payments for all services paid under the OPPS, other than drugs and biologicals, pass-through devices, and some new technology services. The nature of basing 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. Moreover, as the OPPS is a budget neutral relative weight system, it is the relativity of the medians that is important and not the specific median itself. Therefore, it is important that the same measure of central tendency (in this case the median cost) be used to establish the weights for all OPPS services to which the conversion factor applies to calculate their payment rates.

We also do not consider the absence of data specific to loose versus stranded brachytherapy sources to be relevant to the calculation of sources' median costs. We have, as the law specified, established source codes for purposes of separate payments that take into account the number, isotope, and radioactive intensity of the sources. As with other medical devices, there will always be incremental improvements in the technology. We consider the configuration of sources as loose or stranded to be an incremental change, whose potential differential costs would be reflected in source cost data as the change penetrates the market for the product. As such, the impact of differing configurations would become apparent in hospital claims data over time as a matter of natural course. Based on the historical technological evolution in stranded brachytherapy sources, we expect that our CY 2005 median costs for sources already reflect their partial market penetration, as indicated in the comments and discussed later in this section. Moreover, we do not agree that special action is necessary to prevent disincentives to the use of improved products. We believe that hospitals and physicians balance the additional benefit 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.

Our review of the GAO findings and examination of OPPS claims data support use of the median costs from CMS'' claims data as the basis for the CY 2007 payment rates for brachytherapy sources. In Table 29 below, we have summarized available historical OPPS information for the iodine and palladium sources studied by the GAO, in the context of our CY 2007 final rule median unit costs.

TABLE 29.—MEDIAN COSTS, PAYMENT RATES, AND GAO STUDY FINDINGS FOR IODINE AND PALLADIUM BRACHYTHERAPY SOURCES

Source	CY 2003 payment rate*	CY 2004 proposed rate**	GAO survey median price @	Estimated CY 2006 median payment #	CY 2007 final rule median unit cost
Iodine-125	$31.33	$36.35	$25.37	$32.63	$36.12
Palladium-103	43.96	44.00	45.46	48.92	48.53

* Based on median from CY 2001 claims.
** Based on median from CY 2002 claims.
@ Purchase price between July 2003 and June 2004.
# Based on charges reduced to cost method.

While the CY 2007 final rule median costs are established as median unit costs calculated using the standard OPPS methodology of applying specific departmental CCRs, if available, to claims' charges, and defaulting to overall hospital CCRs only if departmental CCRs are unavailable, estimated CY 2006 payments are calculated according to the cost-based payment methodology in effect during CY 2006, which reduces charges to costs using overall hospital-specific CCRs. The table shows great consistency of OPPS claims data for these sources over the past 5 years, yielding reasonably stable median costs, with their associated payment rates, as either proposed or finalized over time. The CY 2007 final rule median costs for iodine, although based on claims for services provided approximately 1 to 2 years later than the dates of service for the survey data collected by the GAO regarding hospital purchase prices, are significantly higher than the median GAO purchase prices. For palladium, the final rule median cost is about 8 percent higher. On average, the CY 2007 median cost for iodine sources would be about 11 percent greater than the median payment under the CY 2006 cost-based methodology, while for palladium sources it would be about the same. Thus, we are relatively confident that the CY 2007 final rule brachytherapy source median unit costs from CY 2005 claims that are the basis of the CY 2007 payment rates for sources are reasonably accurate and should ensure continued access by Medicare beneficiaries to brachytherapy services delivered with these commonly used iodine and palladium sources.

We also found that, for the eight other brachytherapy sources for which we have hospital claims data from CY 2005, hospital costs for these sources do not vary more significantly than for the two sources previously discussed. Of these eight sources, gold-198 (C1716), non-HDR iridium-192 (C1719), and yttrium-90 (C2616) were established sources in CY 2003, the only previous year where the OPPS provided separate payments for some brachytherapy sources (other than pass-through payments in years prior to CY 2003). Their CY 2003 payment rates were $22.74, $27.29, and $6,485.37, respectively, relatively consistent with our CY 2007 final rule median costs of $36.61, $23.01, and $10,525.13, respectively, based on CY 2005 claims data. Iodine-125 brachytherapy solution (C2632) was paid in CY 2003 as a pass-through device, without a prospective payment rate. In CY 2003, the OPPS did not pay for cesium-131, ytterbium-169, and linear palladium-102, and had not yet distinguished high activity iodine-125 and palladium-103 sources.

While we have relatively low CY 2005 days and units for several of these 8 sources, we have at least 320 units for each one. We estimate that half of these devices would experience an increase in payment of 4 percent to 38 percent under the CY 2007 final rule methodology compared with their median payments under the CY 2006 cost-based methodology, while the others would experience decreases of 17 percent to 38 percent. This variation reflects the numerous different departmental CCRs that are used to calculate costs for brachytherapy from the relatively small number of hospitals reporting charges for many of the sources, in comparison with their overall hospital CCRs. We can identify no specific problems with the data for these eight sources that would cause us to question the accuracy of the CY 2007 final rule payment rates based on the sources' median costs from CY 2005 claims data. Therefore, we believe that the median cost per source from CY 2005 Medicare claims data provides a sufficient and valid basis to establish a prospective payment rate for each brachytherapy source with available CY 2005 claims data.

Comment: A few commenters questioned our median costs published in the CY 2007 OPPS proposed rule for high activity iodine-125 source (C2634), pointing out the proposed payment rate for C2634 was $25.68, which is lower than the proposed payment rate for the iodine-125 source (C1718) at $35.42. One commenter indicated that this reflected a rank order anomaly in proposed payments for high activity brachytherapy sources, and added that high activity iodine-125 sources always cost more, and typically may be many times more expensive than the corresponding low activity sources. The commenter stated that this error in the payment for high activity sources must be corrected for the sources to be clinically available.

Response: While the median cost of C2634 for this CY 2007 final rule with comment period, $32.49, is still lower than the median cost for C1718, at $36.12, the median cost for the high activity source is somewhat higher than proposed, and the gap between the median costs of the two sources has narrowed. The commenters did not provide data supporting their assertion that the cost of the high activity iodine-125 source is typically many times greater than the cost of the traditional low activity iodine-125 source. We acknowledge that the relatively low volume of claims from a small number of hospitals for the high activity iodine source from CY 2005 may contribute to the variability in its median cost, but we see no reason to believe that its median cost would not be appropriately reflective of the costs to hospitals providing the source in CY 2005. The GAO also noted that it expected us to have claims data from CY 2005 that could be used to establish a prospective payment rate for the high activity iodine-25 source.

Comment: Two commenters objected to our proposal to pay for sources of brachytherapy based on the median cost and asked that CMS set a prospective per source payment rate base on the mean cost derived from our claims data. One commenter believed that sources of brachytherapy should be paid based on prospectively set mean costs because they should be paid on the same basis as radiopharmaceuticals, for which we proposed to pay based on mean cost because both brachytherapy sources and radiopharmaceuticals contain radioactive material, are regulated by the Nuclear Regulatory Commission, and have the same storage, handling, and disposal requirements.

Response: We disagree that sources of brachytherapy should be paid identically to radiopharmaceuticals. Radiopharmaceuticals are defined by MMA as drugs and drugs are, by law, paid based on hospital average acquisition cost. Sources of brachytherapy are not required by law to be paid at average acquisition cost, and therefore we are setting the CY 2007 payment for these items based on median costs derived from our claims data, like most other OPPS services that are not drugs. We refer readers to the discussion below, in response to a comment, concerning our policy for payment of the handling and storage costs of brachytherapy sources.

Comment: A few commenters asserted that CMS did not provide an estimate of the effect on payments for brachytherapy sources due to the proposed change from a payment methodology of charges reduced to cost to a median cost methodology. They recommended that CMS evaluate the impact of any proposed changes in payment methodologies for brachytherapy sources and radiopharmaceuticals.

Response: In fact, we did consider the impact of the proposed brachytherapy source payment methodology and alternatives as discussed in section XXVII.B.1.b. of the CY 2007 proposed rule (71 FR 49681).

Comment: One commenter disagreed with our proposal that the cost of brachytherapy sources should be subject to the outlier provisions of the OPPS, indicating that historically brachytherapy sources have not been subject to additional outlier payments. The commenter also stated that services assigned to status indicator ''K'' status have not been eligible for outlier payments for the past 2 years. The commenter indicated that these types of changes are burdensome on hospitals and believed that brachytherapy sources should be excluded from outlier calculations, like separately paid drugs and devices receiving pass-through payments.

Response: Unlike separately paid drugs and devices eligible for pass-through payments, our proposal for brachytherapy sources is to pay for them based on median costs, which the commenter supports. Therefore, we are merely making our policy for brachytherapy sources consistent with our policy regarding other APC payments based on median costs, including that they be subject to the outlier provisions of section 1833(t)(5) of the Act. We are finalizing our proposal to make prospectively paid brachytherapy sources subject to the outlier provisions of section 1833(t)(5) of the Act. We note that we inadvertently did not show the necessary conforming regulation text in the proposed rule. Accordingly, we are making a conforming technical change to the regulation text at § 419.43(f) to delete brachytherapy sources from the services and groups excluded from outlier payments.

We noted in the proposed rule that HDR iridium-192 (code C1717) is a reusable source across treatment sessions and across patients. We believed that it was unclear whether hospitals had been reporting the number of units provided accurately, in accordance with our instructions to report one unit per treatment. Thus, while we proposed that HDR iridium be paid separately on the basis of the median cost per source as we proposed to pay for the other brachytherapy sources, we invited comments on alternatives to using this methodology for this source in particular, such as on the basis of median cost per treatment day from hospital claims.

We received a large number of comments specifically addressing the CY 2007 OPPS proposal for payment of HDR iridium, including suggestions for alternatives to payment based on the median unit cost of the source.

Comment: A number of commenters noted that the unit cost of HDR iridium is particularly variable, depending on the number of treatments provided by a hospital in a given calendar quarter before the source must be renewed. They believed that HDR iridium was, therefore, unlike most other OPPS services, for which hospital costs did not typically vary as greatly in relationship to service volume. They argued that providing payment at charges reduced to costs for this source, in particular, was important to ensuring patient access to HDR iridium treatment in their communities where the service volume may be low, such as at rural hospitals. Partial breast irradiation, with closely spaced treatments provided over a short time period in comparison with traditional treatment with external beam radiation therapy over many weeks, was cited as an important example of the value of HDR iridium in improving the care and quality of life for patients undergoing treatment for breast cancer.

The commenters expressed concern that the proposed payment of $134.93 per fraction may provide inadequate payment, particularly to hospitals that do not provide a high volume of HDR brachytherapy, notably smaller and mid-sized hospitals. Some of the commenters agreed with our concern that hospitals may not be reporting accurate units and charges for this reusable source. The commenters recommended that HDR iridium should continue to be paid on a per treatment or per fraction basis, and not be paid per treatment day, due to the significant variations among different treatment protocols. Therefore, the commenters concluded that CMS should continue to pay for HDR iridium per fraction.

A few commenters indicated that there is great variability in the cost of HDR iridium treatments, with such variations occurring because of the treatment site (for example, breast, uterus, prostate). These treatment variations result in differences in the resources needed, such as the number of source runs for each case. The commenters also indicated that our claims data for HDR iridium-192 presented huge variations in cost per unit source on claims and across hospitals, with costs ranging from $0 to $4,746. In addition, the commenters pointed out that the GAO report made no definitive recommendations regarding payment for the HDR iridium source. A number of commenters stated that CMS should continue to pay for HDR iridium based on the charges reduced to cost payment methodology.

Response: Our proposal to pay for HDR iridium-192 on a per source basis, which is equivalent to a per treatment or per fraction payment for this brachytherapy source, factors in the clinical variability in the number of treatments per day with this source. HDR iridium is a radioactive source with a 90-day life span that is purchased and used multiple times in numerous patients over its life. During a treatment with HDR iridium, the radioactive source is briefly inserted into each temporary treatment catheter that has been placed into a patient's treatment area and then removed. It never comes in direct contact with the patient so it may be used for multiple patients. We believe that the cost of the radioactive source per treatment procedure is the same, irrespective of how many dwell positions or source runs are provided in the variable numbers of catheters placed in patients. However, we also understand that a per day payment methodology that does not take into consideration the number of treatments per day could be problematic, because the total day's source cost when more than one treatment is provided on a day for the same Medicare beneficiary would be significantly greater than if only one treatment was performed on that day. We believe that a per source payment, which equates to a per treatment payment, for HDR iridium as proposed is appropriate, given these considerations.

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. In this respect, HDR iridium is similar to capital equipment that hospitals buy to perform procedures and that has a limited lifespan. Hospitals' costs for such equipment must be spread over their charges for the procedures performed, so the cost per procedure would vary significantly depending on the number of services provided.

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 hospital services. We examined our full year CY 2005 claims data for HDR iridium, as suggested by the GAO, and found the hospital costs for this source did not vary much more than for the other brachytherapy sources, including

iodine and palladium. We note that, based on our analysis, on average the CY 2007 final rule median cost for HDR of $141.75 based on the source's median unit cost from CY 2005 claims would be about 7 percent higher than under the CY 2006 cost-based methodology, which yields an estimated median payment of $132.30, similar to the pattern observed for iodine and palladium sources. While we recognize that the average unit cost of an iridium source purchased by a hospital would be related to the number of treatments provided with the source and that hospitals must bill Medicare based on projections of their unit cost, we have no reason to believe that our CY 2007 final rule payment rate based on the median unit cost for HDR iridium would place continued access to this source at risk. Like many services under the OPPS for which hospitals purchase reusable equipment and supplies, hospitals' unit costs for iridium sources would vary based on the number of treatments a hospital provides before the source must be renewed, thus incurring additional costs. Again, under a PPS 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 PPS could pay more or less than the cost of delivering a specific service in an individual case.

Regarding the comment that the GAO report made no definitive recommendations regarding payment for the HDR iridium source, this recommendation was based on the lack of data produced by the GAO's own survey, and the report indicated that it was the GAO's opinion that CMS has outpatient claims data from all hospitals that have used iridium. The GAO recommended that, in order to identify a suitable methodology for separate payment for HDR iridium, CMS would be able to establish an average cost and evaluate whether that cost varies substantially and unpredictably. In the efficient delivery of high dose rate brachytherapy services, our claims data provide no evidence that the hospital costs associated with HDR iridium vary greatly and unpredictably, so we believe that our CY 2005 claims provide an appropriate basis upon which to establish the CY 2007 prospective payment rate for HDR iridium for each treatment. This rate should help ensure that hospitals continue to operate efficiently in providing HDR brachytherapy treatments to Medicare beneficiaries.

Comment: One commenter recommended that CMS continue paying hospitals ''based on use of the HDR Iridium-192 source,'' but that CMS establish a maximum charge for HDR Iridium, that is, $700 per fraction. The commenter also suggested that each provider continue to establish a charge based upon the source costs per year divided by the number of fractions, thus allowing low volume HDR facilities to offer the service, while not overpaying high volume facilities.

Response: We do not instruct hospitals on establishing charges or restrict hospital charges for items billed to Medicare. Hospitals establish charges based on many factors, including, but not limited to, the costs of items and services and the market conditions in the communities that they serve. Moreover, the OPPS is not a system that pays hospital charges. The OPPS rates generally are based upon relative weights calculated from Medicare claims data and converted to payment rates by a conversion factor. Prospective payment rates under the OPPS are based on the median cost for each APC from historical hospital claims, with trimming of claims data only at the extremes to eliminate those claims of exceptionally high or low cost from contributing to APC median cost development. The commenter did not indicate how a maximum charge would alleviate problems associated with making appropriate payments for HDR iridium to hospitals, or any goals such a policy would accomplish. Additionally, the commenter did not provide the basis of its recommendation that the maximum charge should be capped at $700 per fraction.

Comments: A large number of commenters requested that iodine-125 liquid brachytherapy solution, C2632 (which will be paid under A9527, effective January 1, 2007, as stated elsewhere in this section), which is used in patients with brain cancer, continue to be paid on the basis of charges reduced to cost. The commenters claimed that the proposed payment is insufficient to meet the cost of the iodine-125 (I–125) solution, along with handling and other administrative costs associated with the source. The commenters stated that hospitals must continue to be able to offer this vital brain cancer radiotherapy option. Several commenters believed that the proposed payment of $19.32 is not sufficient to cover the cost of one mCi, the 150–200 mCi in a 1 mL vial of I–125 solution, or the usual 150–450 mCi required for a typical case. One commenter noted that while appropriate coding requires reporting one unit per mCi, or 150 units per 1 mL vial, hospitals are confused regarding the correct unit of billing, which undermines the accuracy of data on which CMS relies. One commenter stated that the ''actual hospital charge'' of a 1 mL vial of I–125 solution is $5,900, which at the rate of 150 mCi per vial is $39.33 per mCi, while our proposed payment rate was $19.32 per mCi.

This commenter also mentioned that the APC Panel report from the March 2006 Panel meeting noted that some brachytherapy sources, including C2632, ''demonstrate relatively inconsistent mean and median numbers of sources used,'' and that CMS staff pointed out concerns about variability of the mean and median statistics. The commenter contracted an outside consultant to analyze CY 2005 OPPS claims data for C2632. The contractor concluded that there are wide variations in how hospitals billed for units of I–125 solution, which points to unreliable cost data on which to base payments for CY 2007.

Response: The commenters did not establish why payment based on the median unit cost for the I–125 liquid brachytherapy solution is insufficient. Most commenters did not provide any information on the cost of a one mL vial of I–125 solution or sufficient further information supporting their claim that the proposed payment rate is insufficient. The commenter who stated that the ''actual hospital charge'' for a 1 mL vial of I–125 solution is $5,900 is a manufacturer of equipment that uses the I–125 solution for its brain cancer treatments and was the only commenter to provide some information on the cost of the I–125 solution. We note that we proposed to pay for the I–125 solution on a per mCi basis. This per source payment methodology is designed to capture the variability in costs per treatment, depending on the radiation dose. We also observe that the typical treatment of 150–450 mCi cited would receive payments between $2,898 and $8,694 per treatment, at the proposed payment rate of $19.32 per mCi.

We have issued instructions on the correct OPPS billing for the brachytherapy solution. Transmittal 132, Change Request 3154, dated March 30, 2004, notes how to account for the cost of handling and supervision related to radiation sources. The commenters claimed that hospitals are confused regarding the number of units of I–125 solution per vial. Our payment has historically been made on a per mCi basis, and this approach will continue for CY 2007, consistent with the predecessor C-code unit (C2632) and, for CY 2007, the permanent A-code unit (A9527). Therefore, when a vial of I–125

solution contains 150 mCi, there are 150 billing units of I–125 solution per vial, resulting in an OPPS payment, if all billing units are used, of $2,898 based on the CY 2007 proposed payment rate.

CMS staff did point out to the APC Panel at the March 2006 meeting our concerns about variability in statistics for numbers of sources used and wondered whether significant differences between the median and mean mCi reported per day could point to coding confusion regarding the correct billing of units for individual cases. We asked the Panel members to respond and provide any recommendations. Individual Panel members familiar with brachytherapy source costs, as well as the Data Subcommittee in general, believed that the median costs per unit appeared to generally be reasonable for the most commonly furnished sources, but that erroneous billing of the units of sources could affect the median unit costs of some sources, including C2632. We are continuing to study the variability of brachytherapy source data, and note that there are significantly greater units for some sources, such as C2632, based on full year CY 2005 data, than were included in the partial CY 2005 data the Panel reviewed in March 2006. We believe it is appropriate to treat I–125 solution like all other brachytherapy sources for CY 2007 and establish its payment rate based on its median unit cost from CY 2005 claims data.

Comment: One commenter did not believe we had factored into the cost of brachytherapy the need for special handling of sources by nuclear physicists and sought payment consideration for these handling costs.

Response: We explicitly consider the special handling of brachytherapy sources by nuclear physicists in our ratesetting policies. We instructed providers, in Transmittal 132, Change Request 3154, dated March 30, 2004, to report charges for the supervision, handling, and loading of radiation sources, including brachytherapy sources, in one of two ways: report the charge separately using CPT 77790, in addition to reporting the associated HCPCS procedure code(s) for application of the radiation source; or include the charge as part of the charge reported with the HCPCS procedure code(s) for application of the radiation source. (We further noted in that transmittal that providers should not bill a separate charge for brachytherapy source storage costs, which are treated as part of the department's overhead costs.) Reporting in either of these ways results in the costs of special handling being packaged into payments for brachytherapy procedures.

Comment: Some commenters asked that CMS continue to pay for brachytherapy sources on the basis of charges reduced to cost because the APC Panel and Practicing Physicians Advisory Council (PPAC) recommended it. They also stated that continuation of payment based on charges reduced to cost would ensure that there are no barriers to access and would avoid their concerns with CMS data. The commenters stated that payment based on this methodology has worked well for the past 2 years and should be continued for at least CY 2007 and CY 2008. Noting the GAO report was due no later than January 1, 2005, the commenters believed that the intent of Congress in section 621(b) of the MMA was to provide 2 years of payments for brachytherapy sources based on charges reduced to cost after the publication of the GAO study to allow no less than 2 years for Congress, CMS, and the public to further analyze brachytherapy device cost and payment information, and the findings of the GAO survey in particular, before payment based on charges reduced to cost would cease. They believed that CMS should continue payment based on charges reduced to cost for CY 2007 and CY 2008 to comply with what they viewed as the intent of Congress, because the GAO report was not released until July 2006, about 18 months after its due date of January 1, 2005, for publication.

One commenter supported the concept of prospective payment for brachytherapy sources when the payment rates can be based on data that are stable over time and reasonably accurate. The commenter believed that the GAO report was sound, and it supported the GAO's recommendations regarding payment of C1718, iodine-125, per source and C1720, palladium-103, per source. For other sources, the commenter recommended that CMS continue to pay on the basis of charges reduced to cost. The commenter believed this was especially important for HDR iridium, which entails particular data challenges in developing an accurate per treatment or per fraction median cost.

Response: We recognize that at its August 2006 APC Panel meeting, the Panel recommended that CMS continue the current methodology of charges reduced to cost using the overall hospital CCR for payment of brachytherapy sources for 1 year (see recommendations of the APC Panel at *http://www.cms.hhs.gov/FACA/).* The Panel reviewed a letter of comment on this issue requesting continuation of the CY 2006 cost-based payment methodology for CY 2007, but no public presentation was heard. While we acknowledge the Panel's recommendation, we note that the Panel did not provide specific rationale for its recommendation, nor did it provide an explanation of what it perceived to be the problem with the proposed median costs. Accordingly, we do not choose to adopt the Panel's recommendation.

We also acknowledge that the PPAC recommended that CMS abandon the proposal to pay for brachytherapy sources based on median unit costs calculated from claims data and reexamine its claims data for sources (see recommendation 57 H.1 in the summary of the August 2006 PPAC meeting at *http://www.cms.hhs.gov/FACA/*). The Panel's discussion of the issue at its August 2006 meeting centered on its belief that hospitals incorrectly reported HCPCS codes and charges for brachytherapy sources. However, as discussed in detail previously, we observe significant stability of claims-based costs for the most commonly used sources over time, and hospitals have generally had 6 years of experience with reporting the codes and charges for brachytherapy sources, upon which their specific source payments were based throughout that time period. Therefore, as we do not agree with the underlying rationale behind PPAC's recommendation, we are likewise not accepting its recommendation.

We also note that the statute requires payment based on charges reduced to cost for sources furnished between January 1, 2004, and December 31, 2006. The law is clear as to the timeframe for this payment approach and is not linked to the issuance of the GAO report, as commenters suggested was the intent of Congress. Moreover, we have considered the GAO's findings in setting prospective payment rates for sources of brachytherapy, which we believe is fully consistent with the provisions of the MMA.

Comment: A few commenters recommended that CMS institute mandatory device code edits for brachytherapy procedures assigned to APCs 0312, 0313, and 0651, requiring the reporting of alphanumeric HCPCS codes for brachytherapy sources, which are always required for the delivery of brachytherapy. More generally, the commenters stated that they support expanding the CY 2007 device edit policy to all device-related APCs. They also remarked that the CMS source data were insufficiently representative of actual source costs because many hospitals that charged for brachytherapy

procedures did not include codes and charges for sources on the claims for these procedures, which could not have been performed without the use of brachytherapy sources. The commenters asked that CMS require hospitals to bill the alphanumeric HCPCS codes for sources as a condition of being paid for the brachytherapy procedures that cannot be performed without sources, in order to promote correct coding and to improve the quality of the claims data. The commenter also believed that hospitals should be educated regarding how to report charges for brachytherapy sources used in the outpatient department.

Response: Device edits are appropriate for APCs that have the costs of the relevant devices packaged into the costs of the procedural APCs. We require device edits for certain APCs in order to ensure that charges for the required devices are included on the claims, so that payments for device costs are appropriately packaged into the payments for the procedures that use the devices. Moreover, we impose device edits in association with specific procedures only when an item is of significant cost whose payment is packaged into the APC payment for the procedure. We do not impose claims edits for items, such as brachytherapy sources, that are separately paid and for which hospitals have a very strong incentive to bill Medicare. Specifically, APCs 0312, 0313, and 0651 do not have payment for the costs of brachytherapy sources packaged into the procedural APC payments. We believe that hospitals that furnish brachytherapy services either bill us for the sources separately using their alphanumeric HCPCS codes or apparently choose to package the charges for the sources into charges for the services in which they are applied and not seek separate payment for the sources. The latter reporting practice would lead to our overestimation of the costs of brachytherapy procedures. In addition, if hospitals include the charges for the sources in the charges for the procedures in which they are applied, a requirement for reporting of codes for the sources could result in these hospitals billing token charges, thus undermining the correct determination of the unit cost per source.

As required by the law, we currently are paying separately for brachytherapy sources, as we have been for most sources every year since the beginning of the OPPS in CY 2000. We will be paying for sources separately in CY 2007 as well. Because payments are provided separately for brachytherapy sources reported with specific HCPCS codes, device edits are not needed to ensure appropriate payments for brachytherapy procedures. The reporting of brachytherapy source HCPCS codes is required for hospitals to receive payment for brachytherapy sources, and this should be sufficient incentive for providers to report brachytherapy source codes.

After consideration of the comments received, as well as the recommendations of the APC Panel, the PPAC, and the GAO, we have decided to base payment for all sources of brachytherapy for which we have CY 2005 claims on their median unit costs derived from CY 2005 OPPS claims data. We refer readers to Addendum B of this final rule with comment period for the CY 2007 national payment rates and copayments for the sources of brachytherapy. We note that there is a new permanent Level II alphanumeric HCPCS codes for iodine-125 brachytherapy solution for CY 2007. The new code, A9527, has a long descriptor, Iodine I–125, sodium iodide solution, therapeutic, per millicurie, that describes the same brachytherapy source as the predecessor C-code, C2632, Brachytherapy solution, iodine 125, per mci, for which we are currently making separate payment under the OPPS. As of January 1, 2007, with the effective date of HCPCS code A9527, we will delete C2632. We will crosswalk claims data and establish the prospective payment rate for A9527 based on our CY 2005 claims for C2632. Table 30 in this final rule with comment period contains the median costs of brachytherapy sources from CY 2005 claims data and the HCPCS codes to be used in CY 2007 to report these devices.

Therefore, we are finalizing our proposed payment methodology for brachytherapy sources based upon their median unit costs from CY 2005 claims data for CY 2007 without modification. While this methodology is fully consistent with the statutory requirement of separate payment for brachytherapy sources based on their number, isotope, and radioactive intensity, it will also provide hospitals with an incentive to operate efficiently in providing brachytherapy services to Medicare beneficiaries.

Because brachytherapy sources will no longer be paid on the basis of their charges reduced to cost, we proposed to discontinue our use of payment status indicator ''H'' for APCs assigned to brachytherapy sources. We proposed to use status indicator ''K'' for all brachytherapy source APCs for CY 2007. We also proposed for CY 2007 to change the definition of status indicator ''K'' to ensure that ''K'' appropriately describes brachytherapy source APCs. Payment status indicators are discussed in section XV.A. of the preamble of this final rule with comment period.

We did not receive any public comments specific to the proposal to change the status indicator definitions for brachytherapy sources. Therefore, we are adopting as final for CY 2007, without modification our proposed changes to the definitions of status indicators ''H'' and ''K'' to address CY 2007 brachytherapy source payment.

Table 30 below provides a complete listing of the HCPCS codes, long descriptors, APC assignments, median costs, and status indicators that we will use for brachytherapy sources paid separately under the OPPS in CY 2007.

TABLE 30.—SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2007

HCPCS code	Long descriptor	CY 2007 APC	CY 2005 median cost	CY 2007 status indicator
C1716	Brachytherapy source, Gold 198, per source	1716	$36.61	K
C1717	Brachytherapy source, High Dose Rate Iridium 192, per source	1717	141.75	K
C1718	Brachytherapy source, Iodine 125, per source	1718	36.12	K
C1719	Brachytherapy source, Non-High Dose Rate Iridium 192, per source	1719	23.01	K
C1720	Brachytherapy source, Palladium 103, per source	1720	48.53	K
C2616	Brachytherapy source, Yttrium-90, per source	2616	10,525.13	K
A9527 (C2632 deleted).	Iodine I–125, sodium iodide solution, therapeutic, per millicurie	2632	20.30	K
C2633	Brachytherapy source, Cesium-131, per source	2633	90.31	K

TABLE 30.—SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2007—Continued

HCPCS code	Long descriptor	CY 2007 APC	CY 2005 median cost	CY 2007 status indicator
C2634	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	32.49	K
C2635	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	54.25	K
C2636	Brachytherapy linear source, Palladium-103, per 1MM	2636	39.28	K

As indicated in our CY 2007 OPPS proposed rule (71 FR 49598), there was one source for which we had no claims data or payment information from the CY 2005 claims data available for the development of the proposed rule, and this statement remains true based on our recent analysis of complete CY 2005 claims data for this final rule with comment period. We added Ytterbium-169 (HCPCS code C2637) for payment effective October 1, 2005, because it met the requirements of section 1833(t)(2)(H) of the Act as a separate brachytherapy source. It was our understanding at the time of development of the proposed rule that this source, which is for use in HDR brachytherapy, was not yet marketed by the manufacturer, although it had been approved by the Food and Drug Administration (FDA). Therefore, we had no claims data for this brachytherapy source in order to develop a prospective payment rate, as we did for the other brachytherapy sources for CY 2007. In addition, it was our understanding that no price for the product existed, as it had not yet been marketed. Thus, we also had no external information regarding the cost of this source to hospitals. We weighed our payment options for CY 2007 for brachytherapy sources for which we had no payment or claims information, such as the present case with Ytterbium-169. This included considering our CY 2007 payment options for other new brachytherapy sources that come to our attention, which historically have been newly recognized under the OPPS on a quarterly basis. We discussed these payment options in our CY 2007 OPPS proposed rule (71 FR 49598 and 49599), and they are reviewed below.

One option for CY 2007 was to pay for the currently existing HCPCS code C2637 for Ytterbium-169 at charges converted to cost. However, this would be inconsistent with our final policy with regard to payment for brachytherapy sources under prospectively established payment rates. The law specifically required us to pay for all brachytherapy sources based upon charges converted to cost for CYs 2004 through 2006. However, that provision will expire for the CY 2007 OPPS. In addition, this methodology would be inconsistent with the prospective payment methodologies we use to provide payments for other new items and services under the OPPS for which we do not yet have claims data.

A second option was to assign the code to its own APC or to a New Technology APC with a payment rate set at or near the lowest CY 2007 payment rate for any source of brachytherapy paid on a per source basis (as opposed, for example, to per mci), for CY 2007. However, we had no claims data or other information regarding the cost of HCPCS code C2637 to hospitals. This payment policy would resemble our policy regarding the APC assignment of not otherwise classified codes, which are assigned to the lowest level APC in their clinically compatible series. However, HCPCS code C2637 is a specifically defined brachytherapy source, and such a payment rate would not recognize the clinical distinctions among brachytherapy sources, including their differences in isotopes and radioactive intensities, that are relevant to their clinical uses in low dose rate (LDR) versus HDR brachytherapy. The solid brachytherapy source with the lowest final median cost for CY 2007 is HCPCS code C1719, for non-HDR Iridium-192, with a median cost of $23.01 per source, which is implanted in LDR brachytherapy.

A third option was to assign HCPS code C2637 to its own APC or to a New Technology APC with a payment rate established at or near the proposed payment rate for HCPCS code C1717, which describes HDR Iridium-192. Like HCPCS code C2637, HCPCS code C1717 is used for HDR brachytherapy, and HCPCS code C1717 is the most commonly used source for HDR brachytherapy under the OPPS. However, this approach would not take into consideration significant differences in the two sources, including their radioactive isotopes and energy levels.

The fourth option was to assign HCPCS code C2637 to its own APC or to a New Technology APC with a prospective payment rate based on external data provided to us regarding the expected cost of the source to hospitals. If we were provided reliable and relevant cost information for the source, we could establish its payment rate based on that information and our review of other pertinent considerations, as we do for new technology services under the OPPS. Under this option, in the absence of external cost information, we would not recognize HCPCS code C2637 under the OPPS for CY 2007 until we received such information and could establish a payment rate in a quarterly OPPS update. We provided the brachytherapy source Ytterbium-169 a HCPCS code in CY 2005 at the manufacturer's request, based on the belief that the source would be marketed shortly. However, the product has not yet been marketed. Therefore, we recognize a HCPCS code for an item that is not currently available to hospitals. We do not typically issue and maintain as payable a HCPCS code for an item that is not marketed. Under this option, if the source were marketed mid-quarter in CY 2007 and cost information was provided to us, there would be no payment available for the source until the next OPPS quarterly update, which would establish the payment rate for HCPCS code C2637 and its effective date.

After weighing the above options, we proposed the second option discussed, that is, to assign C2637 to its own APC or a New Technology APC with a payment rate set at or near the lowest proposed payment rate for any source of brachytherapy paid on a per source basis. This option resembled our policy regarding the APC assignment of not otherwise classified codes, in the absence of any data currently available. Once we had claims data, or obtain external data, we could consider movement to another APC, if warranted.

We specifically invited comments on how we should establish the CY 2007 payment amount for Ytterbium-169 (HCPCS code C2637), especially with consideration of the four options discussed above, and on how we should generally proceed in the future to set

payment amounts for established or new brachytherapy sources eligible for separate payment under section 1833(t)(2)(H) of the Act, for which we have no claims-based cost data.

We received a number of public comments concerning our four proposed CY 2007 payment options for Ytterbium-169 and/or other new brachytherapy sources without hospital costs from claims data. A summary of the comments and our responses follow.

Comment: A few commenters recommended that we pay for ytterbium, and other new or established brachytherapy sources when no hospital claims data are available, at charges reduced to cost, which was generally the commenters' recommendation on payment for all sources. Several commenters claimed that ytterbium would be available to hospitals in CY 2007. The commenters noted that ytterbium is an HDR source with unique characteristics and that, as described in its original request to CMS for a HCPCS code, ytterbium has a shorter half-life than HDR Iridium-192, requiring replacement every 32 days versus 90 days for HDR iridium. The commenters also noted different shielding and target activity for ytterbium in comparison with HDR iridium. Because there are no other sources comparable to ytterbium, some commenters believed the most appropriate payment methodology was charges reduced to cost for a minimum of 2 years, while CMS collects claims data. The commenters believed that CMS should similarly employ the payment methodology of charges reduced to cost for other new sources when there are no hospital claims data available. A number of commenters recommended that CMS pay for new sources on the basis of charges reduced to cost for a period of 3 years.

Reponse: The commenters presented no compelling arguments that new sources for which there are no claims data need to be paid at charges reduced to cost. Such an approach is contrary to the way we generally pay for other new nonpass-through items and services based on prospective payment rates through their APCs in the OPPS. We note that none of the commenters, including the manufacturer of ytterbium, provided the cost of that source when it reportedly will be marketed in CY 2007. However, we agree with the commenters that we need to pay appropriately for new brachytherapy sources in order to ensure continued developments in the technology. We have determined that our proposed option, to pay for new brachytherapy sources based upon the lowest per source payment rate of currently available sources, could provide payments for new sources that were too low to permit continued new developments in brachytherapy technology. Therefore, after weighing the comments and the four options, we are adopting as final the fourth option discussed for CY 2007. That is, 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. This approach is consistent with our usual treatment of new technologies under the OPPS. We do not pay for new technologies, other than pass-through devices, under the OPPS at charges adjusted to cost. Instead, for new technology services we utilize external data and other information available to us, including claims data on related services, to establish appropriate New Technology APC assignments for new services until we have costs from claims data specific to the new services. We would not assign a brachytherapy source to a New Technology APC because such APCs contain only services, and, according to the statute, we are to establish separate groups for payment of brachytherapy sources reflecting their number, isotope, and radioactive intensity. Therefore, when we establish HCPCS codes for new brachytherapy sources, we will utilize external data and other information available to us to establish a prospective payment rate specific to the source, for use until we have hospital costs from claims data. Consistent with this practice, although we solicited specific comments on payment for the ytterbium source in the CY 2007 proposed rule, to date we have received no cost data and have no other information that we could use to establish an informed prospective payment rate for the source. Therefore, we are assigning C2637 the nonpayable status indicator ''B'' for January 1, 2007, because we have no claims information or external cost data that would allow us to assign C2637 to its own APC with a prospective payment rate. Should we later receive relevant information, we could establish a payable status indicator and appropriate payment rate for the ytterbium source in a future OPPS quarterly update.

In our CY 2007 OPPS proposed rule, we again invited the public to submit recommendations for new HCPCS codes to describe new brachytherapy sources in a manner reflecting the number, isotope, and radioactive intensity of the sources (71 FR 49599). We requested that commenters provide a detailed rationale to support recommended new sources and send recommendations to us. We noted that we would continue our endeavor to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly basis (71 FR 49599). We specified that such recommendations should be directed to the Division of Outpatient Care, Mail Stop C4–05–17, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

As indicated in the CY 2007 OPPS proposed rule (71 FR 49599), we had considered the definition of the term ''brachytherapy source'' in the context of current medical practice, and in light of the language in section 1833(t)(2)(H) of the Act. We proposed to define a device of brachytherapy eligible for separate payment under the OPPS as a ''seed or seeds (or radioactive source)'' as indicated in section 1833(t)(2)(H) of the Act, which refers to sources that are themselves radioactive, meaning that the sources contain a radioactive isotope. Therefore, for example, we proposed that we would not consider specific devices that did not utilize radioactive isotopes to deliver radiation to be radioactive sources as envisioned by the statute.

We received numerous public comments in response to our request for new brachytherapy source recommendations and our proposed definition of the term ''brachytherapy sources.'' A summary of the comments and our responses follow.

Comment: A large number of commenters disagreed with our proposed definition of brachytherapy sources for separate payment for a variety of reasons. Several commenters stated that our definition based on section 1833(t)(2)(H) of the Act was too narrow, and should be broadened to include new and innovative nonradioactive sources, such as ''electronic'' brachytherapy sources. The commenters indicated that brachytherapy sources do not need to be radioactive to deliver therapeutic doses of brachytherapy. They recommended that CMS consider all new technologies now FDA-cleared for brachytherapy and broaden our definition for separate payment to include innovative radioactive and nonradioactive sources. Many commenters believed that adopting the proposed definition of brachytherapy sources for separate payment would prevent Medicare beneficiary access to care and hamper the development of new cancer therapies, such as ''electronic'' brachytherapy. Some commenters indicated that brachytherapy is not

defined by the type of source used to treat the cancer, but by the treatment that is delivered to the patient. A few commenters stated that, through discussions with legislators, it was their understanding that the intent of the legislation was to provide separate payment for all devices of brachytherapy and not to exclude any devices.

Reponse: As indicated in the CY 2007 OPPS proposed rule (71 FR 49599) and reiterated in this preamble above, 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 continue to believe 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, the statutory language is likewise clear that devices of brachytherapy paid for separately must reflect ''the number, isotope, and radioactive intensity of such devices furnished'.'' Accordingly, we further believe that section 1833(t)(2)(H) of the Act applies only to radioactive devices of brachytherapy.

We point out that forms of radiation delivery such as nonradioactive brachytherapy, which was used by commenters as the principal example of other forms of brachytherapy, do not constitute a brachytherapy source as contemplated by the statute. In addition to not containing a radioactive isotope, these forms of radiation delivery are dependent on external equipment to deliver therapeutic radiation to the treatment sites within the body.

Therefore, we will 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.

Comment: A few commenters claimed that section 1833(t)(2)(H) of the statute does not limit CMS to consider as new brachytherapy sources seeds or radioactive sources that are themselves radioactive. Some commenters cited section 1833(t)(2)(H) of the Act, while others defined current cancer therapies as ''a drug or biological that is used in cancer therapy, including (but not limited to) a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, a bisphosphonate, and a device of brachytherapy * * *'' and cited section 1833(t)(6) of the Act as authority for that definition. The commenters then stated that this definition did not require that a device of brachytherapy consist of a seed or seeds or radioactive sources, as we proposed, and that section 1833(t)(6) of the Act allegedly clearly indicated ''but not limited to,'' such that this list was not exclusionary. Another advocate of creating a new source code for ''electronic'' brachytherapy, cited section 1833(t)(2)(B) of the Act, which generally indicated that the Secretary may establish groups of services within the classification system that are comparable clinically and with respect to resources. Therefore, the commenters believed CMS should be able to group ''electronic'' brachytherapy with other sources, if they are comparable.

Reponse: The commenters miscite the statute, erroneously implying it is part of section 1833(t)(2)(H) of the Act. Section 1833(t)(6)(A)(ii) of the Act is the source of the commenters' quote and does not deal with separate payment of brachytherapy sources. Rather, the context of the quote is pass-through treatment of cancer therapies current when the Balanced Budget Refinement Act (Pub. L. 106–113) was enacted. The statutory authority mandating separate groups for payment discussed above is based on section 1833(t)(2)(H) of the Act. Specifically, section 1833(t)(2)(H) of the Act clearly states: ''With respect to devices of brachytherapy consisting of a seed or seeds (or radioactive source), the Secretary shall create additional groups of covered OPD services that classify such [brachytherapy] devices separately from the other services * * * in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished * * *.'' We believe that Congress clearly limited any requirement for separate payment of brachytherapy sources to those which reflect the number, isotope, and radioactive intensity of the sources and to a ''seed or seeds (or radioactive source)'' as stated in section 1833(t)(2)(H) of the Act. Furthermore, while section 1833(t)(2)(B) of the Act provides the authority to create new APCs to group similar services together or distinguish new and/or different services to group together in terms of clinical characteristics and resource costs, it must be read in conjunction with the requirements given in section 1833(t)(2)(H) of the Act. We do not believe that nonradioactive devices that deliver radiation are appropriately grouped with brachytherapy sources for separate payment, given that the statute also requires separate payment groups for brachytherapy sources to reflect the number, isotope, and radioactive intensity of the sources. We also remind the commenters that payment for devices under the OPPS, other than brachytherapy devices and those devices described by categories with active pass-through status, is packaged into the procedural APC payments for those services in which they are used.

Comment: A few commenters supported our definition of brachytherapy source.

Reponse: We appreciate the support for our proposal.

Comment: Another commenter requested a clarification regarding the definition of ''source,'' claiming that the word source leaves unclear whether multiple brachytherapy seeds would constitute multiple sources, or, because they are all implanted at one time, they would constitute a single source.

Reponse: Multiple brachytherapy seeds implanted during a single treatment session constitute multiple sources for billing on the claim to Medicare. For example, if 50 brachytherapy seeds are implanted, a hospital should report on its claim to CMS that it used 50 units of the source.

Comment: Several commenters recommended that CMS establish new HCPCS codes and descriptors for separate payment of additional brachytherapy sources. Specifically, several commenters recommended that CMS establish new codes for stranded sources, namely Iodine-125, Palladium-103, RAPID Strand Iodine-125 (a brand of iodine-125), and cesium-131 sources in CY 2007. Possible new codes and descriptors suggested for two of the stranded sources were: C26xx, Brachytherapy device, Stranded Iodine-125, per source; and C26xx, Brachytherapy device, Stranded Palladium-103, per source. One commenter recommended that CMS create a new source code for separate payment based on its product name: C26xx, Brachytherapy device, RAPID Strand Iodine-125, per source.

A few commenters recommended that CMS establish a new source code for separate payment as follows: Brachytherapy device, Stranded Cesium-131, per source. The commenters described stranded brachytherapy sources as embedded into the stranded suture material and separated within the strand by material of an absorbable nature at specified intervals. They claimed that this approach ensured the initial and long-term position of each source when implanted in and around tumors. The

commenters claimed that stranded sources were different from ''traditional'' sources in a number of ways, such as improved patient safety and clinical outcomes in the treatment of prostate cancer; increased production costs; requirements for separate FDA clearances; and potential for permitting greater radioactive intensity for treatment of specific patients because of their more precise positioning. The commenters further claimed that stranded sources could be placed at the periphery of the prostate or outside the prostate gland, permitting treatment of extra-prostatic extension of cancer without the potential for migration into another body organ. The commenters also pointed out that CMS has separately coded differences in configurations of previously established isotopes among brachytherapy source codes (that is, linear palladium-103 is separately coded as C2636). Some commenters claimed that thousands of Medicare patients received stranded iodine and palladium in CY 2006, whose specific costs would not have been reflected through separate codes for these source variants.

Some commenters asserted that the lack of separate coding results in no separate data on the clinical practice for stranded sources. They claimed that CMS' CY 2005 data do not reflect important new clinical protocols that have emerged over the past few years, which have resulted in increased clinical use of stranded and ''custom-stranded'' sources for the treatment of prostate cancer. The commenters indicated that absence of data concerning stranded brachytherapy sources was a significant flaw in CMS' current data because stranded sources were distinct from traditional brachytherapy sources.

Reponse: Section 1833(t)(2)(H) of the Act requires the creation of separate APC groups for brachytherapy sources that reflect the number, isotope, and radioactive intensity of the brachytherapy devices (sources) furnished. Stranding of existing sources of a certain isotope, such as iodine or palladium, is a specific clinical configuration that does not affect the number, isotope, and radioactive intensity of the brachytherapy sources, and thus would not lead to a separate APC grouping. While we created a new source code, C2636, linear palladium-103, per 1 mm, even though a code already existed for palladium-103 (C1720), we determined that the linear palladium source led to a change in the number of sources used, because it required a different, and therefore separate, measurement, per millimeter, as opposed to per source (that is, seed).

We agree that it is probable that thousands of Medicare patients received stranded iodine and palladium in CY 2006, and further agree that stranded iodine and palladium are likely well-represented in our historical claims data, such that stranded source costs and utilization are reflected in the source codes for iodine and palladium, C1718 and C1720, respectively. Therefore, their use should be well-represented in the respective median costs for these C-codes in our CY 2005 data used to establish CY 2007 payment rates. The GAO drew similar conclusions in its study of brachytherapy source purchase prices, where they believed that their purchase price data reflected information across the full spectrum of brachytherapy source configurations provided by hospitals during the study period. Neither the GAO data nor the CY 2005 Medicare claims data reflect significant variation in the hospital costs of iodine and palladium sources. Our preferred treatment of iodine, palladium, and cesium sources is consistent with our general expectation that, as technology evolves and grows in utilization, the costs of the newer technologies will increasingly be reflected in the claims data used to establish prospective payment rates for future services.

Accordingly, we are not creating new brachytherapy source codes for separate payment for stranded iodine-125, stranded palladium-103, RAPID Strand Iodine-125, or stranded cesium-131 sources.

Comment: A number of commenters recommended that CMS establish a new brachytherapy source code and descriptor for ''electronic'' brachytherapy, effective January 1, 2007, with the following recommended code descriptor: C26xx, Brachytherapy device, High Dose Rate X-ray radiation, per source. The commenters made no recommendation on how to define ''per source.'' The commenters stated that technological advances demonstrate that nonradioactive sources can deliver a therapeutic radiation dose similar to a radioactive source or seed. They claimed that brachytherapy treatment does not define the type of source; instead, it defines a type of treatment and there may be many kinds of sources used in such treatments.

Response: We agree that nonradioactive sources may be capable of delivering a therapeutic radiation dose similar to a radioactive source or seed. However, we believe that nonradioactive sources do not meet the definition of brachytherapy sources for separate payment under section 1833(t)(2)(H) of the Act as previously indicated in our discussion of the definition of brachytherapy sources eligible for separate payment. Consistent with our discussion of the definition of a brachytherapy source, we are not creating a new brachytherapy source code for separate payment for ''electronic'' brachytherapy.

Comment: One commenter, the manufacturer of the Intrabeam system, recommended that CMS designate the radiation source used in the Intrabeam procedure as a brachytherapy device and provide separate payment for the source. The commenter claimed the radiation from the Intrabeam system is delivered directly into a tumor cavity, and therefore, by definition, is a form of brachytherapy. The commenter also claimed that the Intrabeam radiation source is a point source that is similar to other brachytherapy sources, such as seeds or pellets. The commenter stated that the wording of section 1833(t)(2)(H) of the Act, ''with respect to devices of brachytherapy consisting of a seed or seeds (or radioactive source), the Secretary shall create additional groups of services * * *'' to establish separate brachytherapy source payment would include the Intrabeam brachytherapy source within that definition of a source. The commenter argued that the temporarily activated gold of the Intrabeam system is a radioactive source as described in the statute. The commenter claimed that the statutory language does not limit brachytherapy sources to only radioactive isotopes, as is evidenced by the more general language ''or radioactive source.''

Response: Based on the commenter's description, the Intrabeam system relies upon a miniature x-ray source, where electron beams travel to strike a gold target and x-rays are then emitted to treat the tissue surrounding a tumor cavity. The Intrabeam procedure uses external equipment to generate the electron beam, and the gold target is not itself a radioactive isotope used to provide radiation treatment. As noted previously, such forms of brachytherapy do not constitute a brachytherapy source as contemplated by the statute. In addition to not containing a radioactive isotope, such forms of radiation delivery are dependent on external equipment to deliver therapeutic radiation to the treatment sites within the body. The statute requires us to establish separate payment groups for brachytherapy sources that classify them separately based on their number, isotope, and radioactive intensity. We do not believe the concept of an isotope applies to the

Intrabeam system. Therefore, we are not creating a new brachytherapy source code for separate payment for the radiation source used in the Intrabeam system.

After carefully considering the public comments received, we are not accepting any of the recommendations provided above by commenters for the establishment of new HCPCS codes to describe new brachytherapy sources for CY 2007. However, consistent with our general practice, we will consider recommendations submitted by the public for new brachytherapy sources during CY 2007, as discussed earlier. In addition, we are adopting as final our proposed definition of the term ''brachytherapy source'' without modification.

VIII. Changes to OPPS Drug Administration Coding and Payment for CY 2007

A. Background

From the start of the OPPS until the end of CY 2004, three HCPCS codes were used to bill drug administration services provided in the hospital outpatient department:

- Q0081 (Infusion therapy, using other than chemotherapeutic drugs, per visit)
- Q0083 (Chemotherapy administration by other than infusion technique only, per visit)
- Q0084 (Chemotherapy administration by infusion technique only, per visit).

A fourth OPPS drug administration HCPCS code, Q0085 (Administration of chemotherapy by both infusion and another route, per visit), was active from the beginning of the OPPS through the end of CY 2003.

Each of these four HCPCS codes mapped to an APC (that is, Q0081 mapped to APC 0120, Q0083 mapped to APC 0116, Q0084 mapped to APC 0117, and Q0085 mapped to APC 0118), and the APC payment rates for these codes were made on a per-visit basis. The per-visit payment included payment for all hospital resources (except separately payable drugs) associated with the drug administration procedures. For CY 2004, we discontinued using HCPCS code Q0085 to identify drug administration services and moved to a combination of HCPCS codes Q0083 and Q0084 that allowed more accurate calculations when determining OPPS payment rates.

In CY 2005, in response to the recommendations made by commenters and the hospital industry, OPPS transitioned to the use of CPT codes for drug administration services. These CPT codes allowed for more specific reporting of services, especially regarding the number of hours for an infusion, and provided consistency in coding between Medicare and other payers. However, 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 hospital outpatient department, without regard to whether or not the CPT code would receive a separate APC payment during OPPS claims processing.

While hospitals were just 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 proposed a crosswalk that mapped the expected CY 2006 CPT codes (represented by CY 2005 G-codes used in the physician office setting, the closest proxy at the time) to the APC payment structure implemented in CY 2005. Our crosswalk was reviewed by the APC Panel at both the February and August 2005 meetings, and was included in the CY 2006 OPPS proposed rule. During the proposed rule comment period, we received a number of comments that prompted several revisions to our proposed crosswalk, including the development of complex claims processing logic to assign correct payment for certain drug administration services that would vary based on other drug administration services provided during the same patient visit. These revisions were a result of the growing understanding, facilitated by the preview of CPT drug administration coding guidelines developed by the CPT Editorial Panel, in the hospital community of the multiple implications associated with adopting the newly introduced CPT concepts of initial, sequential, and concurrent services.

Upon review of the completed revisions to our proposed CY 2006 methodology, and following a comprehensive assessment of all public comments, 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 six 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. In addition, numerous commenters indicated that implementing certain CPT codes in a fashion consistent with the code descriptors would present hospitals with difficult operational and administrative challenges, because concepts integral to the codes were inconsistent with the clinical patterns of drug administration services provided in hospital outpatient departments. In addition to coding changes, CY 2006 payment rates for drug administration services were updated based upon CY 2004 claims, and we continued the claims processing logic that required hospitals providing drug administration services to report all applicable drug administration HCPCS codes, despite some codes being collapsed into one APC for payment purposes.

B. CY 2007 Drug Administration Coding Changes

In the CY 2007 OPPS proposed rule, we proposed to continue the CY 2006 OPPS drug administration coding structure, which combined CPT codes with several alphanumeric HCPCS C-codes. However, we solicited comments from hospitals regarding their experiences in implementing, for purposes of reporting to other payers, the CY 2006 CPT codes reflecting the concepts of initial, sequential, and concurrent services.

Due to the discrepancies between APC payments (based on per-visit hospital claims data) and per-service CPT/HCPCS coding in CY 2005 and CY 2006, we provided special instructions to hospitals regarding the appropriate use of modifier 59 in relation to OPPS drug administration services in order to

ensure proper OPPS payments consistent with our claims processing logic. As the need no longer existed, for CY 2007 we proposed to instruct hospitals to apply modifier 59 to drug administration services using the same correct coding principles that they generally use for other OPPS services.

At its August 2006 meeting, the APC Panel recommended that CMS recognize only the AMA's CPT codes for outpatient hospital reporting of drug administration services in CY 2007. We discuss our response to this recommendation along with our response to comments presented below.

We received numerous comments from individual hospitals, health systems, university medical centers, physicians, community cancer centers, pharmaceutical companies, specialty societies, and various healthcare associations, on our proposal to continue with the existing CY 2006 OPPS drug administration coding structure for CY 2007, which combined CPT codes with several C-codes, as well as comments on the use of the CPT codes.

Comment: A few commenters requested that CMS continue with the current CY 2006 coding scheme of using CPT and C-codes for CY 2007, while many others requested that CMS use the CPT codes. The commenters supportive of our CY 2007 proposal indicated that the CY 2006 CPT drug administration codes were not applicable in the hospital setting because these codes were created specifically for physician use. Several commenters urged CMS to work with the CPT Editorial Panel and others to make revisions to the existing CPT codes so they are more reflective of hospital services.

Overall, the vast majority of commenters requested that CMS adopt the full set of CPT codes for drug administration services in CY 2007, as many hospitals have been using these codes for non-Medicare payers for the past year. Several commenters indicated that the use of the CPT codes would reduce hospital's current operational burden related to charging different payers with different code sets, including the burden of maintaining two very different sets of codes for essentially the same services. They added that OPPS use of the full set of CPT codes would also promote consistency and transparency across sites of service and payment systems. The commenters also noted that, contrary to last year's substantial concerns regarding the operational aspects of implementing these codes, they have now adopted the full CPT code set, including full code descriptors and applicable CPT guidelines. However, even those commenters favoring adoption of the full set of drug administration CPT codes acknowledged that some outstanding questions remain regarding billing scenarios using the CPT codes, and they requested additional guidance from CMS on these issues. Nevertheless, commenters were overwhelmingly in favor of reporting the same codes to all payers.

Response: In the CY 2006 OPPS final rule with comment period (70 FR 68679), we indicated that we decided not to recognize 13 of the 33 CPT drug administration codes in an effort to minimize the administrative and operational burden hospitals would have reportedly faced if we had adopted all 33 of the CY 2006 drug administration CPT codes. In particular, many hospitals expressed concern regarding significant administrative problems in implementing the subset of CY 2006 CPT drug administration codes that incorporated the concepts of initial, sequential, and concurrent. At that time, a substantial number of commenters requested that, if CMS were to implement the full set of CY 2006 CPT codes in the hospital outpatient setting, in order for the codes to be applicable to the hospital setting, CMS would need to direct hospitals to disregard elements of the code descriptors. As it is not our practice to alter CPT codes in order to apply them to a particular site of service, we decided not to implement the full set of CPT codes at that time. Instead, we developed alphanumeric HCPCS C-codes for the hospital setting to replace those CY 2006 CPT drug administration codes with the problematic concepts of initial, sequential, and concurrent.

During CY 2006, we received anecdotal information related to hospitals' experience implementing the full set of CY 2006 CPT codes for non-Medicare payers. While yet another transition to new drug administration codes was frustrating, these commenters, like commenters responding to our CY 2007 proposed rule request for information, noted that the operational issues were no longer a primary concern with drug administration coding, and they had gained valuable experience over the past year reporting these codes to non-Medicare payers. Instead, their concern was the time, effort, and administrative costs associated with maintaining two code sets for one group of services.

After considering the recommendation of the APC Panel discussed above, and after carefully considering all the public comments received on the CY 2007 OPPS proposed rule, we have decided to adopt the full set of CPT codes for CY 2007 for use under OPPS. Therefore, we are accepting the August 2006 recommendation of the APC Panel to use only CPT codes for the reporting of drug administration services in the CY 2007 OPPS. Table 31 lists the alphanumeric HCPCS codes that were created to replace the CPT codes reflecting the concepts of initial, sequential, and concurrent, that are deleted effective December 31, 2006.

TABLE 31.—DRUG ADMINISTRATION C-CODES THAT WILL NO LONGER BE REPORTABLE UNDER THE OPPS IN CY 2007

HCPCS Code	Long description
C8950	Intravenous infusion for therapy/diagnosis; up to 1 hour.
C8951	Intravenous infusion for therapy/diagnosis; each additional hour (List separately in addition to C8950).
C8952	Therapeutic, prophylactic or diagnostic injection; intravenous push of each new substance/drug.
C8953	Chemotherapy administration, intravenous; push technique.
C8954	Chemotherapy administration, intravenous; infusion technique, up to one hour.
C8955	Chemotherapy administration, intravenous; infusion technique, each additional hour (List separately in addition to C8954).

Comment: We received a few comments requesting that we retain HCPCS code C8957 (Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring the use of portable or implantable pump), if we finalize a policy to transition to the full set of CPT codes for CY 2007. These commenters expressed appreciation for CMS' development of the Level II HCPCS code, as there is currently no CPT code that describes this service.

Response: We appreciate the support of commenters in the development of this code, and we agree that there is no comparable CPT code for this service. As such, we are retaining HCPCS code C8957 for use in the CY 2007 OPPS because there is no comparable CPT code available to report this service.

Table 32 lists drug administration HCPCS codes, associated status indicators, and CY 2007 APC assignments, where applicable, for CPT codes that will be newly recognized under the OPPS for reporting drug

administration services provided in hospital outpatient departments on or after January 1, 2007.

TABLE 32.—CY 2007 NEWLY RECOGNIZED DRUG ADMINISTRATION CPT CODES*

2007 CPT code	2007 description	2007 APC	CY 07 SI
90760	Intravenous Infusion, hydration; initial, up to one hour	0440	S
90761	Intravenous Infusion, hydration; each additional hour (list separately in addition to code for primary procedure).	0437	S
90765	Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); initial, up to one hour.	0440	S
90766	Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); each additional hour (List separately in addition to code for primary procedure).	0437	S
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).	0437	S
90768	Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure).	—	N
90774	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug.	0438	S
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).	0438	S
96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug	0439	S
96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure).	0439	S
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	0441	S
96415	Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure).	0438	S
96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour.	0438	S

* Current Procedural Terminology (CPT) codes and descriptors are copyrighted by the American Medical Association (AMA).

For CY 2007, we reiterate our CY 2006 final rule statement reminding hospitals that they are expected to report all drug administration CPT codes in a manner consistent with their descriptors, CPT instructions, and correct coding principles. As we have done in the past, we will release instructions separately from this final rule with comment period that will provide additional OPPS-specific guidance for hospital outpatient departments providing drug administration services in CY 2007.

Comment: A few commenters requested that, if CMS implement the full set of CPT codes, CMS should also provide hospitals with specific instructions on how to bill for CPT codes 90761, 90766, and 96415, as their CY 2006 code descriptors included a statement that they were to be billed for each hour ''up to 8 hours'' or ''1 to 8 hours.'' The commenters requested OPPS billing instructions in the event that infusions reported with these codes lasted longer than 8 hours.

Response: As indicated in Table 32, the CPT Editorial Panel has removed the reference to ''up to 8 hours'' and ''1 to 8 hour'' in the code descriptors for these three infusion service for CY 2007. Therefore, we do not believe any additional guidance is required for hospitals at this time.

Comment: Several commenters requested additional instructions regarding the administration of IVIG, hyperimmune IVIG, and DNA- or RNA-based therapies. Specifically, the commenters requested that CMS identify these items as biological response modifiers and instruct hospitals to report chemotherapy administration codes for these services in recognition of the significant resources incurred by hospitals that provide them.

Response: CPT instructions for the CY 2006 CPT code set included a statement that chemotherapy administration codes are appropriate for chemotherapy services but also apply to ''parenteral administration of non-radionuclide antineoplastic drugs; and also to antineoplastic agents provided for treatment of noncancer diagnoses (for example, cyclophosphamide for auto-immune conditions) or to substances such as monocolonal antibody agents, and other biologic response modifiers.'' As is our longstanding practice, we defer questions about CPT code definitions to the AMA CPT Editorial Panel as they are the creators and maintainers of the CPT code set.

Comment: Several commenters requested that CMS remove various National Correct Coding Initiative (CCI) edits related to drug administration codes. These commenters expressed frustration about the increased administrative burden associated with identifying separate instances of drug administration services provided on the same day as a procedure that includes a drug administration service.

Response: We continue to believe that CCI edits for drug administration services are appropriate for the hospital outpatient department setting. We refer commenters with questions and concerns related to particular CCI edits to the National Correct Coding Initiative Policy Manual for Medicare Services at *http://www.cms.hhs.gov/NationalCorrectCodInitEd/.*

C. CY 2007 Drug Administration Payment Changes

Prior to CY 2005, hospitals were reporting per-day drug administration codes under the OPPS. These codes did not distinguish between the number of services, types of service, or duration of services provided. Hospitals received per-day APC payments for chemotherapy infusions, non-chemotherapy infusions, and chemotherapy other than infusion. With the implementation of CPT codes in CY 2005, hospitals began reporting separate codes and associated charges for many drug administration services for purposes of the OPPS. The CY 2007 update process offered us the first opportunity to consider this data for purposes of ratesetting.

For the CY 2007 proposed rule, we explained that we expected codes for additional hours of infusion to be reported with codes for the first hour of

infusion. This would result in a substantial set of claims that were unusable for ratesetting purposes because multiple services would be present on the same bill. (See section II.A. of this preamble for a further discussion of multiple bills and our ratesetting methodology). In order to use these claims, we explained our process of adding three CY 2005 drug administration CPT codes 90781 (Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; each additional hour, up to eight (8) hours); 96412 (Chemotherapy administration, intravenous; infusion technique, one to 8 hours, each additional hour); and 96423 (Chemotherapy administration, intra-arterial; infusion technique, one to 8 hours, each additional hour) to the bypass list in the CY 2007 proposed rule in order to create ''pseudo'' single claims that would be useable for OPPS ratesetting purposes. After creation of these ''pseudo'' single claims, we applied the standard OPPS methodology to calculate HCPCS median costs for these three drug administration codes and mapped their respective data to the APCs to which we assigned CY 2005 drug administration claims data for purposes of calculating these proposed APC median costs.

As we explained in the CY 2007 proposed rule, bypassing these three CPT codes and developing additional ''per unit'' claims provided a methodology to calculate median costs for these previously packaged drug administration services and to attribute all of their cost data to their assigned APCs. However, this methodology allocates all packaging on the claim related to drug administration to the associated first hour drug administration code. Because these additional hours of infusion codes were always reported with other drug administration services, we expected that the packaging related to additional hours of infusion would be appropriately assigned to the drug administration services on the same claim. While we stated our belief that there are some packaged costs that are clinically related to the second and subsequent hours of infusion, especially for infusions of packaged drugs spanning several hours, we were not able for purposes of the CY 2007 proposed rule to accurately assign representative portions of packaged costs to multiple different services due to the limitations of our claims data. In the proposed rule, we indicated that we believed this proposed methodology took into account all of the packaging on claims for drug administration services and provided a reasonable framework for developing median costs for drug administration services that were often provided in combination with one another.

After calculating HCPCS code median costs for all drug administration services, including injections and antigen therapy services, we created a comprehensive set of new APC groupings of CY 2005 HCPCS codes for drug administration services and based our assignments upon hospital resources utilized as reflected in HCPCS code median costs and clinical coherence. The result of this analysis was the development of six proposed drug administration APC levels based on CY 2005 claims data for the CY 2007 OPPS. The proposed structure was displayed in Table 30–1 of the CY 2007 OPPS proposed rule, and a refined table, reflective of the complete updated CY 2005 hospital claims data, is shown below in Table 33.

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Table 33.--Final Six-Level APC Structure of CY 2005 CPT Drug Administration Codes Used to Develop CY 2007 APC Payment Rates

CY 2007 Drug Administration APC Level	CY 2005 CPT/HCPCS Code	Description	CY 2007 APC Reflecting Claims Data
LEVEL I	90472	Immunization admin, each add	0436
	90473	Immune admin oral/nasal	
	90474	Immune admin oral/nasal addl	
	90799	Ther/prophylactic/dx inject	
	95115	Immunotherapy, one injection	
	96549	Chemotherapy, unspecified	
LEVEL II	90471	Immunization admin	0437
	90781	IV infusion, additional hour	
	90782	Injection, sc/im	
	90788	Injection of antibiotic	
	95117	Immunotherapy injections	
	95144	Antigen therapy services	
	95145	Antigen therapy services	
	95146	Antigen therapy services	
	95147	Antigen therapy services	
	95148	Antigen therapy services	
	95149	Antigen therapy services	
	95165	Antigen therapy services	
	95170	Antigen therapy services	
	G0008	Admin influenza virus vac	
	G0009	Admin pneumococcal vaccine	
	G0010	Admin hepatitis b vaccine	
LEVEL III	90783	Injection, ia	0438
	90784	Injection, iv	
	96400	Chemotherapy, sc/im	
	96405	Chemo intralesional, up to 7	
	96406	Chemo intralesional over 7	
	96412	Chemo, infuse method add-on	
	96423	Chemo ia infuse each addl hr	
	96542	Chemotherapy injection	
LEVEL IV	96408	Chemotherapy, push technique	0439
	96420	Chemo, ia, push technique	
LEVEL V	90780	IV infusion therapy, 1 hour	0440
	96520	Port pump refill & main	
	96530	Syst pump refill & main	

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In the proposed rule, we noted that proposed placement of the CY 2005 drug administration HCPCS codes into the six APC levels followed logical,

clinically coherent principles, and was consistent with both expected and observed differences in hospital resource costs, both across levels and within each level. For example, the first hour of chemotherapy infusion was assigned to Level VI, while additional hours of chemotherapy infusion were assigned to Level III. This structure was mirrored by the nonchemotherapy codes that showed the first hour of nonchemotherapy infusion assigned to Level V, while additional hours of nonchemotherapy infusion were assigned to Level II.

Using this structure as a base, we assigned the CY 2006 OPPS drug administration codes to the six-level APC structure based on their clinical and expected hospital resource characteristics. This general structure was presented to the APC Panel during the March 2006 meeting and was our proposed structure for CY 2007. The Panel recommended using the bypass methodology as described above for the three additional hours of infusion codes to develop their median costs and supported separate payment for each additional hour of infusion for CY 2007. In the proposed rule, we accepted the APC Panel's recommendation for CY 2007 to use the proposed structure with the bypass and ''per unit'' methodology as described above as it established a drug administration payment structure that included a methodology to pay for infusion services by the hour.

Hospitals' cooperation during CY 2005 in reporting all drug administration services, whether or not separate payments were made for all such services, allowed us to develop robust median costs for individual services so that we had sufficient information to propose this more specific APC payment structure for drug administration services for CY 2007. In the proposed rule, we indicated that we believed that this structure would make appropriate payments for the hospital resources required to provide drug administration services, as we had large numbers of claims for many specific drug administration services that revealed significant and differential costs. In particular, we noted that using the six-level APC structure should allow us to make more accurate payments to hospitals for complex and lengthy drug administration services furnished to Medicare beneficiaries for many medical conditions, while also providing accurate payments for individual services when they were provided alone.

The APC Panel made a number of additional recommendations regarding payment for CY 2007 OPPS drug administration services at its August 2006 meeting in addition to the recommendation, discussed above, that CMS adopt the full set of CPT drug administration codes for CY 2007 OPPS purposes. First, the Panel recommended that if CMS does not recognize only the AMA CPT codes for drug administration services for CY 2007, CMS should allow hospitals to separately bill and receive payments for therapeutic infusions and hydration infusions provided in the same encounter. We do not believe that a response to this recommendation is required, as we have adopted the full set of CPT codes for CY 2007, as discussed above. Second, the Panel recommended that CMS make payment for a second or subsequent intravenous push of the same drug by instituting a modifier, developing a new HCPCS code for the procedure, or implementing another methodology in CY 2007. We discuss this recommendation along with comments on this issue in further detail below. Third, the Panel recommended that CMS provide payment for all intravenous pushes and therapeutic injections for pain management and other clinical conditions, regardless of the setting (for example, post-operative anesthesia care unit, cardiac catheterization laboratory). Again, we discuss this issue in greater detail below. Finally, the Panel recommended that CMS provide claims analyses of the contribution of packaged costs (considering packaged drugs and other packaging) to the median cost of each drug administration service.

During the March and August 2006 meetings of the APC Panel, the Panel recommended that we provide additional information specific to the costs of packaged items that are represented in drug administration APC rates. Specifically, the Panel recommended that:

- CMS provide the Panel with data that indicate the costs of packaged drugs that are incorporated into drug administration payment rates (March 2006).
- CMS provide claims analysis of the contributions of packaged costs (considering packaged drugs and other packaging) to the median cost of each drug administration service (August 2006).

We have performed a preliminary analysis on a subset of CY 2005 claims data (the data that was used in preparation for the CY 2007 proposed rule). We intend to provide a more complete analysis based on CY 2005 final rule data to the APC Panel during its next meeting; this preliminary analysis only serves as a brief summary of our initial findings.

We identified CY 2005 single claims (including ''pseudo'' single claims derived from the process detailed in section II.A.1. of this preamble) for drug administration services. We used all active CY 2005 drug administration codes, but excluded the additional hour infusion codes (as these hours were not separately payable in CY 2005). In addition, their treatment as codes on the bypass list results in no packaging being attributed to their ''pseudo'' single claims. Correct coding results in their claims always being multiple claims, so we have no correctly coded natural single claims for these procedures.

We identified 16 separate revenue codes where we expected hospitals would associate packaged drugs—namely, those revenue codes that are in the 250 series (Pharmacy), 260 series (IV Therapy) and 630 series (Drugs Require Specific ID). We assumed that, for purposes of this analysis, packaged drug costs were included on claims with revenue codes listed above or with a drug HCPCS code that in CY 2005 was assigned status indicator ''N.'' We also assumed that hospitals reported the charges for the packaged drugs on the same claim on which they reported the drug administration code, with the same date of service.

We calculated both the median and mean percentages on these single and ''pseudo'' single claims for: (1) All packaged costs (drug or not); and (2) the subset of packaged drug/pharmacy costs (defined as a code for either a drug revenue code cost or a packaged drug HCPCS code). We calculated the median costs by calculating the percentages for each single bill (including ''pseudo'' singles), arraying them, and calculating the 50th percentile of the array. We calculated the mean costs by summing the packaged costs of each type for the code and dividing each by the sum of all total costs for the code.

Our initial analysis indicates that, for the highest volume drug administration codes, there is a significant amount of drug packaging costs on their claims that are used for ratesetting. For example, CPT code 90780 for the first hour of nonchemotherapy intravenous infusion has a median of 27 percent of packaging of any type and a median of 15 percent of drug/pharmacy packaging, showing clearly that the cost of packaged drugs is reflected in the median for the code. Its respective mean amounts are 30 percent and 22 percent. Similarly, for CPT code 6410, used to report the first hour of chemotherapy intravenous infusion, the median amount of packaging of any type is 21 percent, and the median amount of drug/pharmacy packaging is 13 percent.

Its mean amounts are 27 percent and 20 percent respectively. The findings are also similar for CPT code 96422 for the first hour of an intra-arterial chemotherapy infusion. Its median amount of packaging is 51 percent, and the median amount of drug/pharmacy packaging is 34 percent.

We expect to replicate this study using final rule data for presentation to the APC Panel at its first meeting in CY 2007 and to present our results in more detail. However, we believe that these findings demonstrate that the costs of packaged drugs are reflected in the payment for the services with which they are furnished, contributing significant costs to establishment of the ultimate drug administration services payment rates. We note that in many cases in which drug administration codes are billed, Medicare also pays for separately paid drugs at ASP+6 percent. Therefore, the total payment for the drugs administered in an encounter is the sum of payment for separately paid drugs and the portion of the APC payment for drug administration services that reflects the packaged costs of drugs/pharmacy. As mentioned above, we intend to present this study, with updated data, to the APC Panel at the next Panel meeting. Therefore, we are specifically requesting feedback regarding the usefulness of this information to the hospital community.

We received numerous comments on our payment proposal for drug administration services in the CY 2007 OPPS proposed rule.

Comment: A number of commenters believed that the assignments of CY 2005 cost data to the six APCs to develop their proposed median costs were appropriate. Many commenters were extremely supportive of the CY 2007 proposal to pay separately for each hour of drug infusion, indicating that this payment methodology would provide appropriate payment for infusions whose resources varied depending on the length of the infusions. Several commenters noted that the current CY 2006 methodology of paying for drug administration services does not pay separately for the second and subsequent hours of drug administration, and instead, packages them into payment for the first hour of drug administration. One commenter suggested that the packaging of the second and subsequent hours for drug administration resulted in inadequate reimbursement to hospitals because the payment did not reflect the true cost of providing the service, particularly in those instances that involved patients who received chemotherapy infusions that last 2 or more hours.

Response: We appreciate the commenters' support for our proposal to pay for drug administration services through a six-level APC structure for CY 2007, with separate payment to be provided for each hour of drug infusion. We remind commenters that our APC rates are based upon median costs calculated from historical hospital claims, and hospitals reporting multiple hours of infusion service were instructed to report the costs for these hours beginning in CY 2005.

Comment: Several commenters expressed their concerns regarding the low proposed payment rates for three chemotherapy administration codes described by CPT codes 96440 (Chemotherapy administration into pleural cavity, requiring and including thoracentesis); 96445 (Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis); and 96450 (Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture). In particular, commenters disagreed with our proposed APC assignments for CPT codes 96440 and 96445 to APC 0439 (Level IV Drug Administration), which had a proposed payment rate of $97.50, and CPT code 96450 to APC 0441 (Level VI Drug Administration), which had a proposed payment rate of $154.31. These commenters reported that the chemotherapy administration services described by these three CPT codes are far more intensive and require more facility resources than the other drug administration services currently assigned to the same APCs.

The commenters further illustrated that when CPT code 96440 or CPT code 96445 is reported, hospitals cannot report separately the surgical procedure that is required for the drug administration service, such as CPT code 32000 (Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent) or CPT code 49080 (Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial). They observed that the proposed payments for both surgical procedures were $224.20, and they believed that payments for the more extensive drug administration services should, therefore, be significantly higher than $224.20. The commenters strongly urged CMS to reevaluate the APC assignments for these chemotherapy administration codes. One commenter proposed three options for how CMS could make changes to the APC assignments for the three CPT codes. Specifically, they requested that CMS reassign CPT codes 96440, 96445, and 96450 to higher paying APCs, create a new APC group with a significantly higher payment rate for them, or instruct providers to report both the surgical procedures and the related drug administration codes as separate line items for the single service.

Response: We will not instruct hospitals to report CPT codes in a manner that is inconsistent with their code descriptors, such as would be the case if we asked hospitals to separately report the minor surgical procedures required to administer the chemotherapy services, when those puncture procedures are included in these drug administration code descriptors. We also note that the final median costs for these procedures are $160.03 for CPT code 96450 based on 394 single claims, $37.12 for CPT code 96440 based upon 38 single claims, and $61.98 for CPT code 96445 based upon 43 single claims are related to the median costs of their proposed APCs. We carefully reviewed all the comments received and our CY 2005 claims data, in the context of the clinical characteristics of these three services, as well as considered the low volume of claims for their single year of hospital cost data.

As we proposed, we continue to believe these services should be assigned to drug administration APCs because they are best characterized as chemotherapy administration services, albeit with special methods of delivery. However, we are reassigning CPT codes 96440 and 96445 from APC 0439 to APC 0441 (Level VI Drug Administration), which has a final median cost of $151.86 as the highest paying CY 2007 drug administration APC. If we were to create another drug administration APC specifically for these three services, its median cost from CY 2005 claims for the special chemotherapy administration services would be less than the median cost of APC 0441 for CY 2007. In addition, based on our CY 2005 claims data from almost 400 single claims, we believe that the proposed APC assignment for CPT code 96450 is accurate and reflects the resource costs associated with performing the procedure. We will monitor our claims data in the future to see if additional changes are warranted to the APC assignments of these chemotherapy services. Therefore, for CY 2007, we are assigning CPT codes 96440 and 96445 from APC 0439 to APC 0441, which has a final median cost of $151.86, and we are finalizing our proposal without modification to assign CPT code 96450 to APC 0441.

Comment: Several commenters expressed concern about the decrease in

payment for the ''first hour of infusion'' codes from CY 2006 to their proposed CY 2007 rates. They asked that CMS verify that our calculations were correct and that the proposed rates were appropriate.

Response: Based on our CY 2006 payment methodology, we made one payment per day for administration of a particular type of infusion, regardless of its length, and packaged payment for additional hours of infusion of the same type. For example, the CY 2006 payment of $189.04 for CPT code 96410 (Chemotherapy administration, intravenous; infusion technique, up to one hour), reflected a payment for the median chemotherapy infusion, regardless of the number of hours of infusion. In contrast, for CY 2007 we proposed to pay separately for each hour of infusion. In the case of chemotherapy infusions, we proposed to pay $154.31 for the first hour, CPT code 96413, and $48.58 for each additional hour of infusion, CPT code 96415. We have confirmed that our calculations were correct for both the proposed rule and this final rule with comment period. The apparent decrease in payment for the first hour of infusion is a direct result of our proposal to unpackage payment for the additional hours of infusion and provide separate payment for each hour as opposed to a per-day payment. Because many chemotherapy infusions take place over more than one hour, the payment for the first hour appeared to decrease. As discussed earlier in this section, in our methodology we also assigned all packaging on the drug administration claims to the first hour of infusion codes to allow us to use multiple claims for ratesetting. We believe this payment methodology will provide more accurate payment to hospitals for the specific drug administration services they provide in CY 2007.

Comment: One commenter expressed concern over the methodology used in calculating the CY 2005 median cost for the non-chemotherapy intravenous (IV) push injection services, specifically CPT code 90784 (Therapeutic, prophylactic diagnostic or diagnostic injection (specify material injected); intravenous), and requested clarification on our methodology. The commenter indicated that providers reported CPT code 90784 in CY 2005 with multiple units when more than one IV push injection was provided, along with a dollar charge reflecting each injection. The commenter requested clarification as to whether CMS factored the multiple units into its payment rate calculation, and whether CMS discarded these claims from the ratesetting process because they may have been considered as multiple procedure claims.

Response: We were unable to use claims reporting multiple units of CPT code 90784 on the same date of service for ratesetting, because we had no way to attribute the packaging on the claims to the appropriate unit of the code. We also had no way of discerning from the CY 2005 claims whether multiple units of CPT code 90784 were reported for more than one intravenous push of the same drug, or multiple pushes of different drugs were provided. CPT code 90784 was deleted for CY 2006, and replaced by CPT codes 90774 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug) and 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)). The situations discussed by the commenter would be reported and paid differently in the CY 2007 OPPS based upon the CY 2007 CPT code descriptors for IV push injections. According to our standard OPPS methodology as proposed based on median costs from single claims, we used only single claims for CPT code 90784 for ratesetting for APC 0438 as shown in Table 33 above. However, we examined our claims data and found that in over two-thirds of the cases, hospitals billed only a single unit of CPT code 90784 per day for an IV push injection. Therefore, we believe that our payment rate for the CY 2007 intravenous push injection CPT codes 90774 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug) and 90775 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug) through APC 0438 (Level III Drug Administration) is appropriate.

After carefully considering the public comments related to our proposed six-level APC structure for drug administration services, we are finalizing our proposal with modification to assign all CY 2007 HCPCS codes for drug administration services to six new drug administration APCs, as listed in Table 34, with payment rates based on median costs for the APCs as calculated from CY 2005 claims data. We note that because our CY 2007 proposal reflected our assignment of CPT codes and C-codes to these APCs consistent with our drug administration coding proposal for CY 2007, we are finalizing our assignment of the newly recognized CPT codes to the APCs where their related C-codes were proposed for assignment. In the case of CPT code 90768 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion), we are packaging its payment for CY 2007 to maintain consistency, because concurrent infusions were not previously separately reported in the OPPS and their costs are already packaged into our CY 2007 payments. We believe that this approach provides consistency and will allow us to collect hospital claims data over the next two years to assess whether changes to the APC assignments for these newly recognized CPT codes should be considered. Because the newly recognized CPT codes discriminate among services more specifically than the CY 2006 C-codes, as was the case when the OPPS transitioned from more general Q-codes to more specific CPT codes for the reporting of drug administration services in CY 2005, for a period of 2 years drug administration services will be paid based on the costs of their predecessor HCPCS codes until updated data are available for review.

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Table 34.--CY 2007 Final Six-Level Drug Administration APC Structure

Final CY 2007 APC	Final APC Status Indicator	Final CY 2007 APC Median Cost	CPT/HCPCS Code	Description
0436	S	$11.06	90472	Immunization admin, each add
			90473	Immune admin oral/nasal
			90474	Immune admin oral/nasal addl
			90779	Ther/prop/diag inj/inf proc
			95115	Immunotherapy, one injection
			96549	Chemotherapy, unspecified
0437	S	$24.11	90471	Immunization admin
			90761	Hydrate iv infusion, add-on
			90766	Ther/proph/dg iv inf, add-on
			90767	Tx/proph/dg addl seq iv inf
			90772	Ther/proph/diag inj, sc/im
			95117	Immunotherapy injections
			95145	Antigen therapy services
			95146	Antigen therapy services
			95147	Antigen therapy services
			95148	Antigen therapy services
			95149	Antigen therapy services
			95165	Antigen therapy services
			95170	Antigen therapy services
0438	S	$48.53	90773	Ther/proph/diag inj, ia
			90774	Ther/proph/diag inj, iv push
			90775	Ther/proph/diag inj add-on
			96401	Chemo, anti-neopl, sq/im
			96402	Chemo hormon antineopl sq/im
			96405	Chemo intralesional, up to 7
			96406	Chemo intralesional over 7
			96415	Chemo, iv infusion, addl hr
			96417	Chemo iv infus each addl seq
			96423	Chemo ia infuse each addl hr
			96542	Chemotherapy injection
0439	S	$96.85	96409	Chemo, iv push, sngl drug
			96411	Chemo, iv push, addl drug
			96420	Chemo, ia, push technique
0440	S	$110.55	90760	Hydration iv infusion, init
			90765	Ther/proph/diag iv inf, init
			96521	Refill/maint, portable pump
			96522	Refill/maint pump/resvr syst
0441	S	$151.86	96413	Chemo, iv infusion, 1 hr
			96416	Chemo prolong infuse w/pump
			96422	Chemo ia infusion up to 1 hr
			96425	Chemotherapy, infusion method
			96440	Chemotherapy, intracavitary
			96445	Chemotherapy, intracavitary
			96450	Chemotherapy, into CNS
			C8957	Prolonged IV inf, req pump

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Comment: In addition to the APC Panel recommendation introduced above, a number of commenters requested that CMS pay separately for multiple pushes of the same drugs, specifically for a second or subsequent IV push performed during the same episode of care, to cover the resource costs associated with providing the additional injections and drugs. Similar to the recommendation of the APC Panel, commenters suggested several options on how CMS could implement such a policy.

Response: We thank the commenters for their suggestions. However, consistent with our policy for reporting intravenous pushes of the same drug only once in CY 2006 and consistent with the definition of the CPT codes that will be used in CY 2007 to report these services, we will continue to provide payment for an intravenous push of each drug only once during a hospital encounter in CY 2007. In addition, we do not believe it would be appropriate to unbundle procedures by creating a new HCPCS code for an element of a service that should be reported with existing CPT codes when they are used in the CY 2007 OPPS. We also see no need to develop a modifier to identify these situations. We expect that hospitals will adjust their charges for the CPT codes used to report IV push injections accordingly, based on their experiences with providing intravenous injections of drugs in the outpatient setting.

Therefore, we are not accepting the recommendation of the APC Panel to make payment for multiple pushes of the same drug in a single hospital encounter.

Comment: In addition to the APC Panel recommendation introduced above, several commenters advised CMS to provide payments for all intravenous pushes and therapeutic injections for pain management and other clinical conditions, regardless of the setting in which they are administered.

Response: The OPPS is a prospective payment system that provides payment for groups of services that are similar both clinically and in terms of resource use. We package into payment for each procedure or service within an APC group the costs associated with items or services that are directly related to performing a procedure or furnishing a service. Drug administration services are only paid separately in conjunction with many other procedures performed on the same day if they are distinct procedural services that are reported in a manner consistent with the principles of correct coding. We apply National Correct Coding Initiative edits as appropriate to services performed under the OPPS. More information regarding these edits may be found in the National Correct Coding Initiative Policy Manual for Medicare Services as referenced earlier in this section.

Therefore, we are not accepting the recommendation of the APC Panel to pay separately for all intravenous pushes and injections for pain management and other clinical conditions. Consistent with our current payment policy, in some cases their payment is packaged into payment for the associated procedures.

Comment: Several commenters requested that CMS allow hospitals to bill separately and receive payments for the first hour of therapeutic infusions and hydration infusions when provided in the same encounter.

Response: With the use of CPT codes for the reporting of drug administration services under the CY 2007 OPPS, hospitals may bill for therapeutic drug administration and hydration services provided in the same encounter. However, as mentioned above, we expect hospitals to adhere to CPT coding instructions and instructions for the use of these codes. We do not believe that allowing hospitals to submit claims for, and receive separate payment for, the first hour of a therapeutic infusion and the first hour of a hydration infusion provided in one encounter through a single vascular access site would be consistent with CPT coding principles. Therefore, we are not adopting the commenters' proposal.

We note that in the CY 2007 OPPS proposed rule we discussed HCPCS code G0332 (Preadministration-related services for intravenous infusion of immunoglobulin, per infusion encounter (This service is to be billed in conjunction with administration of immunoglobulin)) in this section of the preamble. However, for the CY 2007 OPPS final rule with comment period, we discuss this code and other issues relating to IVIG in section V.B.III. of this preamble.

IX. Hospital Coding and Payments for Visits

A. Background

Currently, CMS instructs hospitals to use the CY 2006 CPT codes used by physicians and listed in Table 35 to report clinic and emergency department (ED) visits and critical care services on claims paid under the OPPS.

TABLE 35.—CY 2006 CPT CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS AND CRITICAL CARE SERVICES

CPT Code	Descriptor
CPT Evaluation and Management 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 CPT 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).

TABLE 35.—CY 2006 CPT CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS AND CRITICAL CARE SERVICES—Continued

CPT Code	Descriptor
Critical Care Services CPT Codes	
99291 ...	Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes.
99292 ...	Each additional 30 minutes.

The majority of CPT code descriptors are applicable to both physician and facility resources associated with specific services. However, we have acknowledged from the beginning of the OPPS that we believe that CPT Evaluation and Management (E/M) codes were defined to reflect the activities of physicians and do not describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients and critical care encounters. Presently, CPT indicates that office or other outpatient visit codes are used to report E/M services provided in the physician's office or in an outpatient or other ambulatory facility. For OPPS purposes, we refer to these as clinic visit codes. CPT also indicates that emergency department visit codes are used to report E/M services provided in the emergency department, defined as an ''organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.'' For OPPS purposes, we refer to these as emergency department visit codes. 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 the April 7, 2000 OPPS final rule (65 FR 18434), CMS 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 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.

During the January 2002 APC Panel meeting, the APC Panel recommended that CMS adopt the American College of Emergency Physicians (ACEP) intervention-based guidelines for facility coding of emergency department visits and develop guidelines for clinic visits that are modeled on the ACEP guidelines.

In the August 9, 2002 OPPS proposed rule, we proposed 10 new G-codes (Levels 1–5 Facility Emergency Services and Levels 1–5 Facility Clinic Services) for use in the OPPS to report hospital visits. We also asked for public comments regarding national guidelines for hospital coding of emergency department and clinic visits. We discussed various 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. We note below our analysis of the various models.

1. Guidelines Based on the Number or Type of Staff Interventions

Under this model, the level of service reported would be based on the number and/or type of interventions performed by nursing or ancillary staff. In the intervention model, baseline care (including registration, triage, initial nursing assessment, periodic vital signs as appropriate, simple discharge instructions, and examination room set up/clean up) and possibly a single minor intervention (for example, suture removal, rapid strep test, or visual acuity) would be reported by the lowest level of service. Higher levels of service would be reported as the number and/or complexity of staff interventions increased.

The most commonly recommended intervention-based guidelines were the facility-coding guidelines developed by the ACEP. The ACEP model uses examples of interventions to illustrate appropriate coding. Coders extrapolate from these examples to determine the correct level of service to report. The ACEP model uses the types of interventions rather than the number of interventions to determine the appropriate level of service. This means that the single most complex intervention determines the level of service, whether it was the only service provided (in addition to baseline care), whether other similarly complex interventions were also provided, or whether other interventions of less complexity were also provided. The intervention model is based on emergency department/clinic resource use, is simple, reflects the care given to the patient, and does not require additional facility documentation. However, we expressed concern that the intervention model may provide an incentive to provide unnecessary services and that it is susceptible to upcoding. In addition, it is not particularly focused on measuring and appropriately reporting a code reflecting total hospital resources used in a visit. Furthermore, the ACEP model requires extrapolation from a set of examples that could make it prone to variability across hospitals.

2. Guidelines Based on the Time Staff Spent With the Patient

Under this model, the level of service would be determined based on the amount of time hospital staff spent with a patient. The underlying assumption is that staff time spent with the patient is an appropriate proxy for total hospital resource consumption. In this model, if only baseline care (as described above) were provided, a Level 1 service would be reported. Higher levels of service would be reported based on increments of staff time beyond baseline care. For example, Level 2 could be reported for 11 to 20 minutes beyond baseline care, and Level 3 could be reported for 21 to 30 minutes beyond baseline care. This model is simple, correlates with total hospital resource use, and provides an objective standard for all hospitals to follow. However, we observed that this model would require additional, potentially burdensome documentation of staff time, could provide an incentive to work slowly or use less efficient personnel, and has the potential for upcoding and gaming.

3. Guidelines Based on a Point System Where a Certain Number of Points Are Assigned to Each Staff Intervention Based on the Time, Intensity, and Staff Type Required for the Intervention

In this model, points or weights are assigned to each facility service and/or intervention provided to a patient in the clinic or emergency department. The level of service is determined by the sum of the points for all services/interventions provided. Commenters on the August 9, 2002 proposed rule recommended various approaches to a point system, including point systems that assigned points based on the amount of staff time spent with the

patient, the number of activities performed during the visit, and a combination of patient condition and activities performed. A point system would correlate with facility resource consumption and provide an objective standard. In addition, it is not as easily gamed because time-based interventions can be assigned a set number of points. However, we noted that a point system could present a significant burden for hospitals in terms of requiring additional, clinically unnecessary documentation. Point systems that are complex could require dedicated staff to monitor and maintain them.

4. Guidelines Based on Patient Complexity

Several variations were recommended in comments on the August 9, 2002 proposed rule, including assignment of levels of service based on ICD–9–CM (International Classification of Diseases, Ninth Edition, Clinical Modification) diagnosis codes, based on complexity of medical decision making, or based on presenting complaint or medical problem. The premise for these guideline systems is that many emergency departments follow established protocols based on patients' presenting complaints and/or diagnoses. Therefore, assigning a level of service based on patient diagnosis should correlate with facility resource consumption. These systems may require the use of a coding ''grid,'' which lists more than 100 examples of patient conditions and diagnoses and assigns a level of service to each example. When the patient presents with a condition that does not appear on the grid, the coder must extrapolate from the grid to the individual patient. We expressed concern that these systems are extremely complex, demand significant interpretive work on the part of the coder (who may not have clinical experience), and are subject to variability across hospitals. While no clinically unnecessary documentation would be required because the system is based on diagnoses that are already reported on claims, there is a significant potential for upcoding and gaming.

In the August 9, 2002 OPPS 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 the CY 2007 proposed rule, we indicated that we were reconsidering this perspective. We discuss this issue further below.

In the November 1, 2002 OPPS final rule, we specified that we would not create new codes to replace existing CPT E/M codes for reporting hospital visits until national guidelines have been developed, in response to commenters who were concerned about implementing code definitions without national guidelines. 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, and that are compliant with HIPAA requirements. We explained that organizations such as the American Hospital Associations (AHA) and the American Health Information Management Association (AHIMA) had such expertise and would be capable of creating hospital visit guidelines and providing ongoing education of providers. 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 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, but 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 proposed rule. The AHA and AHIMA acknowledged that ''continued refinement will be required as in all coding systems. The Panel * * * looks forward to working with CMS to incorporate any recommendations raised during the public comment period'' (AHA/AHIMA guidelines report, page 9). The AHA and AHIMA indicated that the guidelines were field-tested several times by panel members at different stages of their development. The guidelines are based on an intervention model, where the levels are determined by the numbers and types of interventions performed by nursing or ancillary hospital staff. Higher levels of services are reported as the number and/or complexity of staff interventions increase.

Although we did not publish the guidelines, the AHA and AHIMA released the guidelines through their Web sites. Consequently, we received numerous comments from providers and associations, some in favor and some opposed to the guidelines. We undertook a critical review of the recommendations from the AHA and AHIMA and made some modifications to the guidelines based on comments we received from outside hospitals and associations on the AHA/AHIMA guidelines, clinical review, and changing payment policies in the OPPS regarding some separately payable services.

In an attempt to validate the modified AHA/AHIMA guidelines and examine the distribution of services that would result from their application to hospital clinic and emergency department visits paid under the OPPS, we contracted a study that began in September 2004 and concluded in September 2005 to retrospectively code, under the modified AHA/AHIMA guidelines, hospital visits by reviewing hospital visit medical chart documentation gathered through the Comprehensive Error Rate Testing (CERT) work. While a review of documentation and assignment of visit levels based on the modified AHA/AHIMA guidelines to 12,500 clinic and emergency department visits was initially planned, the study was terminated after a pilot review of only 750 visits. The contractor identified a number of elements in the

guidelines that were difficult for coders to interpret, poorly defined, nonspecific, or regularly unavailable in the medical records. The contractor's coders were unable to determine any level for about 25 percent of the clinic cases and about 20 percent of the emergency cases reviewed. The only agreement observed between the levels reported on the claims and levels according to the modified AHA/AHIMA guidelines was the classification of Level 1 services, where the review supported the level on the claims 54–70 percent of the time. In addition, the vast majority of the clinic and emergency department visits reviewed were assigned to Level 1 during the review. Based on these findings, we believed that it was not necessary to review additional records after the initial sample. The contractor advised that multiple terms in the guidelines required clearer definition and believed that more examples would be helpful. Although we believe that all of the visit documentation for each case was available for the contractor's review, we were unable to determine definitively that this was the case. Thus, there is some possibility that the contractor's assignments would have differed if additional documentation from the medical records were available for the visits. In summary, while testing of the modified AHA/AHIMA guidelines was helpful in illuminating areas of the guidelines that would benefit from refinement, we were unable to draw conclusions about the relationship between the distribution of current hospital reporting of visits using CPT E/M codes that are assigned according to each hospital's internal guidelines and the distribution of coding under the AHA/AHIMA guidelines, nor were we able to demonstrate a normal distribution of visit levels under the modified AHA/AHIMA guidelines.

B. CY 2007 Proposed and Final Coding Policies

As discussed above, the majority of all CPT code descriptors are applicable to both physician and facility resources associated with specific services. However, we believe that CPT E/M codes were defined to reflect the activities of physicians and do not describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients and critical care encounters. While awaiting the development of a national set of facility-specific codes and guidelines, we have advised 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 November 1, 2002 OPPS final rule, we specified that we would not create new codes to replace existing CPT E/M codes for reporting hospital visits until national guidelines have been developed, in response to commenters who were concerned about implementing code definitions without national guidelines. While we do not yet have a formal set of guidelines that we believe may be appropriately applied nationally to report different levels of hospital clinic and emergency department visits and to report critical care services, we have made significant progress in developing potential guidelines. Therefore, in the CY 2007 OPPS proposed rule (71 FR 49604–49618), we proposed for CY 2007 the establishment of HCPCS codes to describe hospital clinic and emergency department visits and critical care services. Prior to our implementation of national guidelines for the new hospital visit HCPCS codes, we proposed that hospitals might continue to use their existing internal guidelines to determine the visit levels to be reported with these codes. We anticipated that many providers would choose to use their existing guidelines for reporting visits with CPT codes. We did not expect a substantial workload for a provider that chose to adjust its guidelines to reflect our policies.

We acknowledged that it could be burdensome for providers to bill G-codes rather than CPT codes. In this case, because current CPT E/M codes do not describe hospital visit resources, we saw no alternative other than to create new G-codes. CPT has not yet created clinic and emergency department visit and critical care services codes that describe hospital resource utilization. It is important to note that G-codes may be recognized by other payers.

1. Clinic Visits

For clinic visits, we proposed to establish five new codes to replace hospitals' reporting of the CPT clinic visit E/M codes for new and established patients and consultations listed in Table 35. Providers have been reporting five levels of CPT codes through CY 2006, and we believed that it would be fairly easy to crosswalk current internal hospital guidelines to these five new codes. Commenters to prior 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. The proposed codes are listed in Table 36 below.

TABLE 36.—CY 2007 PROPOSED HCPCS CODES TO BE USED TO REPORT CLINIC VISITS

HCPCS code	Short descriptor	Long descriptor
Gxxx1	Level 1 hosp clinic visit.	Level 1 hospital clinic visit.
Gxxx2	Level 2 hosp clinic visit.	Level 2 hospital clinic visit.
Gxxx3	Level 3 hosp clinic visit.	Level 3 hospital clinic visit.
Gxxx4	Level 4 hosp clinic visit.	Level 4 hospital clinic visit.
Gxxx5	Level 5 hosp clinic visit.	Level 5 hospital clinic visit.

Comment: Although a few commenters were in favor of creating G-codes for CY 2007, numerous commenters requested that CMS postpone creation of G-codes until national guidelines are implemented. Almost all of these commenters stated that it would be extremely time consuming to train staff in the new coding system, only to retrain them 1 to 2 years later, when national guidelines were implemented. They believed that if national guidelines were established for CY 2007, hospitals could justify the time commitment and training expense. They added that prior to the establishment of national guidelines, however, there is little incentive for hospitals to transition to G-codes. Several commenters noted that there would be no benefit of improved data if hospitals transitioned to G-codes without guidelines because the median cost data captured from the G-codes would parallel current data because hospitals would still be using their own internal guidelines. It was implicit in many comments that once national guidelines are established, hospitals would agree to transition to G-codes. However, other commenters objected to the G-codes because other payors either fail to accept them or do not assign proper payment to them. Several commenters suggested that a proposal be submitted to the AMA requesting hospital-specific Category I visit codes.

Response: In response to the numerous comments related to creation of G-codes, we are postponing finalizing G-codes for clinic visits until national guidelines have been established, when we will again consider their possible utility. We are responding to the requests of many commenters who stated that it would be too difficult for them to first transition to G-codes and then to transition to national guidelines

shortly thereafter. Most commenters indicated a preference for training their staff once, for both coding and guidelines, even if it means that the training would be significant. In the meantime, as discussed further below, we will to continue work to develop national guidelines. For CY 2007, providers should continue to use CPT codes to bill for clinic visits.

Comment: Several commenters compared hospital resource cost differences between new and established patient visits and discussed whether it was necessary to distinguish between the two types of visits. The commenters were divided as to whether this distinction was necessary or useful. While some commenters stated that it would be appropriate to continue using different codes for new and established patients because of the observed median cost differences, other commenters found it cumbersome to bill a different code for each type of visit. One commenter speculated that hospitals often choose a new versus an established visit code based upon which code the physician bills, instead of choosing a code based on whether the patient is new or established at that particular hospital. One commenter suggested that the additional resources for new patients be reflected in the guidelines, rather than in the coding. Yet another commenter indicated that new patients did not necessarily use more hospital resources than established patients, and questioned whether both types of codes were necessary.

Response: We initially 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 visits. However, because hospitals will continue to bill CPT codes for CY 2007, they must continue to distinguish between new and established patients, according to the CPT code descriptor. Therefore, these codes will continue to be payable under the OPPS for CY 2007. 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 three years.'' To apply this definition to hospital visits, we stated in the April 7, 2000 final rule with comment period that the meanings of ''new'' and ''established'' pertain to whether or not the patient already has a hospital medical record number. If the patient has a hospital medical record that was created within the past 3 years, that patient is considered an established patient to the hospital. The same patient could be ''new'' to the physician, but an ''established'' patient to the hospital. The opposite could be true if the physician has a longstanding relationship with the patient, in which case the patient would be an ''established'' patient with respect to the physician and a ''new'' patient to the hospital.

Because hospitals will be reporting CPT codes for CY 2007, they must continue to distinguish between new and established patients, according to the CPT code descriptor. However, it may be unnecessary for hospitals to report consultation CPT codes if either the new or established patient visit code accurately describes the service provided. To simplify billing, as many commenters requested, we are now considering whether consultation codes are necessary, or if hospitals could bill either a new patient visit or an established patient visit, instead of a consultation, as appropriate in these cases. We could assign status indicator ''B'' to the consultation codes and instruct hospitals to bill a new or established visit code. While developing the proposal to create G-codes in place of the clinic visit CPT E/M codes for CY 2007, we determined that hospitals could report G-code levels that reflect their resources used, by applying their guidelines, without the need for codes that differentiate among new, established, or consultation visits. However, because hospitals will continue to use CPT E/M codes for CY 2007, which distinguish between new, established, and consultation visits, we invite further input on this issue, specifically as to whether the consultation codes are necessary for hospitals to report, or whether it would be simpler for hospitals to report either a new patient visit or established patient visit, as appropriate in each circumstance. We are particularly interested to know whether consultation codes are a useful measure of hospital resource use under the OPPS, and how they are different, from a hospital resource perspective, from new patient visits and established patient visits.

In summary, for CY 2007, providers should continue to use CPT codes to bill for clinic visits. The CPT codes for new and established visits and consultations will continue to be payable under the OPPS. Prior to implementation of national guidelines, we are considering whether it would be appropriate for hospitals to bill a new or established E/M visit code instead of a consultation code. In the national guidelines, we still need to determine whether there should be a distinction between new and established visits and consultations. We continue to be interested in the opinions of hospital staff and others who are familiar with these codes. Further discussion of these codes appears in section IX.C. of this preamble.

Comment: A few commenters requested that CMS clarify whether a hospital can bill several clinic visits for services provided to a patient who is seen in one clinic by several clinicians on the same day, although not at the same time. The commenters stated that, in oncology clinics, it is common for patients to have several scheduled visits on one day, provided by an oncologist, physicians trained in other specialties, therapists, or others, depending on the patients' needs. They added that, in some instances, the oncology clinic allows the patient to remain in one clinic room, while asking the various clinicians to meet the patient in the oncology clinic. One commenter noted that the patient usually consumes few hospital resources other than use of the clinic room. These commenters also indicated that HCPCS code G0175 (Scheduled interdisciplinary team conference (minimum of three exclusive of patient care nursing staff) with patient present) would only apply if the patient was seen by all the clinicians at the same time. According to the commenters, the hospital could bill multiple clinic visits if the patient was seen in several different clinics on the same day. They believed that the current policy penalizes oncology clinics for offering services in an efficient manner. One of the commenters requested that CMS change the descriptor of G0175 so that it would apply when a patient was treated by several clinicians on one day, in one clinic, but not necessarily at the same time. The commenter noted that an appropriate payment for the service would be at a rate comparable to the critical care payment rate.

Response: We expect the hospital resources associated with an extended clinic visit involving multiple clinicians to be reflected in the hospital's internal guidelines used to select the level for reporting of the visit. The hospital should bill the clinic visit code that most appropriately describes the service provided. We will maintain the same code descriptor for G0175 for CY 2007 because we believe it is appropriate to pay specifically for interdisciplinary team conferences that contribute to well-coordinated, high quality care, particularly for patients with severe or complex medical conditions. We note that payment for G0175 will be made through APC 0608 (Level V Clinic

Visits) at the highest payment level for clinic visits in CY 2007.

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.'' Under the OPPS, we have restricted the billing of emergency department CPT codes to services furnished at facilities that meet this CPT definition. Facilities open less than 24 hours a day should not use the emergency department 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 (DED) 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, Public Law 99–272 (COBRA).

Section 489.24 of the EMTALA regulations defines ''dedicated emergency department'' as any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under the regulations is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

We believe that every emergency department that meets the CPT definition of emergency department also qualifies as a DED under EMTALA. However, we are aware that there are some departments or facilities of hospitals that meet the definition of a DED 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 DED 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 do not meet the CPT requirements for reporting emergency visit E/M codes, these facilities must bill clinic visit codes for the services they furnish. We have no way to distinguish in our hospital claims data the costs of visits provided in DEDs that do not meet the CPT definition of emergency department from the costs of clinic visits.

Some hospitals have requested that they be permitted to bill emergency department visit codes under the OPPS for services furnished in a facility that meets the CPT definition for reporting emergency department visit E/M codes, except that they are not available 24 hours a day. These hospitals believe that their resource costs are more similar to those of emergency departments that meet the CPT definition than they are to the resource costs of clinics. Representatives of such facilities have argued that emergency department visit payments are more appropriate, on the grounds that their facilities treat patients with emergency conditions whose costs exceed the resources reflected in the clinic visit APC payments, even though these emergency departments are not available 24 hours per day. In addition, these hospital representatives indicated that their facilities have EMTALA obligations and should, therefore, be able to receive emergency department visit payments. While these emergency departments may provide a broader range and intensity of hospital services and require significant resources to assure their availability and capabilities in comparison with typical hospital outpatient clinics, the fact that they do not operate with all capabilities full-time suggests that hospital resources associated with visits to emergency departments or facilities available less than 24 hours a day may not be as great as the resources associated with emergency departments or facilities that are available 24 hours a day and that fully meet 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, we proposed in the CY 2007 OPPS proposed rule (71 FR 49608) to establish a set of five G-codes for use by all entities that meet the definition of a DED under the EMTALA regulations in § 489.24 but that are not Type A emergency departments, as described in Table 33 of the proposed rule and as finalized as Table 37 below in this final rule with comment period. These codes are called ''Type B emergency department visit codes.''

TABLE 37.—CY 2007 FINAL HCPCS CODES TO BE USED TO REPORT EMERGENCY DEPARTMENT VISITS PROVIDED IN TYPE B EMERGENCY DEPARTMENTS

HCPCS code	Short descriptor	Long descriptor
G0380	Lev 1 hosp type B ED visit ..	Level 1 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
G0381	Lev 2 hosp type B ED visit ..	Level 2 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
G0382	Lev 3 hosp type B ED visit ..	Level 3 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
G0384	Lev 4 hosp type B ED visit ..	Level 4 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
G0385	Lev 5 hosp type B ED visit ..	Level 5 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).

For CY 2007, we 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 DED, 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 are called ''Type A emergency visit codes'' and were proposed to replace hospitals' current reporting of the CPT emergency department visit E/M codes listed in Table 35. Our intention was to allow hospital-based emergency departments or facilities that are currently appropriately reporting CPT emergency department visit E/M codes to bill these new Type A emergency department visit codes. We believed that this definition of Type A emergency departments would neither narrow nor broaden the group of emergency departments or facilities that may bill the Type A emergency department visit codes in comparison with those that are currently correctly billing CPT emergency department visit E/M codes. Rather, our proposal refined and clarified the definition for use in the hospital context. We believed that because the concepts employed in the definition of a DED for EMTALA purposes are already familiar to

hospitals, it is appropriate to employ those concepts, rather than the concepts employed in the CPT definition of emergency department, for purposes of defining these new G-codes. As we have previously noted, the CPT codes were defined to reflect the activities of physicians and do not always describe well the range and mix of services provided by hospitals during visits of emergency department patients. We believed that these new codes for reporting emergency department visits to Type A emergency departments are more specific to the hospital context. 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.

The new codes that we proposed for CY 2007 are listed in Table 38 below.

TABLE 38.—CY 2007 PROPOSED HCPCS CODES TO BE USED TO REPORT EMERGENCY DEPARTMENT VISITS PROVIDED IN TYPE A EMERGENCY DEPARTMENTS

HCPCS code	Short descriptor	Long descriptor
Gyyy1	Lev 1 hosp type A ED visit ..	Level 1 hospital emergency department visit provided in a Type A hospital-based facility or visit department. (The facility or department must be open 24 hours a day, 7 days a week and 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; 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).
Gyyy2	Lev 2 hosp type A ED visit ..	Level 2 hospital emergency department visit provided in a Type A hospital-based facility or visit department. (The facility or department must be open 24 hours a day, 7 days a week and 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; 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).
Gyyy3	Lev 3 hosp type A ED visit ..	Level 3 hospital emergency department visit provided in a Type A hospital-based facility or visit department. (The facility or department must be open 24 hours a day, 7 days a week and 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; 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).
Gyyy4	Lev 4 hosp type A ED visit ..	Level 4 hospital emergency department visit provided in a Type A hospital-based facility or visit department. (The facility or department must be open 24 hours a day, 7 days a week and 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; 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).
Gyyy5	Lev 5 hosp type A ED visit ..	Level 5 hospital emergency department visit type provided in a Type A hospital-based facility or visit department. (The facility or department must be open 24 hours a day, 7 days a week and 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; 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).

Comment: As discussed above in section IX.B.1. of this preamble describing coding for clinic visits, numerous commenters requested that CMS postpone adoption of G-codes until CMS has established national guidelines. We will not re-summarize or re-respond to those comments in this section.

As to our proposed coding for emergency department visits, the majority of commenters agreed with our general distinction between Type A and Type B emergency departments. One commenter believed that our definition for Type B emergency departments was too broad because many urgent care centers would meet the definition of Type B emergency department based on the EMTALA criterion that ''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.'' This commenter suggested that urgent care centers that operated primarily with scheduled appointments be required to bill clinic visit codes. Many other commenters stated that our Type B emergency department definition was too narrow and would apply to only a few emergency departments. One commenter requested that CMS add two additional requirements for dedicated Type B emergency departments: (1) They must have transfer agreements with local and/or regional full service hospitals; and (2) they must have the presence of a ''qualified medical person'' (as defined in the EMTALA regulations) during operating hours. One commenter requested that CMS revise the description of an emergency department by replacing the words ''licensed by the State'' with ''authorized or permitted by the State'' to allow for States that do not license emergency departments.

Several providers were concerned that CMS has used and is continuing to piggyback on the AMA's requirement that an emergency department must be open 24 hours a day in order to bill emergency department codes. They believed that if CPT codes do not describe hospital resources, CMS should not follow the CPT rules when billing these CPT codes. One commenter stated that the operating hours of an emergency department was irrelevant, and that the resource costs of the services provided should instead

determine selection of the appropriate code. In other words, the commenter indicated, if a Type B emergency department that was available less than 24 hours a day provided a highly resource-intensive service, that Type B emergency department should bill a Type A emergency department code and be paid at the Type A emergency department rate.

Several commenters requested that CMS distinguish between Type A and Type B emergency departments using a method other than coding, as it would be burdensome for providers to choose the correct code. In addition, one commenter that specializes in coding indicated that it is more appropriate for a code to describe services provided rather than the facility type. Several commenters suggested that providers instead bill Type B emergency department services under a different revenue code than Type A emergency department services.

Response: In response to the numerous public comments received, and as discussed in detail in section IX.B.1. of this preamble on clinic visit coding, we are postponing finalizing G-codes for Type A emergency department visits until national guidelines have been established, when we will again consider their possible utility. For CY 2007, providers should continue to use CPT codes to bill for Type A emergency department visits. However, we are finalizing the definition of Type A emergency departments to distinguish it from Type B emergency departments. As stated above, we believe that this definition of Type A emergency departments will neither narrow nor broaden the group of emergency departments or facilities that may bill the Type A emergency department visit codes in comparison to those that are currently correctly billing CPT emergency department visit E/M codes. Rather, we are refining and clarifying the definition for use in the hospital context. A Type A emergency department is a hospital-based facility or department that must be open 24 hours a day, 7 days a week and 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; 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). We were pleased that most commenters agreed with our distinction between the two types of emergency departments. While we acknowledge the comments that requested that we amend the definition of a Type B emergency department, we will continue to use the EMTALA definition of a dedicated emergency department as defined in 42 CFR 489.24 because, as stated above, we believed that because the concepts employed in the definition of a DED for EMTALA purposes are already familiar to hospitals.

While we understand the reservations expressed by the commenters about the use of G-codes, we believe the creation of G-codes for Type B emergency departments is necessary because there currently are no CPT codes that fully describe 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. These new G-codes will 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.

Further, we acknowledge that some providers prefer that we not distinguish between providers that are open 24 hours a day and those that are not. However, we continue to believe that hours of operation significantly impact hospital resource costs. It is necessarily more costly to operate a department with full capabilities 24 hours a day than to operate with full capabilities 12 hours a day. Emergency departments that are open 24 hours a day serve as a crucial safety net of our health care system, and we are concerned with ensuring that necessary emergency department services are available to Medicare beneficiaries. We are concerned that if we allow emergency departments that are open less than 24 hours a day to bill Type A emergency department codes, the result would be to dilute the median costs associated with the provision of services by emergency departments that are open 24 hours a day, 7 days a week.

We note the commenters' concerns that G-codes may not allow accurate data collection because services for both Type A and Type B emergency department services may be reported under one revenue code. However, we expect hospitals to adjust their charges appropriately to reflect differences in Type A and Type B emergency departments. The current revenue codes do not distinguish between Type A and Type B emergency departments. Therefore, to track the resource costs differences between clinics, Type A emergency departments, and Type B emergency departments, it is necessary to create a new set of codes to be billed by Type B emergency departments. We will consider whether further instructions are necessary in the future to enhance our data collection.

Comment: Several commenters requested that CMS clarify whether Type A emergency department codes, Type B emergency department codes, or clinic visit codes apply in specific situations. One questioned whether a Type A emergency department that has a separate adjacent space that is organizationally part of the Type A emergency department, but treats less severe patients and is often closed at night, would be eligible to bill the Type A emergency department visit codes. The commenter clarified that the primary emergency area is fully staffed 24 hours a day. Several commenters questioned whether services provided at a satellite emergency department that is open less than 24 hours a day, located at a different location than the main campus, could bill the Type A emergency department visit codes. Again the commenter clarified that the primary emergency department was available 24 hours a day. Yet another commenter requested clarification about a Type A emergency department that operated subunits or locations within a Type A emergency department, that are closed part of the day or night, based on fluctuations in patient loads. This commenter noted that these subunits are sometimes referred to as ''Fast Track areas.''

Response: 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.

For CY 2007, we are finalizing our proposal with modification. We are not adopting the G-codes in Table 38 for Type A emergency departments, but we are adopting the G-codes in Table 37 for Type B emergency departments.

3. Critical Care Services

For critical care services, we proposed in the CY 2007 OPPS proposed rule (71 FR 49610) to create two new codes to replace hospitals' reporting of the CPT E/M critical care codes listed in Table 35 above. Providers have been reporting two CPT codes through CY 2006, and we believed that it would be fairly easy to crosswalk current internal hospital guidelines to these two new codes. The proposed new codes are listed in Table 39 below.

TABLE 39.—CY 2007 PROPOSED HCPCS CODES TO BE USED TO REPORT CRITICAL CARE SERVICES

HCPCS code	Short descriptor	Long descriptor
Gccc1	Hosp critical care, 30–74 min.	Hospital critical care services, first 30–74 minutes.
Gccc2	Hosp critical care, add 30 min.	Hospital critical care services, each additional 30 minutes.

Comment: In addition to the many comments we received about G-codes in general, we received many comments on the proposed G-codes specific to critical care. Most comments fell under one of two categories: (1) Remove the minimum time requirement for critical care services; or (2) create one G-code for critical care without trauma activation and one G-code for critical care with trauma activation.

Many commenters requested that CMS allow hospitals to bill critical care without a minimum time requirement. The commenters indicated that it was extremely difficult to measure time while providing critical care services because of the intensity of the services provided. These commenters also indicated that it is easier and more appropriate to use time when measuring physician resources rather than facility resources. They did not believe that time is an appropriate proxy for measuring hospital resource utilization when providing hospital critical care services because the hospital may have its highest resource use in the first 10 minutes of critical care, much earlier than the 30-minute minimum required in the code descriptor. However, because the proposed G-code indicates a minimum of 30 minutes of critical care services before the critical care code can be billed, the commenters indicated that the hospital would not be able to bill for the critical care services it provided. In case we still continued to require a 30-minute minimum, the commenters asked us to clarify how a hospital should count time. They asked: Does it start when the patient is admitted? Should each provider of care measure his own minutes, after which the hospital would add together all the minutes from all the providers involved? In addition, several commenters referenced page 18452 of the April 7, 2000 final rule preamble language, which has been interpreted by commenters to mean that the 30-minute minimum for critical care does not apply under the OPPS. One commenter requested that CMS remove the 30-minute minimum requirement because it creates a disincentive to provide critical care services in an efficient manner. Several commenters indicated that critical care should be the highest level visit code, regardless of time. One commenter suggested that critical care be paid at a flat rate, rather than involving time. Another commenter indicated that its State Medicaid agency did not accept critical care as a payable service and would only pay for the highest level emergency department visit code.

Many commenters requested CMS to finalize the proposal to create G-codes for critical care, but that, in doing so, CMS create one G-code for critical care without trauma activation and one G-code for critical care associated with trauma activation. They also requested that CMS pay differentially for critical care provided with and without trauma activation. The commenters suggested that critical care services with trauma activation require a significantly higher level of hospital resources than critical care services alone. In particular, one commenter who made a presentation during the August 2006 APC Panel meeting suggested that CMS use revenue codes in the 68x series reported on the same date as a critical care service to determine whether a trauma response was activated in association with critical care services in order to facilitate selection of appropriate claims to establish differential payment rates for critical care services with and without trauma activation. The APC Panel recommended that CMS analyze cost data to determine if additional payment for trauma response was appropriate.

Response: We responded to the general comments regarding the use of G-codes in section IX.B.1. of this preamble on clinic visit coding. Under this response, we address the comments specific to critical care coding.

First, we would like to respond to the apparent confusion concerning the April 7, 2000 response to a comment that we pay separately instead of packaging CPT code 99292 (each additional 30 minutes of critical care time). Apparently, many commenters misinterpreted the preamble language in that final rule and believed that it was not necessary to apply a 30-minute minimum before billing a critical care code. However, in response to a request to pay separately for CPT code 99292,

we responded that ''We do not believe that paying hospitals for incremental time as critical care would better reflect facility resources. The most resource-intensive period for the hospital is generally the first hour of critical care. In addition, we believe it would be burdensome for hospitals to keep track of minutes for billing purposes. Therefore, we will pay for critical care as the most resource-intensive visit possible as defined by CPT code 99291.'' In this context, it is clear that our response did not deal with the application of a 30-minute minimum time in the OPPS. Rather, our response dealt only with the issue involved; the packaging of payment for CPT code 99292. Specifically, we indicated that we package CPT code 99292 because it is burdensome for hospitals to track each additional 30-minute increment of time. Instead of requiring this tracking of all minutes of critical care services, we package payment for CPT code 99292 into the payment for CPT code 99291. Our response did not indicate that the 30-minute minimum requirement does not apply to CPT code 99291. In fact, the 30-minute minimum requirement has always applied and will continue to apply for CY 2007 and beyond. As is currently the case, the hospital can bill the appropriate clinic or emergency department visit code if fewer than 30 minutes of critical care is provided. We may provide more specific billing guidance at a later point in time. As described below, for CY 2007, clinic and emergency department visits will be paid at five levels, rather than three levels, which will ensure more accurate payments for these visits. Five payment levels will increase the payment rates for the highest level clinic and emergency department visits, which should benefit hospitals that provide these high-level services.

In response to the commenters who requested that we pay differentially for critical care associated with trauma response, as well as the recommendation of the APC Panel, we performed several studies to determine whether critical care associated with trauma response was costlier than critical care without trauma response. As suggested by the commenter, we used revenue codes in the 68x series reported on the same date as a critical care service to determine whether a trauma response was activated in association with critical care services in order to facilitate selection of appropriate claims. There are specific National Uniform Billing Committee guidelines related to the reporting of trauma revenue codes in the 68x series, first implemented in October 2002. The revenue codes series 68x can only be used by trauma centers/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons. Different subcategory codes are reported by the designated Level 1–4 hospital trauma centers. Only patients for whom there has been prehospital notification based on triage information by prehospital caregivers, who meet either local, state, or American College of Surgeons field triage criteria, or are delivered by interhospital transfers, and are given the appropriate team response can be billed a trauma activation charge.

We analyzed CY 2005 claims for critical care services, dividing claims into two groups: Those with trauma revenue code 68x on the same date of service as CPT code 99291 for the first period of critical care and those without trauma revenue code 68x on the same date of service as the critical care code. The median cost for critical care with a trauma revenue code charge is approximately $894, and the median cost for claims for critical care without a trauma revenue code charge is approximately $403. The proposed CY 2007 median cost for critical care was $495.

We further reviewed the list of providers who billed critical care with a trauma revenue code. We noted that of all the 2,200 hospitals that billed a critical care code during CY 2005, less than 2 percent of these hospitals billed a trauma revenue code on the same date of service as CPT code 99291 one or more times on an OPPS claim. In addition, many of the hospitals that billed critical care with a trauma revenue code also billed critical care without a trauma revenue code. We further investigated whether providers that billed critical care with a trauma revenue code on the same date of service had higher median costs in general than providers that billed critical care without a trauma revenue code. We re-ran the median cost of critical care without a trauma revenue code on the same date of service using only claims from the subset of providers that had billed critical care with revenue code 68x to determine if it was different than the $403 median cost that was calculated using all providers. Our results showed that providers that billed critical care with revenue code 68x had very similar critical care resource costs to other hospitals.

Therefore, for CY 2007, because we see meaningful cost differences between critical care when billed with and without trauma activation, we will pay differentially for critical care when there is trauma activation associated with the critical care and when there is no trauma activation. This will improve the accuracy of payments as related to resource use. Trauma centers provide important local and regional health services and serve valuable roles in their communities through their well-developed emergency capabilities.

In response to commenters' concern about G-codes, we will continue to instruct providers to bill CPT codes 99291 and 99292 for critical care. In addition, we are creating one new G-code, G0390 (Trauma response team activation associated with hospital critical care service), effective January 1, 2007, which is assigned to APC 0618 (Critical Care with Trauma Response), with a median cost of $491.66. When critical care is provided without trauma activation, the hospital will bill CPT code 99291 (and 99292, if appropriate) as usual, and receive payment for APC 0617 (Critical Care), which has a median cost of $402.67, calculated from that subset of single claims for CPT code 99291 without revenue code 68x reported on the same day. If trauma activation occurs under the circumstances described by the National Uniform Billing Committee guidelines that would permit reporting a charge under 68x, the hospital may also bill one unit of G-code G0390, reported with revenue code 68x on the same date of service, thereby paying the hospital $491.66 under APC 0618. The CY 2007 median cost for APC 0618 was established based on the difference in median costs from the two subsets of single claims for CPT code 99291 representing the reporting of critical care services with and without revenue code 68x reported on the same day. The OCE will edit to ensure that G0390 appears with revenue code 68x on the same date of service and that only one unit of G0390 is billed. We believe that trauma activation is a one-time occurrence in association with critical care services, and therefore, we will only pay for one unit of G0390 per day. CPT code 99292 remains packaged for CY 2007. We will monitor usage of the CPT codes for critical care services and the new G-code to ensure that their utilization remains at anticipated levels.

For CY 2007, we are not adopting the proposed HCPCS G-codes in Table 39 for critical care services but we are adopting one new G-code (G0390) for trauma activation and response in association with critical care services.

C. CY 2007 Payment Policy

Since the implementation of the OPPS, outpatient visits provided by

hospitals have been paid at three payment levels for both clinic and emergency department visits, even though hospitals have been reporting five resource-based coding levels of clinic and emergency department visits using CPT E/M codes. Critical care services have been paid at one level, with separate payment for the first 30 to 74 minutes of care and bundling of payment for all additional 30 minute increments of critical care services into payment for the first 30–74 minutes. If the critical care service is less than 30 minutes in duration, it is to be billed as either a clinic visit or an emergency department visit CPT code. Because the three payment rates for clinic and emergency department visits are based on five levels of CPT codes as listed in Table 40, in general the two lowest levels of CPT codes (1 and 2) have been assigned to the low-level visit APC and the two highest levels of CPT codes (4 and 5) have been assigned to the high-level visit APC, with the single middle CPT level CPT code (3) assigned to the mid-level visit APC. Hospital claims data indicate that the cost of providing a visit of the same level is generally significantly higher for emergency department visits in comparison with clinic visits, with the differential increasing at higher levels of services.

Based upon CY 2005 claims data processed through December 31, 2005, the median costs of clinic visit, emergency department visit, and critical care APCs as configured for CY 2006 are listed below.

TABLE 40.—MEDIAN COSTS OF CLINIC AND EMERGENCY DEPARTMENT VISIT AND CRITICAL CARE APCS AS CONFIGURED FOR CY 2006

APC Title	APC Median	Levels of CPT Codes Assigned to APC
Clinic Visits		
Low Level Clinic Visits	$53.14	Level 1 Clinic Visit, Level 2 Clinic Visit.
Mid Level Clinic Visits	61.89	Level 3 Clinic Clinic Visit.
High Level Clinic Visits	89.09	Level 4 Clinic Visit, Level 5 Clinic Visit.
Emergency Department Visits		
Low Level Emergency Visits	$74.44	Level 1 ED Visit, Level 2 ED Visit.
Mid Level Emergency Visits	129.25	Level 3 ED Visit.
High Level Emergency Vists	230.52	Level 4 ED Visit, Level 5 ED Visit.
Critical Care Services		
Critical Care	$478.04	Critical care, first hour.

However, historical hospitals claims data have generally reflected significantly different median costs for the two levels of services assigned to the low and high level visit APCs. While the median costs of these services do not violate the 2 times rule within their assigned APCs, this may not be the most accurate method of payment for these very common hospital levels of visits which clearly demonstrate differential hospital resources. In particular, because of the relatively low volume of the highest levels of services in the clinic and emergency department, our payment rates may be especially low. Therefore, we proposed to create five payment levels for clinic and emergency department visits and one payment level for critical care services.

As discussed in section IX.B. of this preamble, we are not adopting our proposal to replace all visit and critical care E/M CPT codes with G-codes, but we are creating five new G-codes to describe Type B emergency department visits and one new G-code to describe critical care services associated with trauma activation and response in association with critical care services.

In the proposed rule, to determine appropriate payment rates for the proposed new G-codes, we mapped the data from the CY 2005 CPT E/M codes and other HCPCS codes currently assigned to the clinic visit APCs to 11 new APCs, 5 for clinic visits, 5 for emergency department visits, and 1 for critical care services as shown in Table 41 to develop median costs for these APCs. We mapped the CPT E/M codes and other HCPCS codes to the new APCs based on median costs and clinical considerations. The table, which is reprinted below, is relevant for calculating median costs at five payment levels, regardless of whether hospitals use CPT codes or G-codes.

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Table 41.—Proposed Assignment of Claims Data from CY 2005 CPT E/M Codes and Other HCPCS Codes to New Visit APCs for CY 2007

CY 2007 APC Title	CY 2007 APC	HCPCS Code	Short Descriptor
Level 1 Hospital Clinic Visits	0604	92012	Eye exam established pat
		99201	Office/outpatient visit, new (Level 1)
		99211	Office/outpatient visit, est (Level 1)
		G0101	CA screen; pelvic/breast exam
		G0245	Initial foot exam pt lops
		G0248	Demonstrate use home inr mon
		G0249	Provide test material, equipm
		G0264	Assmt otr CHF, CP, asthma
Level 2 Hospital Clinic Visits	0605	92002	Eye exam, new patient
		92014	Eye exam and treatment
		99202	Office/outpatient visit, new (Level 2)
		99212	Office/outpatient visit, est (Level 2)
		99213	Office/outpatient visit, est (Level 3)
		99241	Office consultation (Level 1)
		99242	Office Consultation (Level 2)
		99271	Confirmatory consultation (Level 1)
		99272	Confirmatory consultation (Level 2)
		99431	Initial care, normal newborn
		G0246	Folloup eval of foot pt lop
		G0344	Initial preventive exam
Level 3 Hospital Clinic Visits	0606	92004	Eye exam, new patient
		99203	Office/outpatient visit, new (Level 3)
		99214	Office/outpatient visit, est (Level 4)
		99243	Office consultation (Level 3)
Level 4 Hospital Clinic Visits	0607	99204	Office/outpatient visit, new (Level 4)
		99215	Office/outpatient visit, est (Level 5)
		99244	Office consultation (Level 4)
		99273	Confirmatory consultation (Level 3)
		99274	Confirmatory consultation (Level 4)
Level 5 Hospital Clinic Visits	0608	99205	Office/outpatient visit, new (Level 5)
		99245	Office consultation (Level 5)
		99275	Confirmatory consultation (Level 5)
		G0175	OPPS service, sched team conf
Level 1 Type A Emergency Visits	0609	99281	Emergency department visit
Level 2 Type A Emergency Visits	0613	99282	Emergency department visit
Level 3 Type A Emergency Visits	0614	99283	Emergency department visit
Level 4 Type A Emergency Visits	0615	99284	Emergency department visit
Level 5 Type A Emergency Visits	0616	99285	Emergency department visit
Critical Care	0617	99291	Critical care, first hour

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In the case of the CPT E/M codes for emergency department visits, the assignment of data for the proposed rule from five levels of coding to five levels

of payment was straightforward. However, in some cases of the data for CPT clinic visit E/M codes, we assigned a code to an appropriate clinic visit APC level based upon resource and clinical homogeneity considerations, and that APC assignment did not correspond to the visit level described by the code. For example, CPT 99213 is a Level 3 clinic visit code for an established patient, which would seem to logically map to the Level 3 Clinic Visit APC. However, because CPT 99213 has a median cost of $60.70, it maps more appropriately to the Level 2 Clinic Visit APC, which has an overall median cost of $60.13. In general, CPT codes for established patient visits had lower median costs than new patient visit or consultation codes of the same E/M level, and that variability was reflected in their respective proposed APC data assignments for CY 2007.

For CY 2007, we proposed to assign the five new Type A emergency department visit codes for services provided in a Type A emergency department to the five new Emergency Visit APCs, 0609, 0613, 0614, 0615, and 0616.

For CY 2007, we proposed to assign the five new Type B emergency department visit codes for services provided in a Type B emergency department to the five new Clinic Visit APCs, 0604, 0605, 0606, 0607, and 0608. This payment policy for Type B emergency department visits is similar to our current policy which requires services furnished in emergency departments that have an EMTALA obligation but do 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 require 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, the reporting of specific G-codes for emergency department visits provided in Type B emergency departments will permit us to specifically collect and analyze the hospital resource costs of visits to these facilities in order to determine in the future whether a proposal of an alternative payment policy may be warranted. The OPPS rulemaking cycle for CY 2009 will be the first year that we will have cost data for these new Type B emergency department HCPCS codes available for analysis. This approach to more refined data collection is similar to our approach to drug administration services under the OPPS over the past several years. We collected hospital claims data for specific detailed services using CPT and HCPCS codes for CYs 2005 and 2006, while making payments based on claims data available to us for the less specific HCPCS codes billed by hospitals prior to CY 2005. We recognize that reporting specific drug administration services for which hospitals received no separate or additional payments created some additional administrative burden on hospitals for a period of time, but the resource information collected through the claims submissions has been critical to the development of our proposal of more refined drug administration payment policies. The hospital claims data based upon the CY 2005 drug administration coding structure now form the foundation of our final CY 2007 policy for drug administration services as described in section VIII. of the preamble of this final rule with comment period.

In the proposed rule, we noted that we were particularly concerned with ensuring that necessary emergency department services are available to rural Medicare beneficiaries. We recognize that rural emergency departments may be disproportionately likely to offer essential emergency department services less than 24 hours per day, 7 days a week because of the limited demand for those services and the high costs and inefficiencies associated with providing full emergency department availability during times when few patients present for emergency care. We believe that our OPPS payment policies for Type A and Type B emergency department visits should support the ability of hospitals to provide their communities with essential and appropriate emergency department services efficiently and effectively. We also believe that the payment policies should present no payment incentive for hospitals to provide necessary emergency services less than 24 hours per day, 7 days per week, which could result in limited access to emergency services for Medicare beneficiaries, thereby leading to adverse effects on their health.

Comment: The commenters were divided as to whether to continue with three payment levels or to move to five payment levels for clinic and emergency department visits. Several commenters noted that five payment levels is better because it is similar to the payment structure of other payors, while others noted that three levels was more appropriate because it is difficult to distinguish among four or five levels. Another commenter opposed creation of five levels because its experience has shown that providers tend to choose the middle level automatically. One commenter preferred three levels to five levels to distinguish it from physician coding. Several commenters requested that CMS continue paying at three payment levels until CMS established national guidelines. These commenters also requested that CMS not transition to G-codes until national guidelines were established. They preferred to maintain the status quo until national guidelines were established, at which point they believed it would be more appropriate to also revise the coding and payment structure. The commenters believed that it would be simpler to make the changes all at once, rather than making incremental changes, leading up to the establishment of national guidelines.

Several commenters favored moving to five payment levels before national guidelines were established, and encouraged CMS to finalize the number of payment levels before continuing work on national guidelines. The commenters believed that, if the cost data showed that five payment levels would lead to a more accurate distribution of payment, they were in favor of the change.

While most comments favored the distinction between Type A and Type B emergency departments, several commenters believed that Type B emergency department visits should be paid at Type A emergency department rates, rather than clinic visit rates. The commenters believed that, although these facilities were open less than 24 hours a day, the services provided more closely resemble emergency department services than clinic services, and therefore, their resource costs were higher than clinics. Other commenters believed it was appropriate and reasonable to pay for Type B emergency departments at clinic visit rates until cost data was collected. One commenter was concerned that ''unfettered proliferation of less than full-service emergency departments could reduce access for many individuals who need emergency care after hours when Type B emergency departments are closed. We do not want these facilities to have financial incentives to locate in areas where the population is more affluent and largely insured, leaving full-service hospital emergency departments with an even larger financial burden to care for the uninsured and underinsured after hours.'' The commenter favored the distinction between the two types of emergency departments, but believed the costs of Type B emergency departments is closer to the cost of Type

A emergency department visits than clinic visits. The commenter was unsure of the direct impact this payment policy will have on Type B emergency departments, recognizing that these facilities improve patient access to emergency care. In particular, the commenter wondered how many hospital-based Type B emergency departments exist and how many of them are currently billing at emergency department rates. One commenter noted that emergency departments are suffering financially, and that CMS should pay them at higher rates to ensure continued access. Several commenters suggested that CMS pay Type B emergency departments at a rate somewhere in between the Type A emergency department rates and clinic visit rates until complete cost data are collected.

Several commenters responded to our concern that rural hospitals may be disproportionately likely to offer essential emergency department services less than 24 hours per day, 7 days a week. Specifically, one commenter confirmed through conversations with State associations and hospitals that few emergency departments are open less than 24 hours a day. In particular, the commenter indicated many rural hospitals are designated as CAHs, for which the Medicare CAH conditions of participation require that emergency services are available 24 hours a day. While the commenter had heard of a few emergency departments that were open less than 24 hours a day, it did not believe that any rural emergency departments were open less than 24 hours a day.

One commenter suggested that CMS adjust the copayments so that the Level 1 clinic copayment becomes significantly less than the Level 1 emergency department visit, to provide an incentive for Medicare beneficiaries to receive care in the most cost-efficient setting.

As discussed in section IX.B.3. of this preamble on coding, we received a significant number of comments regarding payment for critical care services associated with trauma activation. We summarized and responded to those comments in that section.

Response: While we acknowledge the concern of several commenters that it is best to remain at status quo until national guidelines are developed, we continue to believe that five payment levels are now appropriate for both clinic and emergency department visits based on median cost data. This will allow us to more accurately distribute clinic and emergency department payments, as also noted by several commenters.

Five payment levels will increase the payment rates for the highest level clinic and emergency department visits, which will benefit hospitals that provide these high-level services. In addition, we do not anticipate that hospitals will need to update their internal guidelines to reflect this change, as it affects payment, not coding. While we have heard anecdotally that some hospitals only bill level 1, level 3, and level 5 clinic and emergency department visit CPT codes to simplify their internal coding, our data indicates a fairly normal distribution, suggesting that overall, providers are billing all five levels of codes. In any case, general coding rules dictate that providers should bill the code that most appropriately describes the service provided. Therefore, for CY 2007, we will finalize our proposal to pay clinic and emergency department visits at five levels, rather than three levels. We will pay for critical care services at two payment rates as well, as described in section IX.B.3. of this preamble on coding.

We re-assessed the APC assignments for the HCPCS codes in Table 41 using updated final rule data. Because hospitals will be reporting CPT codes for clinic visits for CY 2007, they must continue to distinguish between new and established patients and consultations according to the CPT code descriptor. However, it may be unnecessary for hospitals to report consultation CPT codes if either the new or established patient visit code accurately describes the service provided. We do not want to create an incentive for hospitals to bill a consultation code instead of a new or established patient code because we do not believe that consultation codes necessarily reflect different resource utilization than either new or established patient codes. Therefore, because consultation codes may be reported by hospitals during CY 2007, we re-reviewed the resource costs for the consultation codes, as well as the clinical homogeneity of the APCs to which we proposed to map them. As a result of this review, we have moved the consultation codes to the same APC as the established patient code, for each level of service. For example, CPT code 99242, the level 2 consultation code is mapped to APC 0605 (Level 2 Clinic Visits), which is where CPT code 99212, the level 2 established patient code, is mapped. In addition, we mapped the data for the deleted confirmatory consultation CPT codes, 99271–99275, to the same APC as the corresponding consultation code. Moving the consultation codes to the same APC as the corresponding established patient visit code eliminates the incentive for hospitals to bill a consultation code instead of a new or established patient code. Table 42 shows the assignment of claims data from the CY 2005 CPT E/M codes and other codes in the Visit APCs to the new Visit APCs for CY 2007.

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Table 42.--Final Assignment of Claims Data from CY 2005 CPT E/M Codes and Other HCPCS Codes to New Visit APCs for CY 2007

CY 2007 APC Title	CY 2007 APC	HCPCS Code	Short Descriptor
Level 1 Hospital Clinic Visits	0604	92012	Eye exam established pat
		99201	Office/outpatient visit, new (Level I)
		99211	Office/outpatient visit, est (Level I)
		G0101	CA screen; pelvic/breast exam
		G0245	Initial foot exam pt lops
		99241	Office consultation (Level I)
		99271	Confirmatory consultation (Level I)
		G0264	Assmt otr CHF, CP, asthma
Level 2 Hospital Clinic Visits	0605	92002	Eye exam, new patient
		92014	Eye exam and treatment
		99202	Office/outpatient visit, new (Level II)
		99212	Office/outpatient visit, est (Level II)
		99213	Office/outpatient visit, est (Level III)
		99243	Office consultation (Level III)
		99242	Office Consultation (Level II)
		99273	Confirmatory consultation (Level III)
		99272	Confirmatory consultation (Level II)
		99431	Initial care, normal newborn
		G0246	Folloup eval of foot pt lop
		G0344	Initial preventive exam
Level 3 Hospital Clinic Visits	0606	92004	Eye exam, new patient
		99203	Office/outpatient visit, new (Level III)

CY 2007 APC Title	CY 2007 APC	HCPCS Code	Short Descriptor
		99214	Office/outpatient visit, est (Level IV)
		99274	Confirmatory consultation (Level IV)
		99244	Office consultation (Level IV)
Level 4 Hospital Clinic Visits	0607	99204	Office/outpatient visit, new (Level IV)
		99215	Office/outpatient visit, est (Level V)
		99245	Office consultation (Level V)
		99275	Confirmatory consultation (Level V)
Level 5 Hospital Clinic Visits	0608	99205	Office/outpatient visit, new (Level V)
		G0175	OPPS service, sched team conf
Level 1 Emergency Visits	0609	99281	Emergency dept visit (Level I)
Level 2 Emergency Visits	0613	99282	Emergency dept visit (Level II)
Level 3 Emergency Visits	0614	99283	Emergency dept visit (Level III)
Level 4 Emergency Visits	0615	99284	Emergency dept visit (Level IV)
Level 5 Emergency Visits	0616	99285	Emergency dept visit (Level V)

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We have reviewed all of the public comments carefully and continue to believe that it is appropriate to pay Type B emergency department visits at clinic visit rates, until we collect enough data to better determine their resource costs. We have no hospital resource data that would support how to establish appropriate payment rates for Type B emergency department visits at rates between clinic and Type A emergency department rates. The fact that they do not operate with all capabilities full-time suggests that hospital resources associated with visits to DEDs may not be as great as those for full-time hospital emergency departments. Paying clinic rates for visits to Type B emergency departments would be consistent with current OPPS policy and CPT guidelines that a facility that does not meet the CPT definition of emergency department cannot bill emergency department CPT codes and, therefore, cannot receive emergency department visit payments. We agree with the commenter that was concerned about creating incentives for emergency departments to be open less than 24 hours a day, which could thereby place additional burden on the emergency health care system. We do not have precise data on how many Type B emergency departments currently exist, but we believe that they are currently billing the clinic visit CPT codes, as required under the OPPS, and thus this policy would have little impact on current billing practices and payments. Therefore, for CY 2007, we are finalizing our proposal to pay Type B emergency departments at clinic visit rates.

We appreciate the efforts of the commenters that responded to our concern about access to rural emergency departments. As most rural emergency departments are open 24 hours a day, we believe Medicare beneficiaries in rural areas should continue to have access to emergency care.

In response to the commenter that suggested that the copayment for emergency department visits be set at a higher rate than the copayment for clinic visits, we note that the statute and regulation set a general formula that we use to calculate copayments. As stated in 42 CFR 419.41, for CY 2007, a copayment cannot be lower than 20 percent of the payment rate or greater than 40 percent of the payment rate. In addition, we have established through rulemaking a detailed formula that we use to calculate copayments. We do not artificially adjust copayments for any APC unless a statutory provision states that the standard formula does not apply. Because there is no statutory provision that excludes these visit APCs from the standard formula, we cannot ensure a specific relationship between the clinic and emergency department visit copayments.

For CY 2007, we are finalizing without modification our proposal to create five payment levels for clinic and emergency department visits. We are finalizing with modification our proposal to create one payment level for critical care, by providing an additional payment when critical care is associated with trauma activation and response.

D. CY 2007 Treatment of Guidelines

1. Background

As described in section IX.A. of the preamble of this final rule with comment period, since April 7, 2000, we have instructed hospitals to report facility resources for clinic and emergency department outpatient hospital visits using the CPT E/M codes and to develop internal hospital guidelines for reporting the appropriate visit level. In the CY 2003 OPPS final rule with comment period (67 FR 66792), we noted that an independent panel of experts would be an

appropriate forum to develop codes and guidelines. In that final rule with comment period, 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 the 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 should result in a normal curve.

Subsequently, as described above, the AHA and AHIMA formed an independent expert panel, the Hospital Evaluation and Management Coding Panel, and submitted 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. 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. We undertook a critical review of the recommendations and made some modifications to the guidelines based on comments we received from outside hospitals and associations, clinical review, and changing payment policies in the OPPS regarding some separately payable services. In addition, as previously stated, we contracted a study to retrospectively code, under the modified AHA/AHIMA guidelines, hospital visits by reviewing hospital visit medical chart documentation gathered through CERT work. In summary, while the testing of the modified AHA/AHIMA guidelines was helpful in illuminating areas of the guidelines that would benefit from refinement, we were unable to draw conclusions about the relationship between the distribution of current hospital reporting of visits using CPT E/M codes that are assigned according to each hospital's internal guidelines and the distribution of code levels under the AHA/AHIMA guidelines, nor were we able to demonstrate a normal distribution of visit levels under the modified AHA/AHIMA guidelines.

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 believe that the AHA/AHIMA guidelines are the most appropriate and well-developed guidelines for use in the OPPS of which we are aware. Our particular interest in these guidelines is based upon the broad-based input into their development, the need for CMS to move definitively to promulgate national outpatient hospital visit coding guidelines in the near future, and full consideration of the characteristics of alternative types of guidelines. We also believe that hospitals will react favorably to guidelines developed and supported by the AHA and AHIMA, national organizations that have great interest in hospital coding and payment issues, and possess significant medical, technical and practical expertise due to their broad membership, which includes hospitals and health information management professionals. Anecdotally, we have been told that a number of hospitals are successfully utilizing the AHA/AHIMA guidelines to report levels of hospital visits. However, other organizations have expressed concern that the AHA/AHIMA guidelines may result in a significant redistribution of hospital visits to higher levels, reducing the ability of the OPPS to discriminate among the hospital resources required for various different levels of visits. We, too, remain concerned about the potential redistributive effect on OPPS payments for other services or among levels of hospital visits when national guidelines for outpatient visit coding are adopted. We recognize that there may be difficulty crosswalking historical hospital claims data from current CPT E/M codes reported based on individual internal hospital guidelines to payments for any new coding system developed, in order to provide appropriate payment levels for hospital visits reported based on national guidelines in the future.

There are several types of problems with the AHA/AHIMA guidelines that have been identified based upon extensive staff review and contractor use of the guidelines during the validation study. We believe the AHA/AHIMA guidelines require short-term refinement prior to their full adoption by the OPPS, as well as continued refinement over time after their implementation. Our modified version of the AHA/AHIMA guidelines provides some possibilities for addressing certain issues. Our eight general areas of concern regarding the AHA/AHIMA model are listed below. In addition, we have posted to the CMS Web site both the original AHA/AHIMA guidelines and our modified draft version. In the CY 2007 OPPS proposed rule (71 FR 49616), we sought public input before we adopt national guidelines.

We continue to commit that we will provide a minimum of 6–12 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. Outstanding Concerns with the AHA/AHIMA Guidelines

a. Three Versus Five Levels of Codes

The AHA/AHIMA guidelines describe three levels of codes for clinic and emergency department visits, rather than the five levels of codes that currently exist for clinic and emergency department visits. We believe that it is difficult to pay at five levels using these guidelines, unless the guidelines were revised, because hospitals would not have guidelines that applied to the Level 2 and Level 4 visits. As discussed above, our claims data indicate that five payment levels are justified for both clinic and Type A emergency department visits, and, therefore, we are finalizing five levels of clinic and emergency department visit payments so that providers may code at five visit levels and receive payments at five levels as well. In fact, the materials explaining the AHA/AHIMA guidelines state that one of the reasons that the model includes only three coding levels is because CMS only paid at three payment levels. We will now pay at five payment levels for CY 2007 and believe the AHA/AHIMA guidelines may need to be revised to reflect five visit levels.

b. Lack of Clarity for Some Interventions

Some interventions are vague, unclear, or nonspecific, without sufficient examples of documentation in the medical record that may support those interventions. For instance, it is unclear what documentation for the intervention stated as ''Patient registration, room setup, patient use of room, room cleaning'' and assigned in the AHA/AHIMA guidelines to a low-level clinic visit would be necessary to support all aspects of that intervention. In another case, the intervention ''Frequent monitoring/assessment as evidenced by two sets of vital sign measurements or assessments'' that is attributable to a mid-level emergency department visit in the guidelines explains that this may include assessment of cardiovascular, pulmonary, or neurological status. However, it is unclear exactly what coders should look for in the medical record to support this intervention and whether narrative hospital staff descriptions of patient status would be considered to be assessments. These

examples, and others, were identified by the contractor engaged in medical chart reviews as part of the guidelines validation study. The AHA/AHIMA guidelines may benefit from revisions to clarify some interventions and/or provide additional examples based upon questions that arose during field testing of the guidelines or that are raised by hospitals reviewing the AHA/AHIMA guidelines and the modified version posted on our Web site.

c. Treatment of Separately Payable Services

CMS and the APC Panel stated that separately payable services should be excluded from the guidelines because of their concern over the potential for double payment for hospital resources attributed to visit services when those resources were actually used to provide the separately payable services. Consistent with this policy, at the time of their development, the AHA/AHIMA guidelines excluded all services separately payable under the OPPS from the list of interventions. For policy consistency, in our modified draft version of the guidelines, we removed interventions that have now become separately payable under the OPPS through CY 2006, such as bladder catheterizations and some wound care services. However, upon further reflection as we move forward to implement national guidelines, in the proposed rule, we indicated that we are open to reconsidering whether the inclusion of some separately payable services in guidelines to determine visit levels could serve as a proxy for the resources that the patient will consume and that should be attributable to the hospital visit, not the separately payable services. In such cases, consideration of separately payable services in reporting visit levels may not result in double payment for components of those separately payable services. There may be hospital resources used in visits that are not captured in the AHA/AHIMA guidelines' limited number of interventions that are not separately payable. We believe that, in general, a patient with high medical acuity will consume more hospital resources in the visit than a patient with moderate acuity. However, when separately payable interventions are removed from the model, it may be difficult for the limited interventions remaining in the guidelines for each visit level to capture the acuity level of the patient. In addition, the list of HCPCS codes that are packaged can change annually. For example, in the CY 2006 OPPS, bladder catheterization services, which had been packaged in prior years, were first made separately payable, provided certain conditions were met. If the guidelines strictly excluded all separately payable services, the guidelines could also change from year to year, possibly requiring additional education of hospital staff on an annual basis. An extremely ill emergency department patient who may need a significant number of separately payable procedures, but only one or two minor interventions that are not separately payable, may require significant time and attention from hospital staff that is unrelated to the hospital resources generally required for the separately payable procedures. The guidelines may indicate that a low level emergency department visit code should be billed, while, in fact, the patient may require significantly more hospital resources than a mildly ill patient who received the same two minor interventions. In the proposed rule, we indicated that we are open to further discussion and welcomed public comments on the exclusion of separately payable services from the national visit guidelines and whether their inclusion could pose a risk of attributing the same hospital resources to both visits and separately payable services, potentially resulting in duplicate payments for those resources.

d. Some Interventions Appear Overvalued

Several interventions that we believe may be minor are valued at a high level in the guidelines. This could result in visits with relatively less resource intensive interventions being coded as high level visits, leading to an overall visit distribution that was skewed toward the high end. Claims data then would fail to reflect the differential hospital resources associated with hospital visits of five levels. For example, the AHA/AHIMA guidelines consider oxygen administration, described as initiation and/or adjustment from a baseline oxygen regimen, to be a mid-level emergency department intervention, while we believe that the associated hospital resources could be more consistent with its characterization as a low-level emergency department intervention. In another example, the AHA/AHIMA guidelines consider specimen collection(s), other than venipuncture and other separately payable services, to be a mid-level clinic intervention, while we believe this may be more consistent with other low-level clinic interventions, depending upon the numbers and types of different specimens collected. In the proposed rule, we encouraged specific comments on the levels assigned to various interventions in the guidelines, with the goal of differentiating five levels of services in a normal distribution, based on their respective hospital resources.

e. Concerns of Specialty Clinics

The AHA/AHIMA guidelines are unlikely to sufficiently address the concerns of various specialty clinics (for example, pain management clinics, oncology clinics, and wound care centers). Anecdotally, we have heard that the interventions listed in the AHA/AHIMA guidelines do not include many of the interventions commonly performed in specialty clinics and that some of the interventions in the guidelines would never be performed in certain types of clinics. Currently, each provider has its own set of guidelines, and we believe that some specialty clinics have customized guidelines to facilitate coding their visits at different levels based upon the specific hospital resources commonly used in visits to their clinics. While we prefer to have one model that can be applied nationally to each level of clinic visit code for which we make a specific OPPS payment, we are unsure as to whether one model can adequately characterize visit levels for all types of clinics. For example, we have been told that the most appropriate proxy for facility resource consumption in cancer care is staff time due to the intensive staff interactions required to care for patients with cancer, regardless of the reasons for their clinic visits. In the proposed rule, we expressed interest in receiving comments regarding the feasibility of applying national guidelines to specialty clinic visits while ensuring appropriate OPPS payments for those services and suggestions for revisions to the guideline models posted that could improve their utility in reporting such visits.

f. Americans With Disabilities Act

We are concerned that the AHA/AHIMA guidelines' intervention related to the special needs of certain patients may be in violation of the Americans with Disabilities Act, as it may increase the visit level reported, thereby increasing a patient's copayment. Even if additional hospital resources are required to treat patients with disabilities, patients must not have additional financial liability for those services based on their disabilities.

g. Differentiation Between New and Established Patients and Between Standard Visits and Consultations

The AHA/AHIMA guidelines do not differentiate between new versus

established patients or consultations versus standard visits for clinic visits. During the summer 2002 APC Panel meeting, the APC Panel recommended that CMS not differentiate among visit types, specifically new, established, and consultation visits, for the purposes of clinic visit facility coding. Therefore, in the August 9, 2002 OPPS proposed rule, we proposed to accept the APC Panel's recommendation to create five new G-codes to replace the CPT new and established clinic visit and consultation E/M codes. We did not finalize the codes for CY 2003 because of concerns then about creating new G-codes without national guidelines.

During CY 2006 and earlier, there has not been a payment difference between new and established patient visits of the same level, as generally both were mapped to the same APC. The information describing the AHA/AHIMA guidelines indicates that only one set of guidelines was developed for five levels of codes for clinic visits, regardless of a patient's status as a new or established patient or the provision of a consultation visit. This approach may have been related to the lack of a payment differential for different types of clinic visits of the same level under the OPPS when those guidelines were developed. However, several years of hospital claims data regarding the median costs of the specific CPT clinic visit E/M codes consistently indicate that new patients generally are more resource intensive than existing patients across all visit levels, and that consultations are more resource intensive than standard visits, but similar in terms of resources to new patient visits. For example, based upon the final CY 2005 claims used by the OPPS for CY 2007 ratesetting, CPT code 99213, the level 3 clinic visit code for established patients, has a median cost of $60.70. CPT code 99203, the level 3 clinic visit code for new patients, has a median cost of $72.33. CPT code 99243, the level 3 consultation visit code, has a median cost of $72.89. Finally, CPT code 99273, the level 3 confirmatory consultation visit code that was deleted for CY 2006 had a median cost of $98.24. In the proposed rule, we encouraged public comments that discuss the potential differences in hospital clinic resource consumption for new patient visits, established patient visits, and consultations. If there are significant additional hospital resources required to provide new patient visits or consultations, we are unsure whether the interventions in the AHA/AHIMA guidelines would reliably capture these additional resources.

h. Distinction Between Type A and Type B Emergency Departments

There are no AHA/AHIMA guidelines for the reporting of visits to Type B emergency departments that meet the EMTALA definition of a DED, but do not meet the proposed definition of a Type A emergency department, as discussed above. When the AHA and AHIMA created these guidelines, emergency departments that did not meet the CPT definition of emergency department were instructed to bill CPT clinic visit E/M codes. There was no distinction in CPT reporting between emergency departments that, as DEDs, had an EMTALA obligation but did not meet the CPT definition of emergency department and outpatient hospital clinics that did not provide emergency services. For the new G-codes that we created in this final rule with comment period for CY 2007 for Type B emergency departments to use in reporting visits, in the short run hospitals will use internal guidelines to determine their visit levels for Type B emergency department visits, as they will for visits to both clinics and Type A emergency departments. However, with the implementation of national hospital visit guidelines, we will need to specify those guidelines to be used for the purposes of Type B emergency department visit reporting. The AHA and AHIMA have not yet had the opportunity to consider the issue of Type B emergency department visit reporting in their guidelines, and in the proposed rule we welcomed public comments to provide additional perspectives on the appropriate guidelines for reporting visit levels in these Type B emergency departments.

We received a large number of comments related to national guidelines for clinic and emergency department visits and critical care services, some of which described general questions and concerns about using a national model and others with specific suggestions for improving the AHA/AHIMA model. As noted in the CY 2007 proposed rule, we sought broad public input regarding our discussion of national guidelines to inform our guidelines development efforts at this point in time, but we made no specific proposal for CY 2007. Therefore, the comments below are summarized to reflect the breadth and depth of thoughtful input provided by the public, and we will continue to consider these comments and additional public input as we work to develop national guidelines for future implementation.

Comment: Most commenters strongly supported creation of national guidelines, but a few commenters preferred to continue using the internal guidelines that they had been using for several years. Some hospitals had successfully implemented the original AHA/AHIMA model, while others had success with diagnosis-related models and resource intensity point scoring models. One commenter indicated that a diagnosis-based model is not as complicated as we described. The commenter's hospital had great success training its staff and now has little coding variability among its coders. One developer of national guidelines noted that many hospitals had success with problem-based guidelines that it had created. The developer noted that its system was easy to use, produced consistent coding decisions with a normal distribution of visits, and even served as a tool to track effectiveness and efficiency. One hospital asked if it was permitted to continue using its own internal guidelines if CMS had indicated some concerns with that particular type of guidelines. Several hospitals asked us to clarify whether a normal distribution would be expected nationally, across all hospitals, or for an individual hospital. The commenter suggested that it would be appropriate for a trauma center to have a curve that was skewed to the right, toward higher level visit codes. Another commenter suggested that hospitals be instructed to bill the same level code that is billed on the physician side, to simplify coding and reduce excess documentation. The commenter noted that then there would be no concern about redistributive impact because we could simply study the physician E/M code distribution. One commenter requested that the final guidelines use criteria and/or interventions that would be available in electronic medical records, to ease guideline implementation for hospitals with this technology. The same commenter suggested that the guidelines should be very specific and serve as detailed coding instructions rather than just ''guidelines,'' which would make training easier and reduce the number of questions directed at the fiscal intermediaries. The commenter suggested that the guidelines include details, with regulation citations such as ''the patient must be a registered outpatient of the hospital'' as defined in a particular regulation. Several commenters requested that we clarify that the clinic guidelines are intended to be used by any outpatient area that is not an emergency department, even if that outpatient area is not a true clinic and suggested that the guidelines should be titled ''Outpatient visit

guidelines'' instead of ''Clinic visit guidelines.'' One commenter gave examples of outpatient areas that are not clinics, which included outpatient infusion centers, outpatient oncology centers, wound care centers, and outpatient maternity services.

We received many specific comments about the AHA/AHIMA model. The AHA and AHIMA were pleased that we are working on their model and look forward to reconvening the expert panel to continue work on this project. They noted that the model was an initial attempt with a short turnaround time, and that it was never intended to be used as a stand-alone document. They anticipated creating educational supplemental materials that would accompany the guidelines. Several organizations expressed interest in working with CMS as well as the AHA/AHIMA expert panel in the development of national guidelines, including the American College of Emergency Physicians and Lynx Medical Systems.

Several commenters agreed that it was appropriate to continue with five levels of coding to achieve consistency with other payors. Other commenters agreed that retaining five coding levels was appropriate if five payment rates existed. One commenter believed that three levels was simpler and distinguished hospital coding from physician coding, which has five coding levels. The AHA and AHIMA noted that the guidelines originally used three levels because the expert panel found it hard to distinguish between five levels when separately payable services were excluded. However, if separately payable services or other factors such as time could be included, the model could be modified to account for five levels. They requested clear guidance from CMS before proceeding.

Many commenters agreed that multiple interventions were unclear and could be interpreted in several ways. Other commenters asked CMS to clarify exactly which interventions were unclear. One commenter noted that over time, after the guidelines are implemented, the ambiguities will decrease as staff becomes familiar with the model. Several commenters suggested that specific examples of patient acuity or symptoms would be useful. (We noted above that the AHA and AHIMA anticipated that they would provide significant supplemental materials.) Several commenters asked that we clarify the difference between ''triage'' and the medical screening exam required under EMTALA provisions. One commenter suggested that CMS only use interventions that measure quantitative items such as blood pressure, heart rate, and pain threshold scoring, and like items.

Most commenters believed that separately payable interventions should be included in the guidelines because they serve as a proxy for resource use. One commenter noted that the American College of Emergency Physicians' guidelines have an excellent list of interventions, some of which are separately payable. One commenter suggested that we assign a modifier to a code that is separately paid so that it would not be counted toward calculating a visit level. The AHA and AHIMA aptly noted that not all separately payable services reflect patient acuity, so it would be necessary for the Panel to determine which services are appropriate for inclusion. One commenter asked that we continue to exclude separately payable services to avoid double billing and confusion.

Some commenters indicated that most interventions in the original AHA/AHIMA model were appropriately placed, with some interventions that were valued too low and a few that were valued too high. Other commenters disagreed with several CMS-suggested revisions. For example, in the revised model, if emergency department staff performed a body assessment, pain measurement, vitals, and an x-ray, that service would no longer reach a level 1 visit, while under the original AHA/AHIMA guidelines, the service would be coded as a Level 1 visit. Several commenters argued that oxygen administration should not be moved to a low level because it is resource-intensive in terms of staff time and resource use. One commenter stated that specimen collection was appropriately assigned as a Level 1 intervention in a clinic setting but should be higher in the emergency department because staff often need to assist patients who are anxious and having trouble concentrating. Another commenter suggested Level 1 assignment for one to two specimen collections and Level 3 for three or more collections. Two hospitals speculated that their emergency department payment would decrease by 30 to 40 percent as a result of transitioning to the AHA/AHIMA guidelines. There were additional suggestions that specific interventions move from one level to another. Several commenters suggested additional interventions that should be included, such as restroom assistance, memory testing, reviewing medications, obtaining insurance authorization, psychological and spiritual counseling, emotional support, time with the family, discharge instructions, seizure precautions, drug/alcohol influence, prepping for surgery, postmortem care, dietary planning, pain management, and others. Although pre-authorization is not required for Medicare beneficiaries, some commenters noted that hospitals will use these guidelines for all payors, so it may be appropriate to include this intervention. One commenter agreed that continuous irrigation of the eye should not be a Level 5 visit. The AHA and AHIMA stated that its expert Panel looked carefully at each intervention. They noted that their criteria for placement included hospital staff time involved, complexity of intervention, number of hospital staff members required to perform the intervention, and the skill level, qualifications, or credentialing needed to perform the intervention. Other commenters noted that the interventions were focused on interventions performed by nurses, rather than by assorted clinicians and technicians. One hospital expressed interest in submitting further suggestions after the comment period ended.

We received a few comments about applying one set of guidelines to all clinics, including specialty clinics, suggesting that it was unnecessary to create multiple guidelines. Several commenters suggested that any differences could be addressed with time as an element, which is the single biggest resource that varies among clinics. For example, a diabetic patient with limited eyesight requires additional training time to learn to read glucose levels and give the proper amount of insulin. A cancer association submitted an additional example, explaining that a simple blood draw can be time consuming when performed on an oncology patient, whose veins may be damaged from the effects of chemotherapy. One commenter suggested that if more than 50 percent of a visit is used for counseling and care coordination, the visit level should be increased by one level. Several associations stated that it is unlikely that one set of guidelines could apply to all specialty clinics. Specifically, one wound care association recommended that all wound care clinics use the guidelines developed by that particular association. Another wound care association developed an acuity scoring system that has been successfully implemented by wound care clinics.

One commenter suggested that in a time-based model, there would be no American with Disabilities Act (ADA) violation. Another commenter suggested setting a flat copayment rate for all clinic and all emergency department visits to avoid an ADA violation. The

AHA and AHIMA clarified that their intention was not to increase the beneficiary copayment but was intended to reflect resource utilization.

We discuss in sections IX.B. and C. of this preamble the comments that we received about the distinction among ''new'' and ''established'' visits and ''consultations.'' A few commenters suggested that a new patient could be a contributing factor in the guidelines.

We also discuss in sections IX.B of this preamble the comments that we received about Type A versus Type B emergency departments. We received no comments on this topic that were specific to the AHA/AHIMA guidelines.

One organization noted that some revisions may have been necessary due to changes in clinical practice since the guidelines were developed 3 years ago. Another commenter noted that several Level 1 emergency department interventions, such as first aid, are Level 3 clinic interventions, which leads to emergency departments receiving less payment for the same service, even though emergency departments are costlier.

The AHA and AHIMA requested that CMS release the detailed analysis of the Iowa Foundation for Medical Care review of the AHA/AHIMA model so that they can review all concerns. They also requested that CMS clarify the rationale for the other modifications. For example, it sometimes appeared to them as if CMS measured physician time rather than facility resources or hospital staff time. For example, patient education by hospital staff was removed but physician counseling of more than 60 minutes was added.

Response: We appreciate all the comments we received from the public, and we encourage continued submission of comments at any time that will assist us, the AHA/AHIMA expert panel, and other stakeholders interested in the development of national guidelines. Until national guidelines are established, hospitals should continue using their own internal guidelines, even if we have expressed reservations about the type of guidelines that a hospital is currently using. As commenters stated, we would not expect individual hospitals to experience a normal distribution of visit levels, although we would expect a normal distribution across all hospitals after national guidelines are established. We would expect that a small community hospital may provide more low-level services than high-level services, while an academic medical center or trauma center may provide more high-level services than low-level services. The commenters are correct that we intend for these national guidelines to be used by any outpatient hospital department, even if it is not called a clinic.

We would expect these national guidelines to provide for five levels of coding, to parallel the five payment levels that are finalized in this final rule with comment period. It would be impossible to code at three levels and pay at five levels. As described above, we believe that paying at five levels will allow a more accurate payment for clinic and emergency department visits.

We agree with commenters that there may be advantages to including separately payable interventions in the guidelines as examples, because a measure of acuity may be lost in the absence of recognition of these procedures. We also agree with the AHA and AHIMA that it might be easier to distinguish among five levels of coding if separately payable interventions are included as examples.

We appreciate all of the specific comments about interventions that may not be appropriately assigned to levels in the guidelines. We acknowledge that the guidelines are still being developed and require additional testing. While it would be impossible for every single hospital to agree about the placement of every single intervention in the guidelines, we anticipate that the interventions will be assigned in a way that best reflects the resource use of the services provided such that few providers will have objections. We remind providers that under a relative system, if a service is listed as a Level 1 intervention, it does not mean that very few hospital resources are involved. Instead, it means that the resources used in that service must be considered relative to the other interventions in the model.

While most commenters believed that one set of guidelines could apply to all specialty clinics, it may be necessary to incorporate time into the guidelines as well. The AHA and AHIMA expert panel has considered this issue as well.

We will determine whether the Iowa Foundation for Medical Care study of the modified AHA/AHIMA model can be released to the public.

The public comments that we received on this guidelines section of the proposed rule are publicly available to the AHA and AHIMA and their expert panel, as well as other interested parties, along with comments that we received on the two versions of the guidelines posted on the CMS Web site at: *http://www.cms.hhs.gov*. We hope to receive additional input from the AHA and AHIMA and other stakeholders over the upcoming months to address the eight areas of concern that are discussed above, as well as the other issues reviewed above that have been brought to our attention by the public. We plan to communicate progress on the development of OPPS visit guidelines through updates to the OPPS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/* and we may post other versions of draft guidelines in order to solicit additional public input during CY 2007. When we post additional materials to the Web site for purposes of providing information or soliciting further comments regarding national guidelines, we will update the public through all means practically available to us, including communications with professional associations, list-serves, and other broad-based communication forums.

While we understand the interest of some hospitals in our moving quickly to promulgate national guidelines that will ensure standardized reporting of outpatient hospital visit levels, we believe that the issues we have identified and others that may arise are important and require serious consideration prior to the implementation of national guidelines. Because of our commitment to provide hospitals with 6–12 months notice prior to implementation of national guidelines, we expect that we would not implement national guidelines prior to CY 2008. We acknowledge that, once implemented, the guidelines will require periodic review and updating based on factors such as changing medical practices, hospital experiences in reporting the codes, new payment policies under the OPPS, and median costs for levels of services calculated from claims data. We are hopeful that the information received from the AHA, AHIMA and others on such reviews would permit us to effectively, and in a timely manner, address emerging guideline implementation issues, as well as develop desirable future modifications to the guidelines based on hospitals' experiences reporting commonly provided visits. We believe that this ongoing and evolving system should provide the most successful approach to ensuring that OPPS national visit guidelines continue to facilitate consistent and standardized reporting of outpatient hospital visits, in a manner that is resource-based and supportive of appropriate OPPS payments for the efficient and effective provision of visits in hospital outpatient settings.

X. Payment for Blood and Blood Products

A. Background

Since the implementation of the OPPS in August 2000, separate payments have been made for blood and blood products through APCs rather than packaging them into payments for the procedures with which they were administered. Hospital payments for the costs of blood and blood products, as well as the costs of collecting, processing, and storing blood and blood products, are made through the OPPS payments for specific blood product APCs. On April 12, 2001, CMS issued the original billing guidance for blood products to hospitals (Program Transmittal A–01–50). In response to requests for clarification of these instructions, CMS issued Program Transmittal 496 on March 4, 2005. The comprehensive billing guidelines in the Program Transmittal also addressed specific concerns and issues related to billing for blood-related services, which the public had brought to our attention.

In the CY 2000 OPPS, payments for blood and blood products were established based on external data provided by commenters due to limited Medicare claims data. From the CY 2000 OPPS to the CY 2002 OPPS, payment rates for blood and blood products were updated for inflation. For the CY 2003 OPPS, as described in the November 1, 2002 final rule with comment period (67 FR 66773), we applied a special adjustment methodology to blood and blood products that had significant reductions in payment rates from the CY 2002 OPPS to the CY 2003 OPPS, when median costs were first calculated from hospital claims. Using the adjustment methodology, we limited the decrease in payment rates for blood and blood products to approximately 15 percent. For the CY 2004 OPPS, as recommended by the APC Panel, we froze payment rates for blood and blood products at CY 2003 levels as we studied concerns raised by commenters and presenters at the August 2003 and February 2004 APC Panel meetings.

For the CY 2005 OPPS, we established new APCs that allowed each blood product to be assigned to its own separate APC, as several of the previous blood product APCs contained multiple blood products with no clinical homogeneity or whose product-specific median costs may not have been similar. Some of the blood product HCPCS codes were reassigned to the new APCs (Table 34 of the November 15, 2004 final rule with comment period (69 FR 65819)).

We also noted in the November 15, 2004 final rule with comment period, that public comments on previous OPPS rules had stated that the CCRs that were used to adjust charges to costs for blood products in past years were too low. Past commenters indicated that this approach resulted in an underestimation of the true hospital costs for blood and blood products. In response to these comments and 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 methodology for hospitals not reporting a blood-specific cost center, which simulated a blood-specific CCR for each hospital that we then used to convert charges to costs for blood products. Thus, we developed simulated medians for all blood and blood products based on CY 2003 hospital claims data (69 FR 65816).

For the CY 2005 OPPS, we also identified a subset of blood products that had less than 1,000 units billed in CY 2003. For these low-volume blood products, we based the CY 2005 OPPS payment rate on a 50/50 blend of the CY 2004 OPPS product-specific OPPS median costs and the CY 2005 OPPS simulated medians based on the application of blood-specific CCRs to all claims. We were concerned that, given the low frequency in which these products were billed, a few occurrences of coding or billing errors may have led to significant variability in the median calculation. The claims data may not have captured the complete costs of these products to hospitals as fully as possible. This low-volume adjustment methodology also allowed us to further study the issues raised by commenters and by presenters at the September 2004 APC Panel meeting, without putting beneficiary access to these low-volume blood products at risk.

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. For the CY 2006 OPPS, we set the final median costs for blood and blood products at the greater of: (1) The simulated median costs calculated from the CY 2004 claims data; or (2) 95 percent of the CY 2005 OPPS adjusted median costs for these products, as reflected in Table 33 published in the CY 2006 OPPS final rule with comment period.

B. Policy Changes for CY 2007

In the CY 2007 OPPS proposed rule, we proposed to base CY 2007 payment rates for blood and blood products on their median costs from CY 2005 claims data, calculated using a special methodology to simulate blood-specific CCRs if hospitals did not have such specific CCRs. After hearing several public presentations at the August 2006 APC Panel meeting, the Panel engaged in considerable deliberation and recommended that CMS reconsider its methodology to develop payment rates for blood and blood products to more accurately reflect the true costs of blood and blood products to hospitals, including using external data. We include our response to this recommendation in the discussion below.

We received a number of public comments regarding this proposal. A summary of the comments and our responses follows:

Comment: A number of commenters objected to our proposal to base payments for blood and blood products on their simulated median unit costs. They stated that the proposed payments are inadequate to compensate hospitals for the full acquisition costs of blood and blood products. Some commenters said that they appreciated CMS' work to calculate more appropriate payment rates for blood and blood products, but urged CMS to use external data, rather than claims-based data, as a measure of the appropriateness of the median costs derived from the claims process. Specifically, the commenters asked CMS to set the payments for four blood products at 110 percent of the average hospital purchase price for four blood products, specifically, P9016, RBC Leukocytes reduced; P9017, Plasma 1

donor frz w/in 8 hr; P9019, and Platelets; P9035, Platelet pheresis leukoreduced as determined from data submitted by 1600 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). The commenters believed that the 10 percent increase over the survey purchase price findings was necessary to update the amounts to reflect what they thought would be the costs to hospitals for these blood products in CY 2007. They stated that the amounts that resulted were very conservative because they reflected only the cost of the blood and its processing, without including a hospital allowance for the costs of overhead, storage, handling, and waste due to shelf-life limitations. Other commenters asked CMS to set the blood median costs for CY 2007 at 12 percent higher than the proposed rule median costs, because such an increase would result in a significant improvement in reimbursement for products for which the OPPS claims data understated true acquisition costs and would help to ensure continued beneficiary access to the nation's blood supply. Some commenters asked that CMS set the payment for blood at the charge established by large suppliers of blood products. Several commenters requested that CMS calculate the median costs for blood and blood products using only claims with dates of service after July 1, 2005, so that the only claims used in median calculation for these products would be claims that were submitted after the billing guidance and coding edits of CMS Program Transmittal 496 went into effect on July 1, 2005. Other commenters suggested that we establish median costs for basic blood products and, separately, for different types of additional blood processing (for example, irradiation and leukoreduction) to ensure that there would be no rank order anomalies in the medians derived from claims data.

Response: In developing this CY 2007 final rule with comment period, we are accepting the APC Panel's recommendation to review our methodology for developing payment rates for blood and blood products. We have also considered the only recent external data of which we are aware that was mentioned by several commenters. The recent survey by the AABB included reporting of the hospital purchase prices related to providing 4 of the 34 blood and blood products for which we have specific HCPCS codes. An abstract of the resulting report, including the average amounts hospitals paid for the four blood products in CY 2004, is available in the journal ''*Transfusion,*'' 2006 volume 46 Supplement (page 188A). We reviewed the limited information that is currently available from the survey for these four blood products. However, we are unable to determine the extent to which the survey findings could be useful in evaluating the methodology and resulting median costs that were the basis for our CY 2007 proposal of payment rates for all blood and blood products. Our payment methodology for blood and blood products has historically been based upon median hospital costs (consistent with the standard OPPS claims-based methodology for establishing payment rates), and the survey reported average hospital purchase prices, rather than median costs. Moreover, this information was not available to the public at the beginning of the comment period of the CY 2007 OPPS proposed rule, and hence we were not able to request and consider public comments on it. The OPPS methodology to establish relative weights requires standardized cost finding applied to a standardized source of data to ensure that the relative weights for the items and services paid under the system are in the correct relationship to one another. To select four blood products for treatment outside of the standard methodology, substituting external data for claims data, may not result in weights that are appropriately relative to one another. Accordingly, we are not using the AABB survey data in determining the payment rates for blood and blood products for the CY 2007 OPPS.

We also are not adopting one suggestion of the commenters to establish rates based upon the amounts charged by the largest suppliers of blood, because as described earlier regarding use of the AABB survey data, to do so would be contrary to the methodology of the OPPS that is based on a system of relative weights. Similarly, we do not believe it would be appropriate to increase the final median costs of blood and blood products by 12 percent over their proposed CY 2007 median costs because little justification was provided by the commenters for the increase. Lastly, we do not believe we should calculate median costs for this final rule using only claims submitted on or after the July 1, 2005, effective date of the blood instructions in Transmittal 496, because to do so would greatly reduce the number of claims for the low volume blood products. The rates for these products tend to volatile even with an entire year of claims data, because they are furnished in very low volume in outpatient hospital settings. We also are not setting median costs for the product without processing and establishing separate median costs for each different type of processing. Hospitals generally acquire the product processed as specified in the definition of the product they report, and we do not believe that they would be able to charge separately for the unprocessed product (for example, red blood cells) and also charge separately for the processing that occurred before they acquired the already processed product.

Instead, for the CY 2007 OPPS, we are finalizing 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. However, for CY 2007 we are providing 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 is greater than 25 percent. Specifically, we are setting the CY 2007 median costs upon which payments for blood and blood products are based at the higher of the CY 2007 unadjusted simulated median cost or 75 percent of the CY 2006 adjusted median cost on which the CY 2006 payment is based. This results in adjustment to the simulated median costs for CY 2007 for 7 of the 34 blood products. See Table 43 below.

The median costs for blood and blood products in this final rule with comment period are derived from the CY 2005 claims data and have the benefit of reflecting, in part, the clarifications about reporting 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. The instruction went into effect for services furnished on or after July 1, 2005, and therefore, was in effect for the last 6 months of CY 2005. Thus, we expect

that the reporting of charges and units for blood and blood products in CY 2005 has improved over past years, especially with respect to hospitals' inclusion of all charges related to the acquisition, processing, and handling of blood and blood products as specifically described in each of the relevant HCPCS P-code descriptors. We believe that the median costs for blood and blood products from the CY 2005 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.

Of the 34 blood products, median costs per unit (calculated using the simulated blood-specific CCR methodology) for CY 2007 rise for 23 of them compared to their CY 2006 unadjusted simulated median unit costs. These 23 products account for about 82 percent of all units of blood products furnished to Medicare beneficiaries in the hospital outpatient department in our CY 2005 claims data. 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. Of the 11 low volume products, 6 products show increases in their unit costs compared to their CY 2006 unadjusted simulated median unit costs, and 5 products show decreases in their median unit costs compared to their CY 2006 unadjusted simulated median unit costs. The low volume products for which the median costs decline compared to their unadjusted simulated median costs in CY 2006 represent only 0.48 percent of the total units of blood products furnished in the CY 2005 OPPS claims data.

However, we recognize that for some blood products, including one product that is not of low volume, the difference between the CY 2006 adjusted simulated median cost on which CY 2006 payment is based is greater than 25 percent. Therefore, we are providing a transitional payment for CY 2007 by limiting the amount of the decrease for CY 2007 compared to CY 2006 to no more than 25 percent. We believe that this is a necessary and appropriate step in the transition to payments for blood and blood products based fully on claims data.

Fewer blood products actually experience increases in their median costs from CY 2006 to their final CY 2007 median costs because we adjusted the CY 2006 median costs for blood and blood products. Of the 34 blood products, median costs rise for 18 of them compared to the CY 2006 OPPS adjusted simulated median costs on which the CY 2006 payments are based (and which were adjusted to no less than 95 percent of the CY 2005 payment medians). These 18 products account for 81 percent of all units of blood products furnished in our CY 2005 claims data. Of the 11 low volume products, 3 show increases in their median unit costs compared to the CY 2006 OPPS adjusted simulated median unit costs, and 8 show decreases compared to their CY 2006 OPPS adjusted simulated median unit costs. The low volume products that show a decline in medians compared to their CY 2006 adjusted simulated median costs represent only 0.37 percent of the total units of blood products reflected in the CY 2005 claims data.

In summary, we are setting the final payment rates for blood and blood products for CY 2007 based on the unadjusted simulated median costs for blood and blood products that are derived from CY 2005 claims data as we have described, with the exception of the seven products for which we are providing a payment adjustment to smooth their transition to full claims-based payment in the future. We believe that, in most cases, the unadjusted median unit costs developed by this process are valid reflections of the estimated median costs of furnishing these specific blood products, and that no adjustment is required to result in appropriate payments for blood and blood products in CY 2007. Under this policy, based on the CY 2005 claims data, the projected payments will rise for approximately 81 percent of the blood product units paid under the OPPS if patterns of furnishing blood products in CY 2007 remain similar to those in CY 2005. The low volume products whose simulated median costs decline compared to their CY 2006 adjusted simulated median costs are furnished very rarely and by very few providers because, in part, more commonly available products may be used for similar clinical indications. In addition, the median costs of several low volume blood products show a significant increase for CY 2007.

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Table 43.--CY 2007 Payment Median Costs for Blood and Blood Products

HCPCS	SI	APC	Short Description	CY 2007 Units	CY 2007 Unadjusted Simulated Median Unit Cost	CY 2007 Payment Median: Higher of CY 2007 Simulated Median Unit Cost or 75 Percent of CY 2006 Adjusted Simulated Median Unit Cost *	CY 2006 Unadjusted Simulated Median Unit Cost	CY 2006 Adjusted Simulated CCR Median Unit Cost	Difference between CY 2007 Simulated CCR Median Unit Cost and CY 2006 Adjusted Simulated CCR Median Unit Cost
P9010	K	0950	Whole blood for transfusion	2,575	$131.21	$131.21	$117.91	$117.91	11.28%
P9011	K	0967	Blood split unit	190	$136.42	$136.42	$82.50	$82.50	65.36%
P9012	K	0952	Cryoprecipitate each unit	5,136	$48.31	$48.31	$40.33	$47.10	2.57%
P9016	K	0954	RBC leukocytes reduced	618531	$174.71	$174.71	$163.16	$163.16	7.08%
P9017	K	9508	Plasma 1 donor frz w/in 8 hr	46,863	$69.80	$69.80	$70.40	$70.40	-0.85%
P9019	K	0957	Platelets, each unit	28,399	$58.61	$58.61	$51.50	$51.50	13.81%
P9020	K	0958	Plaelet rich plasma unit	711	$153.79	$208.07*	$277.42	$277.42	-44.56%
P9021	K	0959	Red blood cells unit	161,250	$128.78	$128.78	$121.48	$121.48	6.01%
P9022	K	0960	Washed red blood cells unit	2,795	$209.79	$209.79	$172.40	$189.22	10.87%
P9023	K	0949	Frozen plasma, pooled, sd	433	$56.81	$57.11*	$60.38	$76.15	-25.40%
P9031	K	1013	Platelets leukocytes reduced	21,507	$94.53	$94.53	$98.30	$98.30	3.84%
P9032	K	9500	Platelets, irradiated	5,989	$128.81	$128.81	$73.46	$86.55	48.83%
P9033	K	0968	Platelets leukoreduced irrad	5,386	$124.60	$124.60	$102.18	$150.58	-17.25%
P9034	K	9507	Platelets, pheresis	10,689	$450.29	$450.29	$434.01	$434.01	3.75%
P9035	K	9501	Platelet pheres leukoreduced	46,661	$485.89	$485.89	$493.12	$493.12	-1.47%
P9036	K	9502	Platelet pheresis irradiated	1,620	$416.08	$416.08	$317.43	$325.87	27.68%
P9037	K	1019	Plate pheres leukoredu irrad	20,231	$613.80	$61380	$581.01	$581.01	5.64%
P9038	K	9505	RBC irradiated	4,984	$195.85	$195.85	$147.47	$147.47	32.18%
P9039	K	9504	RBC deglycerolized	916	$356.22	$356.22	$343.44	$343.44	3.72%
P9040	K	0969	RBC leukoreduced irradiated	66,390	$216.29	$216.29	$218.04	$218.04	-0.80%
P9043	K	0956	Plasma protein fract,5%,50ml	442	$25.04	$50.96*	$67.94	$67.94	-63.14%
P9044	K	1009	Cryoprecipitatereducedplasma	7,0035	$81.91	$81.91	$74.52	$74.52	9.92%
P9048	K	0966	Plasmaprotein fract,5%,250ml	403	$138.85	$236.78*	$127.36	$315.70	-56.02%
P9050	K	9506	Granulocytes, pheresis unit	495	$260.17	$745.98*	$245.14	$994.64	-73.84%
P9051	K	1010	Blood, l/r, cmv-neg	3,913	$134.83	$155.79*	$207.72	$207.72	-35.09%
P9052	K	1011	Platelets, hla-m, l/r, unit	2,025	$667.70	$667.70	$609.48	$609.48	9.55%
P9053	K	1020	Plt, pher, l/r cmv-neg, irr	1,049	$701.26	$701.26	$654.13	$654.13	7.20%
P9054	K	1016	Blood, l/r, froz/degly/wash	586	$209.82	$209.82	$89.73	$261.93	-19.89%
P9055	K	1017	Plt, aph/pher, l/r, cmv-neg	598	$387.90	$394.50*	$526.00	$526.00	-26.25%
P9056	K	1018	Blood, l/r, irradiated	4,037	$143.44	$143.44	$162.42	$178.37	-19.58%
P9057	K	1021	RBC, frz/deg/wsh, l/r, irrad	84	$493.32	$493.32	$345.53	$345.53	42.77%
P9058	K	1022	RBC, l/r, cmv-neg, irrad	2,301	$260.65	$260.65	$256.76	$266.89	-2.34%
P9059	K	0955	Plasma, frz between 8-24hour	3,479	$76.32	$76.27	$74.70	$74.70	2.17%
P9060	K	9503	Fr frz plasma donor retested	320	$74.06	$74.06	$94.72	$94.72	-21.81%

*Payment at 75 percent of CY 2006 median

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XI. OPPS Payment for Observation Services

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.

For CY 2006, we adopted two coding changes that affect how observation services are reported, and we made changes in the OCE to shift from individual providers to the OPPS claims processing systems the determination of whether or not observation services are separately payable or packaged. Observation services reported using HCPCS code G0378 (Hospital observation services, per hour) that are eligible for separate payment map to APC 0339 (Observation). The CY 2006 payment rate for APC 0339 is $425.08.

In the CY 2007 proposed rule, we proposed a CY 2007 median cost for APC 0339 of $442.16. This reflected relative stability in hospital costs for separately payable observation care. Direct admission to observation (HCPCS code G0379), when separately payable, is currently assigned for payment to APC 0600 (Low Level Clinic Visit) with a CY 2006 payment rate of $52.37. As discussed below, for CY 2007, we proposed to assign direct admission to observation, when separately payable, to APC 0604 (Low Level Clinic Visit). The proposed CY 2007 median cost for APC 0604 was $49.93.

As we stated in the CY 2006 OPPS final rule with comment period (70 FR 68688), the changes that we adopted for CY 2006 were intended to ensure more consistent hospital billing for observation services in order to guide our future analyses of payment for observation care and to simplify how observation services are reported and paid. We refer readers to the CY 2006 OPPS final rule with comment period for a detailed discussion of the G-codes for observation services and the OCE logic changes implemented for CY 2006 (70 FR 68688), and to Program Transmittal 787, issued on December 16, 2005, in which we updated Chapter 4, Section 290 of the Medicare Claims Processing Manual (Pub. 100–04) to reflect the CY 2006 changes and to provide additional guidance to contractors and hospitals.

During the APC Panel's March 2006 meeting, the Observation Subcommittee did not make any recommendations to the Panel other than to request its review of additional data on observation services at the Panel's 2007 winter meeting. The APC Panel adopted the Observation Subcommittee's report and recommended no changes to the criteria for separate payment for observation services or to the coding and payment methodology for observation services.

During the APC Panel's August 2006 meeting, the Observation Subcommittee made several recommendations regarding observation services. The first of these was that CMS should consider adding syncope and dehydration as diagnoses for which observation services would qualify for separate payment. Second, the Observation Subcommittee recommended that CMS perform claims analyses and present data that would allow it to consider revising criteria for separately payable observation services 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 services, and all other criteria for separate observation payment (for example, qualifying diagnosis code, number of hours) are met.

Comment: A few commenters expressed ongoing support for the improved processing of observation claims through use of the OCE to assign separate or packaged status to observation services depending on whether the criteria for separate payment were met, an approach that CMS implemented for CY 2006. The commenters suggested that now that CMS has simplified the process for ensuring separate payment for covered outpatient observation services in specific circumstances, CMS should consider adding syncope and dehydration as diagnoses that qualify for separate observation payment. The commenters did not request CY 2007 implementation, but, rather, their suggestions were consistent with the APC Panel recommendation that CMS should explore this expansion to the list of diagnoses for which observation may be separately paid.

Also related to the APC Panel recommendations, one commenter recommended that CMS perform claims and data analysis that would enable CMS to consider revising the criteria for separately payable observation services when certain procedures that are assigned status indicator ''T'' are reported on the same claim with an emergency department visit and observation services, and all other criteria for separate observation payment are met.

Response: We intend 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 services, as well as the possibility of allowing separate observation payment for claims for observation services that also include specific minor or routine procedures that have ''T'' status indicators. We will continue to work with the APC Panel Observation Subcommittee over the coming months in response to these recommendations. We expect to have preliminary results of the analyses in time for discussion with the full Panel at the next APC Panel meeting in the winter of 2007.

For CY 2007, as we proposed, we are continuing to apply the criteria for separate payment for observation services and the coding and payment methodology for observation services that were implemented in CY 2006, with one exception. In section IX. of this preamble, we are making final changes in APC assignments and payments for clinic and emergency department visits. As part of those changes, low level clinic visits are being moved from APC 0600 (Low Level Clinic Visits) to APC 0604 (Level 1 Clinic Visits), with a final CY 2007 median cost of $50.37. Under the circumstances where direct admission to observation is separately payable, we are finalizing our assignment of HCPCS code G0379 to APC 0604, consistent with its CY 2006 placement in the APC for Low Level Clinic Visits.

Comment: One commenter suggested that CMS adopt ''midnight'' as a defining measure of an overnight stay in hospital outpatient departments. The commenter believed that CMS proposed to apply that definition of an overnight stay in ASCs so beneficiaries in ASCs at midnight would be transferred at that time to hospital outpatient departments for continuing care. The commenter stated that those patients would be unlikely to meet acuity and severity requirements for inpatient admission and would be admitted to observation and that the hospital would be able to bill for the initial care with G0379 because the patient was a direct admission. The commenter expressed concern about the payment inequity between the situation in which a patient is transferred to observation from the

ASC (and the hospital can bill for direct admission to observation) compared to that for patients who are transferred from the hospital's own outpatient department into observation (and the hospital cannot bill).

The commenter suggested that CMS consider a new source of admission code for ''transfer from ASC'' to be used by hospitals. The commenter believed that CMS would benefit from collection of that data.

Response: We believe the commenter has misinterpreted our proposed use of midnight to define an overnight stay in ASCs for CY 2008. There is no requirement for an ASC to transfer a patient who continues to require care at and beyond midnight. For implementation in CY 2008, we proposed to include on the list of procedures for which an ASC facility fee would be allowed any procedure that may be safely performed in the ASC and that does not require an overnight stay. We proposed to exclude from payment of an ASC facility fee any procedure for which prevailing medical practice dictates that the beneficiary would typically be expected to require active medical monitoring at midnight following the procedure (71 FR 49638). Therefore, midnight with respect to an overnight stay is used solely for determining which procedures are eligible to be included on the Medicare ASC list and, thus, payment of an ASC facility fee would be allowed. There is no requirement to transfer patients out of the ASC at midnight.

Our proposed use of midnight to define overnight stay for purposes of evaluating procedures for inclusion on the Medicare ASC list has no payment implications for the hospital outpatient department. The proposal is still open for comment and, therefore, we will make no final decision about the proposal at this time.

As the commenter pointed out, in the circumstances where a patient is transferred from an ASC to a hospital for observation, the hospital may report HCPCS code G0379 (Direct admission of patient for hospital observation care) for the direct admission to observation service, along with HCPCS code G0378 for the hours of observation care. However, unless the observation services meet our criteria for separate payment, the hospital would only receive separate payment for HCPCS code G0379 through APC 0604 (Level 1 Clinic Visits), with a CY 2007 median cost of about $50. Similarly, if a patient has an outpatient surgical procedure performed in a hospital and requires outpatient observation care after the recovery period, the hospital may report the hours of observation using HCPCS code G0379, with payment for the observation care packaged into payment for the surgical procedure. We believe that the current policy is reasonable because, in both cases, hospitals will receive a separate payment for their services, into which payment for the hours of observation care is packaged.

Comment: One commenter sought clarification on whether the CY 2007 median cost calculation for APC 0339 included claims with more than 48 hours of observation. The commenter also sought clarification about whether all hours of observation care beyond 48 hours are noncovered.

Response: As we have stated before in reference to the appropriate duration of observation services, we believe that in the overwhelming majority of cases, decisions can be and are routinely made in less than 24 hours, regarding whether to release a beneficiary from the hospital following resolution of the reason for the outpatient visit or whether to admit the beneficiary as an inpatient. Again, as we have stated repeatedly, all hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered by Medicare, and hospitals receive either packaged or separate OPPS payment for these covered observation services. Similar to CY 2006, in calculation of the CY 2007 median cost for APC 0339, we used all claims for G0244 (Observation care provided by a facility to a patient with CHF, chest pain, or asthma, minimum eight hours), the HCPCS code that hospitals used in CY 2005 to report hour of separately payable observation under the circumstances described by the code. Because this code was only to be reported for observation care that spanned a minimum of 8 hours, we used all claims for G0244 in our median cost calculation for APC 0339 for CY 2007, regardless of the number of units of G0244 reported.

As we stated in Program Transmittal A–02–129 released in January 2003, we will continue to include in the October quarterly update of the OPPS any changes to the list of ICD–9–CM codes required for separate payment of HCPCS code G0378 resulting from the October 1 annual update of ICD–9–CM codes. The applicable ICD–9–CM codes for separate payment for observation services under the CY 2007 OPPS are listed in Table 44 below.

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Table 44.--CY 2007 Eligible Diagnosis Codes for Separate Payment of Observation Services if All Criteria Are Met

Required Diagnosis For:	Eligible ICD-9-CM Code	Code Descriptor
Chest Pain	411.0	Postmyocardial infarction syndrome
	411.1	Intermediate coronary syndrome
	411.81	Coronary occlusion without myocardial infarction
	411.89	Other acute ischemic heart disease
	413.0	Angina decubitus
	413.1	Prinzmetal angina
	413.9	Other and unspecified angina pectoris
	786.05	Shortness of breath
	786.50	Chest pain, unspecified
	786.51	Precordial pain
	786.52	Painful respiration
	786.59	Other chest pain
Asthma	493.01	Extrinsic asthma with status asthmaticus
	493.02	Extrinsic asthma with acute exacerbation
	493.11	Intrinsic asthma with status asthmaticus
	493.12	Intrinsic asthma with acute exacerbation
	493.21	Chronic obstructive asthma with status asthmaticus
	493.22	Chronic obstructive asthma with acute exacerbation
	493.91	Asthma, unspecified with status asthmaticus
	493.92	Asthma, unspecified with acute exacerbation
Heart Failure	391.8	Other acute rheumatic heart disease
	398.91	Rheumatic heart failure (congestive)
	402.01	Malignant hypertensive heart disease with congestive heart failure
	402.11	Benign hypertensive heart disease with congestive heart failure
	402.91	Unspecified hypertensive heart disease with congestive heart failure
	404.01	Malignant hypertensive heart and renal disease with congestive heart failure

Required Diagnosis For:	Eligible ICD-9-CM Code	Code Descriptor
	404.03	Malignant hypertensive heart and renal disease with congestive heart and renal failure
	404.11	Benign hypertensive heart and renal disease with congestive heart failure
	404.13	Benign hypertensive heart and renal disease with congestive heart and renal failure
	404.91	Unspecified hypertensive heart and renal disease with congestive heart failure
	404.93	Unspecified hypertensive heart and renal disease with heart and renal failure
	428.0	Congestive heart failure
	428.1	Left heart failure
	428.20	Unspecified systolic heart failure
	428.21	Acute systolic heart failure
	428.22	Chronic systolic heart failure
	428.23	Acute on chronic systolic heart failure
	428.30	Unspecified diastolic heart failure
	428.31	Acute diastolic heart failure
	428.32	Chronic diastolic heart failure
	428.33	Acute on chronic diastolic heart failure
	428.40	Unspecified combined systolic and diastolic heart failure
	428.41	Acute combined systolic and diastolic heart failure
	428.42	Chronic combined systolic and diastolic heart failure
	428.43	Acute on chronic combined systolic and diastolic heart failure
	428.9	Heart failure, unspecified

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XII. Procedures That Will Be Paid Only as Inpatient Procedures

A. Background

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. Before implementation of the OPPS in August 2000, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to provide only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

In the April 7, 2000 final rule with comment period, we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS (65 FR 18455). These procedures comprise what is referred to as the ''inpatient list.'' The inpatient list specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we discussed in the April 7, 2000 final rule with comment period (65 FR 18455) and the November 30, 2001 final rule (66 FR 59856), we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule with comment period (67 FR 66741), we removed 43 procedures from the inpatient list for payment under OPPS. We also added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- We have determined that the procedure is being performed in numerous hospitals on an outpatient basis; or
- We have determined that the procedure can be appropriately and safely performed in an ambulatory surgical center (ASC) and is on the list of approved ASC procedures or proposed by us for addition to the ASC list.

We believe that these additional criteria help us to identify procedures that are appropriate for removal from the inpatient list.

B. Changes to the Inpatient List

For the CY 2007 OPPS, we used the same methodology as described in the November 15, 2004 final rule with comment period (69 FR 65835) to identify a subset of procedures currently on the inpatient list that are being widely performed on an outpatient basis. These procedures were then clinically reviewed for possible removal from the inpatient list. We solicited input from the APC Panel on the appropriateness of the removal of seven procedures from the inpatient list at the March 1, 2006 APC Panel meeting. Prior to publishing the CY 2007 OPPS proposed rule, we had not received any other candidate HCPCS codes for removal from the OPPS inpatient list based on recommendations from the public. The APC Panel recommended that one of the procedures (CPT code 21181, Reconstruction by contouring of benign tumor of cranial bones, extracranial) be removed from the list, and that we solicit approval from the relevant physician specialty societies prior to proposing removal of the other six procedures. For CY 2007, we ultimately proposed to remove a total of eight procedures from the inpatient list.

Consistent with our established policy for removing procedures from the inpatient list, we rely on our utilization data and clinical staff input in determining which procedures are candidates for removal. We believe that our policy of proposing the procedures for removal and soliciting comments from the public, which includes physician specialty societies, is the most appropriate process to receive input from the public on this issue. Rather than solicit approval from a select group (for example, specific physician specialty societies), in the CY 2007 proposed rule we solicited comments from all interested parties consistent with meeting our obligation to the public regarding outpatient services provided by hospitals.

During the APC Panel meeting in August 2006, a presenter requested that the Panel recommend to CMS removal of 10 procedures from the inpatient list for CY 2007, in addition to those presented in the proposed rule. The 10 procedure codes and their descriptors are displayed in Table 45 below. The APC Panel recommended that CMS remove the procedures from the inpatient list and assign them to appropriate clinical APCs for payment beginning in CY 2007, including considering their assignment to APCs for female reproductive procedures such as APCs 0194 (Level VIII Female Reproductive Proc), 0195 (Level IX Female Reproductive Proc), and 0202 (Level X Female Reproductive Proc).

TABLE 45.—ADDITIONAL PROCEDURES RECOMMENDED BY THE APC PANEL FOR REMOVAL FROM THE INPATIENT LIST FOR CY 2007

HCPCS Code	Long Descriptor
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus).
57283	Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy).
58260	Vaginal hysterectromy, for uterus 250 grams or less.
58262	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s).
58263	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s), and/or ovary(s), with repair of enterocele.
58270	Vaginal hysterectomy, for uterus 250 grams or less; with repair of enterocele.
58290	Vaginal hysterectomy, for uterus greater than 250 grams.
58291	Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s).
58292	Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s), with repair of enterocele.

TABLE 45.—ADDITIONAL PROCEDURES RECOMMENDED BY THE APC PANEL FOR REMOVAL FROM THE INPATIENT LIST FOR CY 2007—Continued

HCPCS Code	Long Descriptor
58294	Vaginal hysterectomy, for uterus greater than 250 grams; with repair of enterocele.

We received numerous comments on our inpatient list proposal for the CY 2007 OPPS. A summary of the public comments and our responses follow:

Comment: Several commenters supported the APC Panel's recommendation made during its August 2006 meeting to remove the 10 procedures listed in Table 45 above.

Response: Although the most recent physician utilization data indicate that the procedures are performed on an inpatient basis 80 to 95 percent of the time, most of them have low volumes. We agree with the presenter and the APC Panel that they are performed predominantly for the younger women in our beneficiary population and, therefore, we believe they may be safely performed in the outpatient department. Therefore, we are removing the procedures as listed in Table 45 above from the OPPS inpatient list and assigning them to appropriate clinical APCs for CY 2007 as noted in Table 46 of this final rule with comment period.

Comment: Many commenters recommended elimination of the inpatient list altogether. Some of the commenters suggested that CMS rely on the Quality Improvement Organizations (QIOs) to handle issues related to care provided in inappropriate settings instead of maintaining the inpatient list, and all of the commenters believed that the decision to admit a beneficiary to the hospital should be left to the physician. They explained that the inpatient list causes confusion for hospitals when they are trying to make decisions about the medical necessity of admission for beneficiaries.

In addition, the commenters suggested that, if CMS does not eliminate the list, CMS should post the inpatient list and an explanation of its purpose on CMS' Web page for physicians and carriers, and that CMS present that same educational information during the Physician Open Door Forum. Further, a number of the commenters suggested that CMS consider implementing an appeals process to allow providers to submit documentation about physician intent, patient clinical condition, and the circumstances that allowed the patient to be sent home safely without an inpatient admission after payment has been denied because the procedure performed in the outpatient department was on the inpatient list.

Response: We appreciate these comments and thoughtful suggestions. 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 believe there are many surgical procedures that are never safely performed for typical Medicare beneficiaries in the hospital outpatient setting, so that it would be inappropriate for us to assign them separately payable status indicators and establish payment rates in the OPPS. However, we welcome the commenters' suggestions to provide more education to physicians about the list and its purpose. We intend to put those suggestions into practice. However, we will not implement an appeals process at this time.

Comment: One commenter recommended that CMS not remove CPT code 22851 (Application of intervertebral biomechanical device(s)(eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace), 22612 (Arthrodesis, posterior or posterolateral technique, single level; lumbar), or 22614 (Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment) from the inpatient list. The commenter stated that CPT code 22851 should not be removed as CMS proposed because the primary procedures with which it is performed (CPT codes 22325 (Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; lumbar); 22326 (Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; cervical); and 22327 (Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, one fractured vertebrae or dislocated segment; thoracic) are still on the inpatient list. The commenters believed that, even though CPT codes 22612 and 22614 were removed from the list in 2003, they should be put back on the inpatient list because the autologous and allograft bone graft procedures with which they are provided are still on the inpatient list.

Response: We proposed to remove CPT code 22851 because we believed that it was being performed safely in the outpatient setting. CPT code 22851 is not used exclusively with the CPT codes cited by the commenter. In fact, in our consultation with physician experts, we found that it is being performed safely in the outpatient setting, but not with the procedures that are on the inpatient list.

We are confident after our additional medical consultation that proposing to remove CPT code 22851 from the inpatient list was appropriate. Therefore, we are finalizing our proposal, without modification, to remove CPT code 22851 from the inpatient list for CY 2007.

We have received no comments prior to this year requesting that we put CPT codes 22612 and 22614 back on the inpatient list. Both of the procedures are performed 99 percent of the time in the inpatient setting, even though they are no longer on the inpatient list. We have a small number of outpatient hospital claims for both CPT codes from CY 2005. We have not seen significant growth in the outpatient performance of these procedures since they were removed the inpatient list several years ago. This is consistent with our belief that these procedures are being performed in the most appropriate setting, and we see no reason to reassign them to the inpatient list. Therefore, we are finalizing our proposal without modification and are not adding CPT codes 22612 and 22614 to the inpatient list for CY 2007.

Comment: One commenter requested that CMS not finalize the proposal to remove CPT code 61720 (Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus). The commenter stated that they have received feedback from physicians that it would not be clinically appropriate to perform the procedure in an outpatient setting. The commenter stated that requiring at least an overnight stay is the standard of care for the procedure. The commenter noted that the APC Panel recommended that CMS consult with the relevant specialty society to confirm

the appropriateness of removing the code from the inpatient list and stated that it was not clear in the proposed rule whether that confirmation was made.

Response: In our proposed rule, we clearly stated that we were interested in comments from the public on our proposals to remove codes from the inpatient list. We also stated that our solicitation of comments from the public includes physician specialty societies. Further, we explained that rather than solicit approval from a select group (physician specialty societies), we believed that solicitation of comments from interested parties was more consistent with meeting our obligation to the public.

We note that aside from this one comment, we received no other responses to our proposal. We would have expected that the physicians who were concerned enough about our proposed removal of CPT code 61720 from the inpatient list that they discussed it with the commenter would have conveyed their concerns directly to us as well. Thus, we have no other information outside of the commenter's assertion to confirm this procedure requires an inpatient stay.

The procedure coded as CPT code 61720 is performed only 26 percent of the time in the inpatient setting. We continue to believe that removing the procedure from the inpatient list is appropriate, and we are finalizing our proposal to do so, without modification.

Comment: One commenter requested that CMS remove three additional procedures, CPT code 37182 (Insertion of transvenous intrahepatic portosystemic shunt(s)(TIPS)(includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)); 45563 (Exploration, repair, and presacral drainage for rectal injury; with colostomy); and 61624 (Transcatheter permanent occlusion or embolization (eg, tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)) from the inpatient list. The commenter provided no rationale for requesting the removal of those procedures.

Response: The utilization data for these codes show that all of them are performed more than 80 percent of the time on an inpatient basis. While we first removed the CPT code for the revision TIPS procedure (CPT code 37183) from the inpatient list for CY 2006, our decision was based, in part, on a recommendation of the APC Panel to do so. We will be following OPPS claims data for that procedure based upon its newly payable status under the OPPS. However, without specific clinical evidence that the initial TIPS procedure and the other procedures recommended by the commenter may be safely performed in the hospital outpatient setting, we believe that it is appropriate to retain those procedures on the inpatient list. Therefore, we are finalizing our CY 2007 proposal, without modification, to retain these three services on the inpatient list.

Comment: One commenter requested that CMS remove two procedures, CPT codes 60502 (Parathyroidectomy or exploration of thyroid(s); re-exploration) and 60520 (Thymectomy, partial or total; transcervical approach), from the OPPS inpatient list. The commenter stated that those procedures are often performed in the same operative session with CPT code 60500 (Parathyroidectomy or exploration of thyroid(s)), which is not included on the inpatient list. The commenter believed that the two procedures (CPT codes 60502 and 60520) may be safely performed in the hospital outpatient department and should be removed from the inpatient list.

Response: We reviewed the outpatient hospital claims data and Part B physician bill data for CPT codes 60502 and 60520. According to the Part B bill data, CPT code 60502 was performed 43 percent of the time in the hospital outpatient setting in CY 2005, and CPT code 65020 was performed 27 percent of the time in that setting. Although there were very few single procedure claims in the OPPS data for these two procedure codes, we did find 12 single procedure claims for CPT code 60502 with a median cost of approximately $2,715.

Taking into account the utilization information, hospital data, cost data, and the advice of our medical advisors, we believe that it is appropriate to remove the two procedures from the inpatient list. Therefore, for CY 2007 we will assign CPT codes 60502 and 60520 to APC 0256 (Level V ENT Procedures), the same APC to which CPT code 60500 is assigned. We will monitor utilization and evaluate the assignments of these codes to APC 0256 as data become available to us (in time for the CY 2009 proposed rule) and as we do for all procedures after making changes in their APC assignments.

Consistent with our CY 2007 proposal, the utilization data and clinical review findings for the eight procedures support our removal of them from the inpatient list. We also are accepting the APC Panel's recommendation regarding the removal of 10 additional procedures from the inpatient list for CY 2007 and the public comment requests that we remove 2 other procedures. Therefore, we are removing a total of 20 procedures from the inpatient list and assigning them to clinically appropriate APCs, as shown in Table 46. The changes to the inpatient list will be effective for services furnished on or after January 1, 2007.

TABLE 46.—PROCEDURE CODES REMOVED FROM INPATIENT LIST AND NEW APC ASSIGNMENTS, EFFECTIVE JANUARY 1, 2007

HCPCS code	Long Descriptor	CY 2007 APC Assignment	CY 2007 Status Indicator
16035	Escharotomy; initial incision	0016	T
21181	Reconstruction by contouring of benign tumor of cranial bones, extracranial.	0254	T
22851	Apply spine prosth device	0049	T
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus).	0202	T
57283	Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy).	0202	T
57292	Construction of artificial vagina; with graft	0195	T
57335	Vaginoplasty for intersex state	0195	T
58260	Vaginal hysterectomy, for uterus 250 grams or less	0195	T

TABLE 46.—PROCEDURE CODES REMOVED FROM INPATIENT LIST AND NEW APC ASSIGNMENTS, EFFECTIVE JANUARY 1, 2007—Continued

HCPCS code	Long Descriptor	CY 2007 APC Assignment	CY 2007 Status Indicator
58262	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s).	0195	T
58263	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s), and/or ovary(s), with repair of enterocele.	0195	T
58270	Vaginal hysterectomy, for uterus 250 grams or less; with repair of enterocele.	0195	T
58290	Vaginal hysterectomy, for uterus greater than 250 grams	0202	T
58291	Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s).	0202	T
58292	Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s), with repair of enterocele.	0202	T
58294	Vaginal hysterectomy, for uterus greater than 250 grams; with repair of enterocele..	0202	T
60502	Parathyroidectomy or exploration of thyroid(s); re-exploration	0256	T
60520	Thymectomy, partial or total; transcervical approach	0256	T
61720	Creation of lesion by stereotactic method, including burr holes and localizing and recording techniques, single of multiple stages; globus pallidus or thalamus.	0221	T
62000	Elevation of depressed skull fracture; simple extradural	0254	T
64804	Sympathectomy, cervicothoracic	0220	T

C. CY 2007 Payment for Ancillary Outpatient Services When Patient Expires (–CA Modifier)

1. Background

In the November 1, 2002 final rule with comment period (67 FR 66798), we discussed the creation of a new HCPCS modifier –CA to address situations where a procedure on the OPPS inpatient list must be performed to resuscitate or stabilize a patient (whose status is that of an outpatient) with an emergent, life-threatening condition, and the patient dies before being admitted as an inpatient. In Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of this modifier when submitting a claim on bill type 13x for a procedure that is on the inpatient list and assigned the payment status indicator (SI) ''C'' (to indicate inpatient services that are not paid under the OPPS). Conditions to be met for hospital payment for a claim reporting a service billed with modifier –CA include a patient with an emergent, life-threatening condition on whom a procedure on the inpatient list is performed on an emergency basis to resuscitate or stabilize the patient. For CY 2003, a single payment for otherwise payable outpatient services billed on a claim with a procedure appended with this new –CA modifier was made under APC 0977 (New Technology Level VIII, $1,000–$1,250), due to the lack of available claims data to establish a payment rate based on historical hospital costs.

As discussed in the November 7, 2003 final rule with comment period, we created APC 0375 (Ancillary Outpatient Services When Patient Expires) to pay for services furnished on the same date as a procedure with SI ''C'' and billed with the modifier –CA (68 FR 63467) because we were concerned that payment under a New Technology APC would not result in an appropriate payment. Payment under a New Technology APC is a fixed amount that does not have a relative payment weight and, therefore, is not subject to recalibration based on hospital costs. In the absence of hospital claims data to determine costs, the clinical APC 0375 payment rate for CY 2004 was set at $1,150, which was the payment amount for the newly structured New Technology APC that replaced APC 0977.

For CYs 2005 and 2006, the payment rates for APC 0375 for services billed on the same date as a ''C'' status procedure appended with modifier –CA were established in accordance with the same methodology we followed to set payment rates for the other procedural APCs in those years, based on the relative payment weight calculated for APC 0375. For APC 0375 specifically, we calculated the relative payment weight from all claims reporting a ''C'' status procedure appended with modifier –CA, using charge data from the relevant calendar year claims for line items with a HCPCS code and status indicator ''V,'' ''S,'' ''T,'' ''X,'' ''N,'' ''K,'' ''G,'' and ''H,'' in addition to charges for revenue codes without a HCPCS code. We continued to make one payment in CYs 2005 and 2006 under APC 0375 for the services that met the specific conditions discussed in previous rules for using modifier –CA.

In the CY 2006 final rule with comment period (70 FR 68700), we discussed our concern about the large increase in the volume of hospital claims billed with modifier –CA from CY 2003 to CY 2004, growing from 18 to 300 claims over that 1-year time period. We acknowledged that because modifier –CA was first introduced for CY 2003, the use of the modifier in CYs 2003 and 2004 may have reflected such an increase due to hospitals' learning curve with respect to the modifier's appropriate use on claims for services payable under the OPPS. We also expressed some concern that numerous claims reflected unanticipated examples of ''C'' status procedures reported with modifier –CA that may not have been provided to patients with emergency life threatening conditions, where the inpatient procedure was performed on an emergency basis to resuscitate or stabilize the patient. We promised to monitor CY 2005 claims data for similar increases.

Our review of the CY 2005 claims data available for the CY 2007 proposed rule revealed a decrease in the use of modifier –CA in comparison with CY 2004 claims. In the final CY 2005 data available for this final rule with comment period, there were 260 claims submitted reporting modifier –CA. Because of the diverse individual clinical scenarios where modifier –CA may be appropriately reported, we expect some variation from year to year

in the number of OPPS claims reporting the modifier and in light of the growth in outpatient claims overall, it is encouraging that the level of claims with –CA modifier decreased compared to CY 2004. It would appear that the hospital learning curve regarding use of modifier –CA may have been completed over the past 3-year period, and that we may expect relatively consistent reporting of this modifier in future years. We note that not only was there no increase in the number of claims reporting modifier –CA in CY 2005, but there were also fewer apparently inappropriate instances of use. Our CY 2005 claims data show the majority of reporting of modifier –CA was in association with what were likely to have been urgent interventions, including the insertion of intra-aortic balloon assist devices and exploratory laparotomies. We believe that the data support our speculation that much of the increase in reporting of the modifier observed in CY 2004 data was a result of hospitals' learning curve regarding the appropriate use of the modifier.

2. Policy for CY 2007

In the CY 2007 OPPS proposed rule (71 FR 49622), we did not propose any change to our policies regarding reporting of modifier –CA for CY 2007, or to our payment policy regarding APC 0375. Therefore, for CY 2007, as we proposed, we are specifying that hospitals continue reporting modifier –CA only under circumstances described in section VI. of Transmittal A–02–129, which provided specific billing guidance for the use of modifier –CA. In addition, we will continue to make one payment under APC 0375 for the services that meet the specific conditions discussed in previous rules for using modifier –CA, based on calculation of the relative payment weight for APC 0375 as described above. We applaud hospitals' improved billing practices and as before, will continue to monitor use of modifier –CA.

The CY 2007 proposed APC 0375 median cost was $3,539, significantly increased from the $2,527 median cost in the CY 2006 proposed rule and the CY 2006 final median cost of $2,717. The CY 2007 final APC 0375 median cost is $3,549. This variation in median costs is expected because the specific cases that populate the claims data for APC 0375 likely exhibit only limited clinical and resource homogeneity among all the claims attributable to that APC in a given year and across different years for the same APC. Such cost variation for APC 0375 from year to year is generally anticipated and accepted because APC 0375 is unique in the OPPS and, by its definition, should always be limited in its use.

We did not receive any public comments on our proposed payment policy for ancillary outpatient services when a patient expires. Therefore, we are finalizing our proposal without modification for CY 2007.

XIII. Nonrecurring Policy Changes

A. Removal of Comprehensive Outpatient Rehabilitation Facility (CORF) Services From the List of Services Paid Under the OPPS

In the CY 2007 OPPS proposed rule (71 FR 49623), we proposed to make a technical change to the regulations at 42 CFR 419.21(d) to remove from the list of services paid under the OPPS certain services furnished by a comprehensive outpatient rehabilitation facility (CORF) when they are provided outside the patient's plan of care (for example, hepatitis B vaccine). Section 1834(k) of the Act, as added by section 4541(a) of Public Law 105–33 (BBA), requires that CORF services be paid using the lesser of actual charges or a fee schedule amount. We instructed fiscal intermediaries to use the MPFS for payments to CORFs. We have not required CORF cost reports, or paid CORFs under the OPPS, since 2001. The revision of the regulation to delete certain CORF services from the list of specified services paid under the OPPS is necessary to conform the regulations to the statutory requirement.

We did not receive any public comments on this issue. Therefore, we are adopting as final, without modification, the technical change to § 419.21(d) to remove from the list of services paid under the OPPS certain services furnished by a CORF when they are provided outside the patient's plan of care (for example, hepatitis B vaccine).

B. Addition of Ultrasound Screening for Abdominal Aortic Aneurysms (AAAs) (Section 5112 of Public Law 109–171 (DRA))

1. Background

Section 5112 of the Deficit Reduction Act of 2005, Public Law 109–171 (DRA), amended section 1861 and related provisions of the Act to provide for coverage under Medicare Part B of ultrasound screening for abdominal aortic aneurysms (AAAs), effective for services furnished on or after January 1, 2007, subject to certain eligibility and other limitations. The final rule governing this new Part B coverage is being established through a separate document, specifically the CY 2007 Medicare Physician Fee Schedule final rule. We refer readers to that document for a full and complete explanation of this coverage provision.

2. Assignment of New HCPCS Code and Payment for Ultrasound Screening for AAAs

When we published the CY 2007 OPPS proposed rule, there was no current CPT code that specifically described an ultrasound screening for AAA. In that same rule, we proposed to establish the following HCPCS code, GXXXX (Ultrasound, B-scan and or real time with image documentation; for abdominal aortic aneurysm (AAA) screening) to be used to bill for the new service under both the Medicare Physician Fee Schedule and the OPPS. In this final rule with comment period, we are assigning HCPCS code G0389 (Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening) to be reported on or after January 1, 2007, to describe an ultrasound screening test for AAA. As required by the statute, Medicare will allow payment for a one-time only screening examination, and this screening test will be available even if the qualifying patient does not present signs or symptoms of disease or illness. In addition, this code does not include any other preventive services that are currently separately covered and paid under the Medicare Part B screening benefits. When these other preventive services are performed, they should be reported using the existing appropriate codes.

We noted previously that ultrasound screening for AAA is also addressed in detail in our final rule to update the MPFS for CY 2007. We are responding to all comments regarding the elements required for the ultrasound screening for AAA, whether the examination is performed in a physician's office or an outpatient hospital setting, and the exception from the Part B annual deductible, in the CY 2007 MPFS final rule.

In the CY 2007 OPPS proposed rule, we proposed that payment for this service be made at the same level as CPT code 76775 (Ultrasound, retroperitoneal (eg, renal aorta modes), B-scan and/or real time with image documentation; limited).

We received several comments on this payment proposal. In particular, the commenters supported the payment assignment of HCPCS code G0389. The commenters agreed that the hospital costs associated with the screening study described by HCPCS code G0389 are very similar to those of the limited retroperitoneal ultrasound diagnostic

examination, which is described by CPT code 76775. Therefore, in this final rule with comment period, we are finalizing this assignment for CY 2007. That is, we are basing the CY 2007 payment for HCPCS code G0389 on equivalent hospital resources and intensity to those contained in CPT code 76775, which is assigned to APC 0266 (Level II Diagnostic and Screening Ultrasound) under the OPPS for CY 2007. We believe that the hospital costs associated with the screening study are very similar to those of the limited retroperitoneal ultrasound diagnostic examination and, therefore, the screening and diagnostic studies should be assigned to the same clinical APC for reasons of clinical and resource homogeneity. Thus, we are assigning G0389 to APC 0266 with a median cost of $95.37 for CY 2007. Consistent with the statute, no Medicare beneficiary deductible will be applied to payment for this AAA screening service.

XIV. Emergency Medical Screening in Critical Access Hospitals (CAHs)

A. Background

Section 1820 of the Act, as amended by section 4201 of the Balanced Budget Act of 1997, provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs), under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participations (CoPs) under 42 CFR Part 485, Subpart F, will be certified as CAHs by CMS. The MRHFP replaced the Essential Access Community Hospital (EACH)/Rural Primary Care Hospital (RPCH) program.

B. Proposed Policy Change

Existing regulations governing CAHs at § 485.618(d) require on-call doctors and nonphysician practitioners who may be attending to urgent/acute medical problems in other areas of the CAH or outside the CAH to report to the CAH's emergency room within 30 minutes (60 minutes if the CAH is located in a frontier or remote area or permissible under the State's rural health care plan) to see a patient in the emergency room of a CAH. Often, these patients do not have emergency medical conditions. With changes to the regulations at § 489.24 that implement the Emergency Medical Treatment and Labor Act (EMTALA) over the past few years, some practitioners have noted to CMS that the requirements regarding who should respond to calls to see patients who present to the emergency department of a CAH are more stringent than for general hospitals.

The provider community recently requested that we change the emergency on-call personnel requirements for CAHs to conform to the regulatory changes published in the **Federal Register** on September 9, 2003 (68 FR 53262). In response to this request, in the proposed rule published in the **Federal Register** on August 23, 2006 (71 FR 49623), we proposed to revise the current CAH CoPs to align the emergency medical screening requirements in CAHs with those applicable to acute care hospitals. We proposed to allow registered nurses, in addition to the personnel currently required at § 485.618(d), to serve as qualified medical personnel to screen individuals who present to the CAH emergency room if the nature of the patient's request is within the registered nurse's scope of practice under State law and such screening is permitted by the CAH's bylaws. This proposed change would effectively eliminate the need for a doctor or nonphysician practitioner to report to the emergency department to attend to a nonemergent request for medical care if a registered nurse is on site at the CAH and has made a determination that the care needed is of a nonemergent nature.

The EMTALA statute at section 1867 of the Act states that a hospital in this context must provide an appropriate (suitable for the symptoms presented) medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition exists (section 1866(a)(1)(I) of the Act imposes the section 1867 requirements on a CAH). The EMTALA regulations at § 489.24(a) state that the examination must be conducted by qualified medical personnel. These qualified medical personnel designated to perform medical screening examinations must be determined qualified by the hospital's bylaws or rules and regulations and must be practicing within the scope of practice under State law.

The regulations at § 489.24(c) relating to the use of a dedicated emergency department for nonemergency services were added in September 2003 (68 FR 53262) to state that if an individual goes to a hospital's dedicated emergency department to request medical treatment, and the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate to determine that the individual does not have an emergency medical condition.

Although EMTALA also applies to CAHs, the CoP for CAH emergency services (§ 485.618(d)) states that a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care, must be on call and available onsite at a CAH within a specified timeframe. Therefore, under this CAH CoP, these are the only CAH personnel who are currently permitted to conduct an appropriate medical screening to determine that an individual, who presents in the manner described above, does not have an emergency medical condition (as required under § 489.24(c)). In contrast, the emergency services CoP for acute care hospitals at § 482.55 does not specify the type of personnel who must be available to provide emergency services and who would, therefore, perform assessments and screenings. The regulation states only that the services must be organized and supervised under the direction of a qualified member of the medical staff and that there must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. Therefore, an acute care hospital may, if it chooses, have protocols that permit a registered nurse to conduct specific emergency medical screenings if the nature of the individual's request for examination and treatment is within the scope of practice of a registered nurse. For emergencies that are outside of a registered nurse's scope of practice, another qualified medical personnel (operating within his or her scope of practice under State law) would conduct the emergency medical screening.

We proposed to revise the CAH standard at § 485.618(d) to allow a CAH, if applicable, the flexibility of including a registered nurse, with training and experience in emergency care and who is on site at the CAH, as one of the qualified medical personnel available for emergency services, particularly emergency medical screenings, if the nature of the individual's request for medical care is within the registered nurse's scope of practice and is consistent with applicable State laws. If the registered nurse begins the emergency medical screening and determines that the nature of the individual's conditions is outside his or her scope of practice under State law, the physician, physician assistant, nurse practitioner or a clinical nurse specialist must be contacted to see the patient

within 30 or 60 minutes to conduct the emergency medical screening and provide stabilizing treatment. If the registered nurse knows initially that the medical screening for the presenting complaint is outside the applicable scope of practice under State law, the physician or other nonphysician practitioner must see the individual within the 30 or 60 minute timeframes (as currently specified in § 485.618(d)(1)).

We recognize that not all CAHs will be able to utilize this flexibility. Some State licensure boards have stated that it is not within the authorized scope of practice for a registered nurse to independently perform an appropriate emergency medical screening for the purpose of determining if an emergency medical condition exists. However, the licensure boards in these States further maintain that it is within the scope of practice for a registered nurse to assess the health status of an individual to determine a nonemergent condition and to provide nursing care or to refer the individual to appropriate medical resources. Therefore, based on State law, some CAHs will not be able to designate registered nurses as qualified medical personnel under our proposed revision to the regulations governing CAHs. However, as we wished to provide flexibility to CAHs and to be consistent with existing EMTALA policy, we proposed the revision to the regulation at § 485.618(d).

C. Public Comments Received on the Proposal

We received 12 comments on our proposal. Our response follows each comment summary.

Comment: All of the commenters supported the proposed revision of the current CoP to allow registered nurses with training and experience in emergency care to conduct specific medical screening examinations under certain provisions. Several of the commenters commended CMS for proposing a rule change that would afford CAHs the staffing flexibility needed to maintain access and to provide efficient emergency and urgent care services for their patients.

Response: We appreciate the support of the provider community and believe that this revision to the current CoP will most likely decrease the regulatory burden for CAHs by allowing them greater staffing flexibility.

Comment: Several commenters pointed out an inconsistency between the preamble language in the proposed rule, which notes that medical screening examinations by a registered nurse would be allowed only if such screenings were permitted by the CAH's bylaws, and the proposed regulation text, which does not mention the bylaws.

Response: We appreciate the commenters bringing this inadvertent omission to our attention. We are revising the regulatory text at § 485.618(d)(2)(ii) in this final rule to indicate that the nature of a patient's request for medical care must be within the scope of practice and consistent with applicable State laws and the CAH's bylaws or rules and regulations in order for a registered nurse to conduct a medical screening examination. This revision to the language is also consistent with the EMTALA regulations at § 489.24(a)(1)(i), which refer to hospital ''bylaws or rules and regulations.''

Comment: One commenter questioned the impact that this change may have on payment and encouraged CMS to ensure that it does not adversely affect the payment that CAHs receive for screening services.

Response: The change being made affects only the CAH CoPs and does not revise the CAH payment regulations, which are codifed at 42 CFR 413.70.

Comment: One commenter noted that, in the FY 2007 IPPS proposed rule for EMTALA false labor certifications, care roles and responsibilities were to be documented in the ''the medical staff bylaws or rules and regulations,'' while under the FY 2007 IPPS final rule, these roles and responsibilities are to be documented in ''medical staff bylaws.'' The commenter requested a clarification on this issue due to concern that the final rule imposed a more restrictive requirement than was proposed by limiting documentation to the bylaws only.

Response: The FY 2007 final IPPS rule is outside the scope of this rule and cannot be addressed here. We will address this comment in a future document.

D. Final Policy

After consideration of the public comments received on the proposed rule, we are adopting the proposed change to § 485.618(d), with minor modifications, to allow a CAH, if applicable, the flexibility of utilizing a registered nurse, with training and experience in emergency care, to conduct specific medical screening examinations only if the registered nurse is on site and immediately available at the CAH when a patient requests medical care and if the nature of the individual's request is within the registered nurse's scope of practice and consistent with applicable State laws and the CAH's bylaws or rules and regulations. As noted above, we have revised the regulatory text to include language regarding the CAH's bylaws, rules, and regulations. The revised regulatory text is now consistent with the preamble language contained in both the proposed rule and this final rule, and with the language in the EMTALA regulations at § 489.24(a).

XV. OPPS Payment Status and Comment Indicators

A. CY 2007 Status Indicator Definitions

The OPPS payment status indicators (SIs) that we assign to HCPCS codes and APCs play an important role in determining payment for services under the OPPS. They indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. Our CY 2007 final status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively. We are using the status indicators and definitions that are listed in Addendum D1, which we discuss below in greater detail.

1. Payment Status Indicators To Designate Services That Are Paid Under the OPPS

The table of proposed status indicators in section XV. of the proposed rule (71 FR 49625) inadvertently listed radiopharmaceuticals under status indicator ''H'' rather than under status indicator ''K.'' Consistent with our CY 2007 proposed payment policy for radiopharmaceuticals (as discussed in section V.B.3.a.(3) of this preamble) and their associated status indicators as correctly listed in Addenda A and B of the CY 2007 proposed rule, the list of status indicators, the items, and their OPPS payment status descriptions are noted in the corrected table below.

CY 2007 PROPOSED PAYMENT STATUS INDICATORS (CORRECTED)

Indicator	Item/code/service	OPPS payment status
G	Pass-Through Drugs and Biologicals	Paid under OPPS; Separate APC payment includes pass-through amount.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; Not subject to coinsurance.
K	(1) Non-Pass-Through Drugs, Biologicals, and Radiopharmaceutical Agents.	(1) Paid under OPPS; Separate APC payment.
	(2) Brachytherapy Sources	(2) Paid under OPPS; Separate APC payment.
	(3) Blood and Blood Products	(3) Paid under OPPS; Separate APC payment.
N	Items and Services Packaged into APC Rates	Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.
Q	Packaged Services Subject to Separate Payment Under OPPS Payment Criteria.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Separate APC payment based on OPPS payment criteria. (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; Separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
X	Ancillary Services	Paid under OPPS; Separate APC payment.

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: ● Ambulance Services ● Clinical Diagnostic Laboratory Services ● Non-Implantable Prosthetic and Orthotic Devices ● EPO for ESRD Patients ● Physical, Occupational, and Speech Therapy ● Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital. ● Diagnostic Mammography ● Screening Mammography	Not paid under OPPS. Paid by fiscal intermediaries under a fee schedule or payment system other than OPPS.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
F	Corneal Tissue Acquisition; Certain CRNA Services; and Hepatitis B Vaccines.	Not paid under OPPS. Paid at reasonable cost.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary.	Not paid under OPPS.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

3. Payment Status Indicators To Designate Services That Are Not Recognized Under the OPPS But That May Be Recognized by Other Institutional Providers

Indicator	Item/code/service	OPPS payment status
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and13x).	Not paid under OPPS. • May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and13x) may be available.

4. Payment Status Indicators To Designate Services That Are Not Payable by Medicare

Indicator	Item/code/service	OPPS payment status
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: • That are not covered by Medicare based on statutory exclusion. • That are not covered by Medicare for reasons other than statutory exclusion. • That are not recognized by Medicare but for which an alternate code for the same item or service may be available. • For which separate payment is not provided by Medicare.	Not paid under OPPS or any other Medicare payment system.

We received several public comments regarding our general use of status indicators.

Comment: Some commenters suggested that each status indicator definition should be ''pure'' and have only one meaning. Specifically, they recommended that the current OPPS status indicator ''B'' be split into two different status indicators, with descriptions that uniquely reflect the two situations in which ''B'' is currently assigned. In CY 2006, the assignment of status indicator ''B,'' which identifies codes that are not recognized by the OPPS when submitted on an outpatient hospital Part B bill type (12X and 13X), reflects two possible reasons for its assignment to any specific HCPCS code: (1) Not paid under OPPS but may be paid by intermediaries when submitted on a different bill type, for example 75X (CORF); or (2) Not paid under OPPS but an alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12X and 13X) may be available. The commenters recommended that CMS continue to assign status indicator ''B'' to codes not paid under the OPPS for the first reason and develop new status indicator ''Z'' for assignment to codes not recognized for the second reason.

The commenters also recommended that CMS publish a separate addendum as part of the OPPS rule that lists the alternative HCPCS Level II codes for the OPPS that should be used for all codes that were assigned the suggested new status indicator ''Z.''

Response: The OPPS has no operational need to split the definition of status indicator ''B'' and to establish a new status indicator ''Z'' as suggested by the commenters. As discussed previously, our status indicators exist for purposes of assisting in determining payment, and a single status indicator ''B'' is sufficient for both circumstances when codes may be paid by intermediaries when submitted on a different bill type but would not be paid under the OPPS or an alternate code might be recognized under the OPPS. In either situation, there is no payment effect that would require the differential use of two separate status indicators.

There are currently 19 different status indicators in Addendum B that are used to indicate whether a service described by a HCPCS code is payable under the OPPS or another payment system and whether particular OPPS payment policies apply to the code. Two new status indicators, ''M'' and ''Q,'' were established in CY 2006 for purposes of identifying the OPPS payment status of certain HCPCS codes. We believe that only a limited number of status indicators in the OPPS are needed to convey the necessary payment-related information, and that additional indicators should only be created at this point when policy necessitates further refinements in this area. We also believe that with 19 status indicators for CY 2007, the set of indicators is appropriately specific, while maintaining the administrative simplicity associated with a modest number of status indicators.

We are unable to develop and publish an addendum that lists the alternative codes that should be used for payment under the OPPS when a HCPCS code is not recognized under the OPPS because an alternate code may be available. Although the commenters suggested that alternative codes are Level II HCPCS codes, in some cases alternate codes are CPT codes that describe specific portions of a service. In other cases, there may be multiple alternative codes that could be used to report complete services or portions of services that were provided, and we have no way to determine in any given situation the specific services a hospital provided for which an alternative code or codes might be available. Therefore, we believe that it is appropriate for hospitals that provide a specific service to determine, in situations where they believe a HCPCS code with a status indicator of ''B'' would be their choice for reporting, whether that code could be reported on a different bill type and be paid, and, if not, determine if the service provided may be correctly reported with one or more other HCPCS codes that are recognized for payment under the OPPS. For some HCPCS codes not recognized under the OPPS, the determination of an appropriate alternate code or codes is straightforward, and we believe

hospitals have already developed such crosswalks for their own use based on the services they provide.

Comment: One commenter stated that the community supported the CMS proposal to continue paying for the acquisition of corneal tissue as status indicator ''F'' as an item or service not paid under OPPS and paid at reasonable cost. The commenter believed that the adoption and implementation of an appropriate payment policy for the acquisition of corneal tissue for procedures provided in a hospital outpatient department setting was absolutely vital to the eye banking system, a network that was established for the single purpose of procuring and providing donated human eye tissue for sight restoring transplantation procedures.

Response: We appreciate the commenter's support.

We are finalizing our status indicator definitions to be consistent with the final CY 2007 OPPS payment policies. Because separately payable radiopharmaceuticals will continue to be paid on a cost-based methodology in CY 2007 as discussed in section V.B.3.a.(3) of this preamble, we will continue to assign them to status indicator ''H'' as indicated in the table set forth below and in Addendum D1 of this final rule with comment period, rather than to status indicator ''K'' as proposed. We also note we are finalizing our proposed description of status indicator ''K'' to include brachytherapy sources because, as discussed in section VII.B. of this final rule with comment period, these sources will be paid based on payment rates through brachytherapy source-specific APCs in CY 2007.

CY 2007 FINAL PAYMENT STATUS INDICATORS TO DESIGNATE SERVICES THAT ARE PAID UNDER THE OPPS

Indicator	Item/code/service	OPPS payment status
G	Pass-Through Drugs and Biologicals	Paid under OPPS; Separate APC payment includes pass-through amount.
H	(1) Pass-Through Device Categories	(1) Separate cost-based pass-through payment; Not subject to coinsurance.
	(2)Radiopharmaceutical Agents	(2) Separate cost-based non-pass-through payment.
K	(1) Non-Pass-Through Drugs and Biologicals	(1) Paid under OPPS; Separate APC payment.
	(2) Brachytherapy Sources	(2) Paid under OPPS; Separate APC payment.
	(3) Blood and Blood Products	(3) Paid under OPPS; Separate APC payment.
N	Items and Services Packaged into APC Rates	Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.
Q	Packaged Services Subject to Separate Payment Under OPPS Payment Criteria.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Separate APC payment based on OPPS payment criteria. (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; Separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
X	Ancillary Services	Paid under OPPS; Separate APC payment.

To make the published Addendum B more relevant to the update of the OPPS, we are displaying in Addendum B of this final rule with comment period those HCPCS codes that describe items or services that are payable under the OPPS, as well as nonpayable codes for which we are making a final change in status for CY 2007. The final status indicators for items and services that are paid under the OPPS are listed in the table above.

A complete listing of HCPCS codes with final OPPS payment status indicators and APC assignments for CY 2007 is available electronically on the CMS Web site *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage.*

B. CY 2007 Comment Indicator Definitions

In the November 15, 2004 final rule with comment period (69 FR 65827 and 65828), we made final our policy to use two comment indicators to identify in an OPPS final rule the assignment status of a specific HCPCS code to an APC and the timeframe when comments on the HCPCS APC assignment would be accepted. These two comment indicators are listed below.

- ''NF''—New code, final APC assignment; comments were accepted on a proposed APC assignment in the proposed pule; 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, with the final CY 2007 definition as listed below:

- ''CH''—Active HCPCS code in current and next calendar year; status indicator and/or APC assignment has changed; or active HCPCS code that is discontinued at the end of the current calendar year.

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. As we proposed, we are continuing that policy in this CY 2007 OPPS final rule with comment period. When used in an OPPS final rule, the ''CH'' indicator is only intended to facilitate the public's review of changes made from one calendar year to another. We are using the ''CH'' indicator in this CY 2007 final rule with comment period to indicate HCPCS codes for which the status indicator and/or APC assignment will change in CY 2007 and to indicate HCPCS codes that are discontinued at the end of the current calendar year. However, only HCPCS codes with

comment indicator ''NI'' in this CY 2007 OPPS final rule with comment period will be subject to comment during the comment period for this final rule with comment period.

In the proposed rule, we used the ''CH'' indicator to call attention to changes in payment status indicators and/or APC assignments in the proposed rule to update the OPPS for CY 2007. We believed that using the ''CH'' indicator in the proposed rule facilitated the public's review of the changes that we proposed to make final in CY 2007. Use of the ''CH'' indicator in the proposed rule was significant because it highlighted changes that were subject to comment during the proposed rule comment period.

The three comment indicators that we are implementing in CY 2007 and their definitions are listed in Addendum D2 of this final rule with comment period.

We received several public comments regarding the use of the proposed CY 2007 comment indicators.

Comment: Several commenters recommended that the comment indicator ''CH'' be limited to only a single change. Currently, ''CH'' is assigned to indicate one of two possible changes. It can signify that the HCPCS code has had a status indicator change, and it can also indicate that the HCPCS code has had an APC reassignment. The commenters argued that limiting ''CH'' to a single change would readily facilitate the identification of the HCPCS code changes and would minimize the need for visual comparison of two separate Addendum B files to determine what has actually changed.

Response: The designation of HCPCS codes with comment indicator ''CH'' is a new process that we initiated in the CY 2006 OPPS final rule to facilitate the public's review of changes that were proposed or finalized from one calendar year to another. We believe the specific reasoning behind the change is not necessary, as our intent is to merely flag the changes from our proposed rule to our final rule. We appreciate the comment and will consider possible refinements to comment indicators in the future that could assist the public in recognizing and identifying proposed and final changes to OPPS payment policies regarding specific items and services of interest.

Comment: Several commenters asked CMS to clarify the use of status indicator ''NI'' and the length of time allowed for public comment regarding HCPCS codes with comment indicator ''NI.'' They also asked at exactly what point in time the ''NI'' designation would be removed.

Response: Comment indicator ''NI'' flags HCPCS codes that are new for the CY 2007 OPPS final rule with comment period and that did not appear in the CY 2007 OPPS proposed rule. Codes with comment indicator ''NI'' in Addendum B are open to comment in this CY 2007 final rule with comment period. The comment period for the OPPS final rule for a specific calendar year is specified as noted in the final rule. After the close of the final rule comment period, ''NI'' has no relevance, and it would not be applied to the same HCPCS codes for the next OPPS update year. The ''NI'' comment indicator is not used in the OPPS proposed rule because the status indicators and APC assignments of all HCPCS codes that appear in the proposed rule are open for public comment.

After carefully considering the public comments received, we are implementing the comment indicators as proposed for CY 2007, with modification to the definition of comment indicator ''CH'' to include active HCPCS codes that are discontinued at the end of the current calendar year.

XVI. OPPS Policy and Payment Recommendations

A. MedPAC Recommendations

The Medicare Payment Advisory Commission (MedPAC) submits reports to Congress in March and June that summarize payment policy recommendations. The March 2006 MedPAC report included the following recommendation relating specifically to the hospital OPPS:

Recommendation 2A: The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2007 by the projected increase in the hospital market basket index less half of the Commission's expectation for productivity growth. A discussion of the MedPAC recommendation regarding updates to the market basket was included in section II.C. (''OPPS Conversion Factor Update for 2007'') of the proposed rule (71 FR 49539).

There have been no subsequent MedPAC recommendations with regard to Medicare payment under the OPPS.

B. APC Panel Recommendations

Recommendations made by the APC Panel at its March and August 2006 meetings are discussed in sections of this preamble that correspond to topics addressed by the APC Panel. Minutes of the APC Panel's March 1–2, 2006 meeting are available online at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp*.

The APC Panel met on August 23–24, 2006 to discuss the CY 2007 OPPS proposed rule and to hear testimony from concerned members of the public. The minutes of the meeting are available at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage*.

C. GAO Recommendations

A discussion of the October 31, 2005 GAO letter of comment on proposed 2006 specified covered outpatient drug (SCOD) rates (GAO–06–17R ''Comments on Proposed 2006 SCOD Rates'') was contained in section V.3.B.a. of the CY 2007 OPPS proposed rule (71 FR 49584). The letter is referenced in section V.B. of this final rule with comment.

A discussion of the April 2006 GAO report entitled ''Medicare Hospital Pharmaceuticals: Survey Shows Price Variation and Highlights Data Collection Lessons and Outpatient Rate-setting Challenges for CMS'' (GAO–06–372) was contained in section V.3.B.a. of the CY 2007 OPPS proposed rule (71 FR 49584). The report is referenced in section V.B. of this final rule with comment period.

A discussion of the July 26, 2006 GAO report entitled ''Medicare Outpatient Payments: Rates for Certain Radioactive Sources Used in Brachytherapy Could be Set Prospectively'' (GAO 06–635) is contained in section VII.B. of this final rule with comment period.

These GAO reports are available for review in their entirety at: *http://www.GAO.gov*.

XVII. Policies Affecting Ambulatory Surgical Centers (ASCs) for CY 2007

A. ASC Background

1. Legislative History

Section 1832(a)(2)(F)(i) of the Act provides that benefits under the Medicare Supplementary Medical Insurance program (Part B) include payment for facility services furnished in connection with surgical procedures the Secretary specifies that are performed in an ambulatory surgical center (ASC). To participate in the Medicare program as an ASC, a facility must meet the standards specified in section 1832(a)(2)(F)(i) of the Act; in 42 CFR 416, subpart B of our regulations, which sets forth general conditions and requirements for ASCs; and in 42 CFR 416, subpart C of our regulations, which provides specific conditions for coverage for ASCs.

The ASC services benefit was enacted by Congress through the Omnibus Reconciliation Act of 1980 (Pub. L. 96–499). For a detailed discussion of the legislative history related to ASCs, we refer readers to the June 12, 1998 proposed rule (63 FR 32291).

Section 626(b) of Public Law 108–173 repealed the requirement formerly found in section 1833(i)(2)(A) of the Act that the Secretary conduct a survey of ASC costs for purposes of updating ASC payment rates and, instead, requires the Secretary to implement a revised ASC payment system, to be effective not later than January 1, 2008. In section XVIII. of the CY 2007 OPPS proposed rule (71 FR 49635), we set forth our proposal for a revised ASC payment system that would be implemented on January 1, 2008. We are in the process of receiving and analyzing public comments on this proposal and we expect to issue a separate final rule for the revised ASC payment system sometime in the spring of 2007 to be effective January 1, 2008.

Section 5103 of Public Law 109–171 amended section 1833(i)(2) of the Act by adding a new subparagraph (E) to place a limitation on payments for surgical procedures in ASCs. If the standard overhead amount under section 1833(i)(2)(A) of the Act for a facility service for such procedure, without application of any geographic adjustment exceeds the Medicare OPPS payment amount 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.

We discuss in section XVII.B. of this preamble additions to and deletions from the list of Medicare-approved ASC procedures to be implemented January 1, 2007, prior to implementation of the revised ASC payment system. In section XVII.C. of this preamble, we discuss the regulatory changes that we are making for our current ASC payment system. In section XVII.D. of this preamble, we address the provisions of sections 1834(d)(2) and (d)(3) of the Act regarding payment amounts and beneficiary coinsurance amounts for screening flexible sigmoidoscopy and screening colonoscopy. In section XVII.E. of this preamble, we address the changes in payment to ASCs mandated by section 5103 of Public Law 109–171. In addition, in section XVII.F. of this preamble, we are making changes in the process to review payment adjustments for insertion of new technology intraocular lenses (NTIOLs). In section XVII.G. of this preamble, we announce the CY 2007 deadline for submitting requests for CMS review of appropriateness of ASC payment for insertion following cataract surgery of an NTIOL.

In section XVIII. of the preamble of the CY 2007 OPPS proposed rule (71 FR 49635), we proposed a revised payment system for ASCs to be implemented effective January 1, 2008, including revisions to the ASC list for CY 2008, the ratesetting method, and the applicable ASC regulations to incorporate the requirements and payments for ASC facility services under the proposed revised ASC system. We will be addressing the public comments received and implementing the revised ASC payment system in a separate final rule that we expect to be published separately in 2007.

2. Current Payment Method

There are two primary elements in the total cost of performing a surgical procedure: (a) The cost of the physician's professional services to perform the procedure; and (b) the cost of items and services furnished by the facility where the procedure is performed (for example, surgical supplies, equipment, and nursing services). Payment for the first element is made under the MPFS. In the proposed rule and in this final rule with comment period, we address the second element, the payment of facility fees for ASC services. We also address the coverage of ASC services in the proposed rule and in this final rule with comment period.

Under the current ASC facility services payment system, the ASC payment rate is a standard overhead amount established on the basis of our estimate of a fee that takes into account the costs incurred by ASCs generally in providing facility services in connection with performing a specific procedure. The report of the Conference Committee accompanying section 934 of the Omnibus Reconciliation Act of 1980 (ORA), Public Law 96–499, which enacted the ASC benefit in December 1980, states that this overhead amount is expected to be calculated on a prospective basis using sample survey data and similar techniques to establish reasonable estimated overhead allowances, which take into account volume (within reasonable limits), for each of the listed procedures. (H.R. Rep. No. 96–1479, at 134–35 (1980).)

To establish those reasonable estimated allowances for services furnished prior to implementation of the revised ASC payment system, section 626(b)(1) of Public Law 108–173 amended section 1833(i)(2)(A)(i) of the Act to require us to take into account the audited costs incurred by ASCs to perform a procedure, in accordance with a survey. Except for screening flexible sigmoidoscopy and screening colonoscopy services, payment for ASC facility services is subject to the usual Medicare Part B deductible and coinsurance requirements and the amounts paid by Medicare must be 80 percent of the standard fee.

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 and to review and update the list of ASC procedures at least every 2 years.

Section 141(b) of the Social Security Act Amendments of 1994, Public Law 103–432, requires us to establish a process for reviewing the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act for intraocular lenses (IOLs) for a class of new technology IOLs (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 in the June 16, 1999 **Federal Register** (64 FR 32198). As stated earlier, in section XVII.E. of the preamble of this final rule with comment period, we discuss the changes that we are making to that process.

A summary of changes to ASC payment rates made prior to CY 1998 may be found in the June 12, 1998 proposed rule (63 FR 32292). The 1998 rule proposed to rebase the ASC payment rates using cost, charge, and utilization data collected by a 1994 survey of ASCs. In that proposed rule, we also proposed to refine the ratesetting methodology that was implemented in the February 8, 1990 **Federal Register** (55 FR 4577). However, the changes that were proposed for the ratesetting methodology were not implemented because of a combination of circumstances resulting in the delayed publication of a final rule. Those circumstances included several extensions to the comment period which ended July 30, 1999, Year 2000 (Y2K) Medicare systems compliancy considerations, and legislative changes required by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), Public Law 106–113, and the Medicare, Medicaid, and SCHIP Benefits Improvement and

Protection Act of 2000 (BIPA), Public Law 106–554. Readers may refer to the March 28, 2003 ASC List Update final rule (68 FR 15268–69) for a detailed discussion of these circumstances and the legislative changes.

3. Published Changes to the ASC List

Section 1833(i)(1)(A) of the Act requires the Secretary to specify surgical procedures that, although appropriately performed in an inpatient hospital setting, can also be performed safely on an ambulatory basis in an ASC, a CAH, or a hospital outpatient department. The report accompanying the legislation explained that the Congress intended procedures currently performed on an ambulatory basis in a physician's office that do not generally require the more elaborate facilities of an ASC not be included in the list of ASC covered procedures (H.R. Rep. No. 96–1167, at 390–91, reprinted in 1980 U.S.C.C.A.N. 5526, 5753–54). In a final rule published August 5, 1982, in the **Federal Register** (47 FR 34082), we established regulations that included criteria for specifying which surgical procedures were to be included for purposes of implementing the ASC facility benefit.

Section 416.65(a) of the regulations specifies general standards for procedures on the ASC list. ASC procedures are those surgical and other medial procedures that are—

- Commonly performed on an inpatient basis but may be safely performed in an ASC;
- Not of a type that are commonly performed or that may be safely performed in physicians offices;
- Limited to procedures requiring a dedicated operating room or suite and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room; and
- Not otherwise excluded from Medicare coverage.

Specific standards in § 416.65(b) limit covered ASC procedures to those that do not generally exceed 90 minutes operating time and a total of 4 hours recovery or convalescent time. If anesthesia is required, the anesthesia must be local or regional anesthesia, or general anesthesia of not more than 90 minutes duration.

Section 416.65(b)(3) of the regulations excludes from the ASC list procedures that generally result in extensive blood loss, that require major or prolonged invasion of body cavities, that directly involve major blood vessels, or that are generally emergency or life-threatening in nature.

A detailed history of published changes to the ASC list and ASC payment rates may be found in the June 12, 1998 proposed rule (63 FR 32292). Subsequently, in accordance with § 416.65(c), we published updates of the ASC list in the **Federal Register** on March 28, 2003 (68 FR 15268) and May 4, 2005 (70 FR 23690).

During years when we have not updated the ASC list in the **Federal Register**, we have revised the list to be consistent with annual calendar year changes to HCPCS and CPT codes. These annual coding updates have been implemented through program instructions to the carriers that process ASC claims. The most recent update to the list to conform to CPT and HCPCS coding changes was published in Transmittal R–720–CP, Change Request 4082, on October 21, 2005. The transmittal may be found on our Web site at: *http://www.cms.hhs.gov/Transmittals/*.

B. ASC List Update Effective for Services Furnished On or After January 1, 2007

1. Criteria for Additions to or Deletions From the ASC List

In April 1987, we adopted quantitative criteria for identifying procedures that were commonly performed either in a hospital inpatient setting or in a physician's office. Collectively, commenters responding to a notice published on February 16, 1984, in the **Federal Register** (49 FR 6023) had recommended that virtually every surgical CPT code be included on the ASC list. Our medical staff reviewed the recommended additions to the list, in consultation with other specialist physicians and medical organizations, as appropriate, to determine which code or series of codes were appropriately performed on an ambulatory basis within the framework of the regulatory criteria in § 416.65. However, when we arrayed the proposed procedures by the site where they were most frequently performed according to our claims payment data files (1984 Part B Medicare Data (BMAD)), we found that many procedures were not commonly performed on an inpatient basis or were performed in a physician's office the majority of the time, and, thus, would not meet the standards in our regulations. Therefore, we decided that if a procedure was performed on an inpatient basis 20 percent of the time or less, or in a physician's office 50 percent of the time or more, it would be excluded from the ASC list. (April 21, 1987 (52 FR 13176)).

At the time, we believed that these utilization thresholds best reflected the legislative objectives of moving procedures from the more expensive hospital inpatient setting to the less expensive ASC setting without encouraging the migration of procedures from the generally less expensive physician's office setting to the ASC. We applied these quantitative standards not only to codes proposed for addition to the ASC list, but also to the codes that were currently on the list, to delete codes that did not meet the thresholds.

The trend towards performing surgery on an ambulatory or outpatient basis grew steadily and, by 1995, we discovered that a number of procedures that were on the ASC list at the time fell short of the 20 percent and 50 percent thresholds, even though the procedures were obviously appropriate in the ASC setting. The most notable of these was cataract extraction with intraocular lens insertion that were already being performed predominately in outpatient settings by the early 1990s, although more than 20 percent were also performed as inpatient procedures. The thresholds would also have excluded from the ASC list certain newer procedures, such as CPT code 66825 (Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)), that were rarely performed on a hospital inpatient basis but that were appropriate for the ASC setting. Strict adherence to the same 20 percent and 50 percent thresholds both to add and remove procedures did not provide latitude for minor fluctuations in utilization across settings or errors that could occur in the site-of-service data drawn from the National Claims History File that we were then using for analysis.

In an effort to avoid these anomalies but still retain a relatively objective standard for determining which procedures should comprise the ASC list, we adopted in the **Federal Register** notice with comment period published on January 26, 1995 (60 FR 5185), a modified standard for deleting procedures already on the list. We deleted from the list only those procedures whose combined hospital inpatient, hospital outpatient, and ASC site-of-service volume was less than 46 percent of the procedure's total volume and that were either performed 50 percent of the time or more in the physician's office or 10 percent of the time or less in an inpatient hospital setting. We retained the 20 percent and 50 percent standard to determine which procedures would be appropriate additions to the ASC list.

In the CY 2007 OPPS proposed rule, we did not propose changes to the criteria for adding or deleting items from the ASC list effective January 1, 2007. However, in section XVIII.B. of the proposed rule, we did discuss

proposed changes in the context of developing a revised ASC payment system to be effective January 1, 2008. The proposed changes to the criteria would result in the addition for CY 2008 of many procedures that do not meet the current criteria for addition to the list. As we indicated earlier, we expect the final rule that will implement the revised ASC payment system effective January 1, 2008 to be published as a separate document in the spring of 2007.

2. Rationale for Payment Assignment

Currently, procedures on the ASC list are assigned to one of nine payment groups based on our estimate of the costs incurred by the facility to perform the procedure. In the CY 2007 OPPS proposed rule, we did not propose any changes to those nine payment groups; and we proposed to assign the procedures to be added to the ASC list to one of those existing payment groups. The payment group to which we assign each addition to the ASC list is judged by our medical advisors to be most appropriate in terms of facility resource inputs. The list of procedures eligible for Medicare payment of a facility fee and the rates for CY 2007 are displayed in Addendum AA of this final rule with comment period. The procedures that are affected by the payment limit required by section 5103 of Public Law 109–171 are identified in that addendum along with their payment rates.

3. Response to Comments to May 4, 2005 Interim Final Rule for the ASC Update

In accordance with section 1833(i)(1) of the Act, as we proposed in the CY 2007 OPPS proposed rule, we are updating the list of procedures that are covered when furnished in an ASC, effective January 1, 2007. In the process of determining which procedures to add to the list, we focused on requests we received from the public in their comments on our May 4, 2005 interim final rule (70 FR 23690). We evaluated codes for which we received requests from the public. The public comments include requests for addition and deletion of specific procedures and for assignment to higher payment groups for specific procedures.

4. Procedures Proposed for Additions to the ASC List

Using the current criteria as described in section XVII.B.1. of this preamble, we identified 14 procedures to propose for addition to the ASC list effective January 1, 2007. The procedures were assigned to one of the nine existing ASC payment groups as indicated in Table 41 of the 2007 OPPS proposed rule (71 FR 49629), set out below as Table 47–A.

TABLE 47–A.—PROCEDURES PROPOSED FOR ADDITION TO THE ASC LIST EFFECTIVE JANUARY 1, 2007

CPT	Short descriptor	ASC payment group
13102	Repair wound/lesion add-on.	1
13122	Repair wound/lesion add-on.	1
13133	Repair wound/lesion add-on.	1
19297	Place breast cath for rad.	9
21356	Treat cheek bone fracture.	3
22520	Percutaneous vertebroplasty, thor.	9
22521	Percutaneous vertebroplasty, lumb.	9
22522	Percutaneous vertebroplasty, add'l.	1
35476	Repair venous blockage.	9
36818	AV fuse, upper arm, cephalic.	3
37205	Transcath IV stent, percutaneous.	9
37206	Transcath IV stent/perc, add'l.	1
43761	Reposition gastrostomy tube.	1
46946	Ligation of hemorrhoids.	1

We received many comments in support of our proposal to add the procedures displayed in Table 47–A. In addition, some commenters requested that we add other procedures, that we assign specific procedures to higher payment groups, and that we not add several of the proposed procedures to the list.

5. Specific Requests for Payment Group Changes to the Proposed ASC List of Additions

Comment: One commenter supported the proposal to add CPT code 21356 (Open treatment of depressed zygomatic arch fracture (eg, Gillies approach)) but requested that CMS assign the procedure to payment group 9 rather than group 3, as proposed. The commenter stated that the ASC costs for the procedure are $1,365, and that the group 3 payment of $510 would not nearly cover those costs.

Response: We assigned the procedure to the same payment groups as CPT code 21355 (Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation) because we believe that facility costs are similar for the two procedures. We re-examined the facility resource requirements and clinical characteristics of CPT code 21356 and remain convinced that our proposed assignment of CPT code 21356 to payment group 3 is appropriate. Therefore, we are finalizing the assignment for this procedure in payment group 3, as proposed.

Comment: A few commenters supported the proposed addition of CPT codes 22520 (Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic); 22521 (Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar); and 22522 (Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body) to the ASC list for CY 2007. The commenters requested that CMS assign CPT code 22522 to payment group 9 as CMS did CPT codes 22520 and 22521. They stated that, although CPT code 22522 represents an add-on procedure, it nonetheless requires a kit that costs in the range of $700 to $1,400. They stated that the facility payment for the procedure is always subject to the multiple procedure discount because it is an add-on procedure, and even the full group 1 payment would not cover those costs.

Response: We agree with the commenters' assertion that when additional kit(s) are required for performing CPT code 22522, those extra costs would not be adequately recognized by payment at the group 1 level, especially because the procedure can only be billed secondarily to another procedure, and payment will always be discounted by half due to multiple procedure discounting. For these reasons, we believe that CPT code 22522 would be more appropriately assigned to payment group 9 than to group 1 as we proposed. We are finalizing the assignment of CPT code 22522 to ASC payment group 9 for CY 2007.

Comment: Some commenters supported the proposal to add CPT code 36818 (Arteriovenous anastomosis, open; by upper arm cephalic vein transposition) to the ASC list for CY 2007 and requested that CMS assign the procedure to a higher ASC payment group than group 3 as we proposed.

Response: We proposed to assign the procedure to group 3 because that is the payment level for CPT code 36819 (Arteriovenous anastomosis, open; by upper arm basilica vein transposition). The commenter provided no evidence to

support assignment to a higher payment group, and we found nothing in our data to suggest that payment for CPT code 36818 should be higher than what we proposed. We believe that assignment to the same level as CPT code 36819 is appropriate and that payment at the group 3 level appropriately recognizes facility costs for the procedure. Therefore, we are finalizing our assignment of CPT code 36818 to ASC payment group 3 as proposed.

Comment: Many commenters supported the proposal to add CPT codes 37205 (Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel) and 37206 (Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel) to the ASC list. However, a number of commenters requested that CMS not add these CPT codes to the ASC list. These commenters stated that the procedures do not satisfy the criteria for inclusion on the ASC list because they involve major blood vessels, would exceed the 90-minute limit on operating room time, and may be associated with complications that are threatening to patient safety.

Response: We found the divergence of responses among the public comments troubling and reexamined our proposal to add these procedures to the ASC list. Although the procedures are being performed about half of the time in hospital outpatient departments (HOPDs), the other half are being performed on an inpatient basis and they virtually are never done in a physician office. As we have stated in the past, there are many procedures that may be safely performed in a hospital outpatient department that may not be safely provided in an ASC, because only the hospital outpatient department has immediate access to the full spectrum of emergency and acute care facilities of the hospital.

Our medical advisors reconsidered our proposal to add CPT codes 37205 and 37206 to the ASC list and determined that it would be in the best interests of Medicare beneficiaries to continue to deny payment for them in ASC facilities. Our medical advisors believe that the procedures would require more than 4 hours of recovery time and would most often require an overnight stay in the facility.

For these reasons, we are not finalizing our proposal to add CPT codes 37205 and 37206 to the ASC list for CY 2007.

Comment: Many commenters supported the proposed addition of CPT code 35476 (Transluminal balloon angioplasty, percutaneous; venous) to the ASC list for CY 2007. In general, the commenters stated that providing access to the procedure in ASCs would be a great benefit to dialysis patients who are often in need of angioplasty procedures. One commenter objected to its addition to the list on the grounds that it was a significant safety risk because the procedures described by CPT code 35476 may involve large veins, with the potential for serious complications that should be handled in the hospital setting.

Some commenters were disappointed that CMS did not also propose to add CPT code 35475 (Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel). They stressed the importance of our support of the Fistula First ESRD quality initiative and stated that including CPT code 35475 would provide patients with a more efficient, but equally effective, option for ensuring the maintenance of their AV fistulas for vascular access. They also stated that inclusion of both CPT codes 35475 and 35476 on the ASC list would save lives, as well as reduce Medicare expenditures because rates of patient complications and hospitalizations would be decreased.

Response: We are sympathetic to the commenters' request for the arterial code, CPT 35475, to be added to the ASC list. We did not propose to add CPT code 35475 because use of the code is not limited to procedures involving arteries in the anatomic sites used for vascular access for hemodialysis or to procedures normally performed to maintain arteriovenous (AV) fistulas. Procedures involving more proximal major arteries, and therefore that present safety concerns for performance in ASCs, are also reported by CPT code 35475, and so the code does not meet the clinical criteria for inclusion on the ASC list.

Additionally, on further review, we also believe it is most clinically appropriate to not finalize our proposal to add CPT code 35476 to the ASC list. Although CPT code 35476 is used to report venous rather than arterial procedures, it is appropriately used to report many different procedures, some of which may involve major veins and that are potentially too unsafe for performance in ASCs.

However, we are committed to the Fistula First end-stage renal disease quality initiative and want to improve access to needed procedural services for dialysis patients if at all possible. We believe that in order to maintain healthy vascular access sites for dialysis patients, physicians may need to perform both venous and arterial angioplasty procedures concurrently. As discussed above, we will not be adding CPT code 35475 for arterial angioplasties to the ASC list, and we are not finalizing our proposal to add CPT code 35476 for venous angioplasties to the ASC list because of safety concerns due to the broad array of vessel angioplasties that could be reported with the two codes. Instead, in order to make those angioplasty procedures for AV fistula maintenance, which could otherwise be appropriately reported with CPT codes 35475 and 35476, available for Medicare payment in ASCs, we are implementing two new HCPCS G-codes to specifically describe the arterial and venous angioplasty procedures to maintain hemodialysis access through arteriovenous fistula or grafts for dialysis patients. These codes are G0392 (Transluminal balloon angioplasty, percutaneous; hemodialysis access fistula or graft; arterial) and G0393 (Transluminal balloon angioplasty, percutaneous; hemodialysis access fistula or graft; venous). We are adding both HCPCS codes G0392 and G0393 to the ASC list for CY 2007 and are assigning them to ASC payment group 9.

Table 47–B displays final decisions regarding the procedures we proposed to add to the ASC list for CY 2007.

TABLE 47–B.—FINAL ADDITIONS FROM THE PROPOSED ADDITIONS TO THE ASC LIST EFFECTIVE JANUARY 1, 2007

CPT	Short descriptor	ASC payment group
13102	Repair wound/lesion add-on.	1
13122	Repair wound/lesion add-on.	1
13133	Repair wound/lesion add-on.	1
19297	Place breast cath for rad.	9
21356	Treat cheek bone fracture.	3
22520	Percutaneous vertebroplasty, thor.	9
22521	Percutaneous vertebroplasty, lumb.	9
22522	Percutaneous vertebroplasty, add'l.	9
36818	AV fuse, upper arm, cephalic.	3
43761	Reposition gastrostomy tube.	1
46946	Ligation of hemorrhoids.	1

The G-codes and other additions to the list that are being made in response to comments on the proposed rule are displayed in Table 48, Additional Procedures for Addition to the ASC List for CY 2007.

6. Requests for Additions to the ASC List from Comments to the August 23, 2006 Proposed Rule

a. Requests Accepted for Additions to the ASC List for CY 2007

Comment: Many comments requested that CMS add CPT code 13153 (Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less) to the ASC list for CY 2007. The commenters supported our proposal to add CPT codes 13102 (Repair, complex, trunk; 1.1 cm to 2.5 cm); 13122 (Repair, complex, trunk; 2.6 cm to 7.5 cm); and 13133 (Repair, complex, trunk; each additional 5 cm or less) to the list, but stated that CMS also should have proposed to add CPT code 13153, which is the only code in this series of CPT codes that was not proposed to be added. They stated that CPT code 13153 is comparable to the other codes already on the list and should be assigned to group 3 with the other codes in its series, CPT codes 13150 (Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less), 13151 (Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm) and 13152 (Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm).

Response: We agree with the commenters. We examined the series of codes and found that CPT code 13153 is the only one not proposed to be on the CY 2007 list. The base code to which CPT code 13153 is an add-on code is 13150 (Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less) and is assigned to payment group 3. We agree that it is appropriate to assign CPT code 13153 to the same payment group as CPT code 13150 because the procedure can only be billed secondarily to another procedure, so payment will always be discounted by half due to multiple procedure discounting. Therefore, we are adding CPT code 13153 to the ASC list in group 3 for CY 2007.

Comment: Several commenters requested that CMS add CPT code 19295 (Image guided placement, metallic localization clip, percutaneous, during breast biopsy) to the ASC list. The commenters stated that this add-on procedure is performed in conjunction with breast biopsies that are on the ASC list. They stated that it is appropriate to allow payment for this service as well.

Response: We agree with the commenters that the addition of CPT code 19295 to the list is appropriate for CY 2007. We are adding it to the list and assigning it to ASC payment group 1. We believe this procedure is important to providing high quality health care for women undergoing evaluation for possible breast cancer, often as a result of the findings from screening mammography.

Comment: One commenter requested the addition of CPT code 31620 (Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s)) to the ASC list. The commenters explained that it is an add-on procedure that is performed in conjunction with bronchoscopies that are on the ASC list, and the procedure meets all of the criteria for inclusion on the list for CY 2007.

Response: We agree with the commenter that CPT code 31620 is an appropriate procedure for payment in the ASC and are adding it to the ASC list for CY 2007 in group 1, where CPT code 31622 (Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing) and other procedures with similar resource requirements are assigned.

Comment: Several commenters requested that CMS add CPT code 43257 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease) to the ASC list for CY 2007. The commenters stated that they believed that this treatment for gastroesophageal reflux disease met all the current clinical criteria for inclusion on the ASC list.

Response: We agree with the commenters that this procedure satisfies our clinical criteria for addition to the list. The utilization data indicate that the procedure is performed 95 percent of the time in the hospital outpatient department. Based on the utilization data that indicate the safety of performing the procedure in outpatient settings in addition to our medical advisors' clinical judgment that it is an appropriate procedure for performance in the ASC, we are adding CPT code 43257 to the list for CY 2007 and assigning it to payment group 3.

Comment: Several commenters requested that CMS add CPT code 57267 (Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach) to the ASC list for CY 2007 and assign it to payment group 7. The commenters stated that the procedure costs were very similar to those for CPT code 49568 (Implantation of mesh or other prosthesis for incisional or ventral hernia repair) and, because that procedure is assigned to payment group 7, CPT code 57267 should also be assigned to group 7.

Response: We agree with the commenters. Our analysis shows that this procedure may be safely performed in the outpatient setting, and that the costs are similar to those for CPT code 49568. Therefore, we are adding CPT code 57267 to the ASC list in payment group 7 for CY 2007.

Comment: One commenter requested that CMS add CPT code 61795 (Stereotactic computer assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal) to the ASC list for CT 2007. The commenter stated that addition of this procedure to the ASC list would provide improved quality of care by providing a method that would minimize trauma and risk for secondary damage to patients during certain procedures.

Response: We agree with the commenters that this procedure is appropriate for inclusion on the ASC list. It satisfies our clinical criteria so we are adding CPT code 61795 to the list and assigning it to payment group 1 with other procedures requiring similar levels of facility resources for CY 2007.

Comment: Several commenters requested that CPT codes 0176T (Transluminal dilation of aqueous outflow canal; without retention of device or stent) and 0177T (Transluminal dilation of aqueous outflow canal; with retention of device or stent) be added to the ASC list for CY 2007 because they are similar to other surgical procedures on the eye that are frequently provided in ASCs. Commenters pointed out that much of the clinical investigation for these canaloplasty procedures was performed by surgeons in ASC settings.

Response: These CPT codes were released by the AMA on July 1, 2006 for implementation on January 1, 2007. We agree with the commenters that they are appropriate for addition to the ASC list and, based on the expected facility costs of the procedures and the associated single use devices, appropriately assigned to payment group 9 for CY 2007. Therefore, we will add these two procedures to the ASC list for CY 2007.

As discussed above, we determined that there are 10 procedures about which we received comments that met the criteria for inclusion on the ASC list for CY 2007 but that we did not propose

to add to the ASC list. We are adding those procedures and assigning them to ASC payment groups as indicated in Table 48.

TABLE 48.—ADDITIONAL PROCEDURES FOR ADDITION TO THE ASC LIST FOR CY 2007

HCPCS	Short descriptor	Payment group
13153	Repair wound/lesion add-on.	3
19295	Place breast clip, percut.	1
31620	Endobronchial us add-on.	1
43257	Upper gi scope w/ thrml txmnt.	3
57267	Insert mesh/pelvic flr add-on.	7
61795	Brain surgery using computer.	1
G0392	AV fistula or graft arterial.	9
G0393	AV fistula or graft venous.	9
0176T	Aqu canal dilat w/o retent.	9
0177T	Acq canal dilat w retent.	9

b. Requests Not Accepted for Additions to the ASC List for CY 2007

There were a number of procedures for which we received requests for addition to the ASC list that we are not adding to the ASC list because they do not meet the criteria set forth in the regulations as § 416.65. Those procedures are listed in Tables 50 and 51 below.

Our data indicate that the procedures listed in Table 49 are performed predominantly in physician offices and are therefore, not eligible for inclusion on the ASC list for CY 2007. Table 49 includes 13 of the procedures we proposed not to add to the ASC list because they are furnished predominantly in the physician office setting, as well as an additional 22 procedures that are performed predominantly in physician offices that commenters to the proposed rule requested we add for CY 2007. One of the procedures on the list in the proposed rule, CPT code 31040 (Exploration behind jaw) is also not being added to the list for CY 2007. It is included in Table 50 rather than in Table 49 below, because it is excluded for not meeting our clinical criteria.

TABLE 49.—PROCEDURES NOT ADDED TO CY 2007 ASC LIST BECAUSE THEY ARE PREDOMINANTLY PERFORMED IN THE PHYSICIAN'S OFFICE

CPT	Short descriptor
11603	Exc tr-ext mlg+marg 2.1–3 cm.
20610	Drain/inject, joint/bursa.
28124	Partial removal of toe.
40812	Excise/repair mouth lesion.
45300	Proctosigmoidoscopy dx.
45303	Proctosigmoidoscopy dilate.
45330	Diagnostic sigmoidoscopy.
46221	Ligation of hemorrhoid(s).
46604	Anoscopy and dilation.
46614	Anoscopy, control bleeding.
46900	Destruction, anal lesion(s).
46910	Destruction, anal lesion(s).
46916	Destruction, anal lesion(s).
62367	Analyze spine infusion pump.
62368	Analyze spine infusion pump.
64402	N block inj, facial.
64405	N block inj, occipital.
64408	N block inj, vagus.
64412	N block inj, spinal accessor.
64413	N block inj, cervical plexus.
64418	N block inj, suprascapular.
64425	N block inj, ilio-ing/hypogi.
64435	N block inj, paracervical.
64445	N block inj, sciatic, sng.
64505	N block, spenopalatine gangl.
64508	N block, carotid sinus s/p.
64555	Implant neuroelectrodes.
64612	Destroy nerve, face muscle.
67028	Injection eye drug.
67105	Repair detached retina.
67110	Repair detached retina.
67145	Treatment of retina.
67210	Treatment of retinal lesion.
67221	Ocular photodynamic ther.
67228	Treatment of retinal lesion.

Comment: Many commenters indicated that CMS should remove the criterion that procedures performed predominantly in the physician's office are not eligible for inclusion on the ASC list for CY 2007 and, specifically, that CMS add CPT code 45330 (Diagnostic sigmoidoscopy) to the ASC list for CY 2007.

Response: The current criteria were used to make decisions regarding inclusion on the CY 2007 ASC list. We did not propose to alter these criteria prior to implementation of the revised payment system, as proposed for CY 2008. Although we proposed to allow procedures predominantly performed in physician offices to be paid under the revised ASC payment system, we will not make final any proposed changes to the criteria for the revised system until we have considered the public comments to that proposal. The comment period will not close for that proposal until after this final rule with comment period has been published. Therefore, for CY 2007, we will continue to adhere to the current criteria for inclusion on the list and will not add procedures that are provided predominantly in the physician office setting to the list.

Procedures that are displayed in Table 49 above include office-based procedures recommended for addition to the ASC list by commenters to the CY 2007 OPPS proposed rule. Procedures that are predominately office-based do not meet our criteria for inclusion on the ASC list. Thus, we are finalizing our proposal to not include on the ASC list any of the services performed predominantly in physician offices as displayed in Table 49.

In the CY 2007 OPPS proposed rule, we indicated that we were not proposing to add to the ASC list 14 procedures for which we received requests for addition because our medical advisors believe that those procedures do not meet the clinical criteria (§ 416.65) for addition. Our medical advisors believed that the procedures listed in Table 43 of the CY 2007 OPPS proposed rule (71 FR 49629) are of a type that:

- Require an overnight or inpatient stay;
- Require a total of 90 minutes of operating time or 4 hours or more of recovery time;
- Require major or prolonged invasion of body cavities or involve major blood vessels;
- Are generally emergent or life-threatening; or
- Are of a type that result in extensive blood loss.

These characteristics make procedures ineligible for addition to the list of ASC procedures. The 14 procedures that we proposed to not be added to the list based on clinical criteria, as well as additional procedures for which we received requests in comments to the August 23, 2006 proposed rule that did not meet the criteria, are displayed below in Table 50.

TABLE 50.—PROCEDURES NOT ADDED TO THE CY 2007 ASC LIST BECAUSE THEY DO NOT MEET CURRENT CLINICAL CRITERIA FOR ADDITION TO THE ASC LIST

CPT	Short descriptor
21390	Treat eye socket fracture.
21406	Treat eye socket fracture.
21407	Treat eye socket fracture.
27412	Autochondrocyte implant knee.
27415	Osteochondral knee allograft.

TABLE 50.—PROCEDURES NOT ADDED TO THE CY 2007 ASC LIST BECAUSE THEY DO NOT MEET CURRENT CLINICAL CRITERIA FOR ADDITION TO THE ASC LIST—Continued

CPT	Short descriptor
29866	Autgrft implnt, knee w/ scope.
29867	Allgrft implnt, knee w/ scope.
29868	Meniscal trnspl, knee w/scpe.
31040	Exploration behind jaw.
35470	Repair arterial blockage.
35471	Repair arterial blockage.
35475	Repair arterial blockage.
35476	Repair venous blockage.
35490	Atherectomy, percutaneous.
35492	Atherectomy, percutaneous.
35493	Atherectomy, percutaneous.
35494	Atherectomy, percutaneous.
35495	Atherectomy, percutaneous.
37205	Transcath IV stent, percutaneous.
37206	Transcath IV stent/ perc, add'l.
42844	Extensive surgery throat.
47562	Laparoscopic cholecystectomy.
47563	Laparo cholecystectomy/graph.
47564	Laparo cholecystectomy/explr.
60210	Partial thyroid excision.
63001	Removal of spinal lamina.
63003	Removal of spinal lamina.
63005	Removal of spinal lamina.
63011	Removal of spinal lamina.
63020	Neck spine disk surgery.
63030	Low back disk surgery.
63035	Spinal disk surgery add-on.
63040	Laminotomy single, cervical.
63042	Laminotomy, single lumbar.
63047	Removal of spinal lamina.
63048	Remove spinal lamina add-on.
63655	Implant neuroelectrodes.
64448	N block inj fem, cont inf.
64449	N block inj, lumbar plexus.

Comment: Some commenters addressed many of the codes that we did not propose to add because we believed that they did not meet the clinical criteria for inclusion on the ASC list for CY 2007. The commenters disagreed with some of our clinical determinations and stated that the procedures were safe for performance on an outpatient basis, satisfy our clinical criteria and should be included on the ASC list. Further, a few commenters noted that, although we proposed to exclude those 14 procedures from the list for CY 2007, we also proposed to add some of them to the list for payment under the CY 2008 revised payment system. They believed that we should add those procedures now rather than wait until CY 2008.

Response: Our medical advisors reviewed all of the procedures requested for addition in the comments. They did not find reason to change their determinations for any of the procedures included in Table 50. At the least, all of those procedures require longer than 4 hours of recovery time and some of them require overnight stays or involve major blood vessels.

As noted by several of the commenters, we did propose to allow Medicare payment for some of the procedures under the revised ASC payment system for CY 2008. Integral to the proposal for CY 2008 is a revision of the criteria used to determine for which procedures Medicare would provide ASC facility payment. We did not propose any revision of the criteria for CY 2007 and clearly indicated in the proposed rule that all decisions regarding the ASC list for CY 2007 would be made according to the current criteria.

We are finalizing our proposal not to include any of the services that do not meet current clinical criteria for addition to the ASC list that are displayed in Table 50 above for CY 2007, with modification to also not include procedures recommended by commenters to the CY 2007 proposed rule that do meet current clinical criteria for addition to the ASC list.

For these reasons, we are making final our decisions not to add any of the procedures included in Table 50 to the ASC list for CY 2007.

Comment: A number of commenters requested that CMS add to the ASC list certain procedures that have very low facility costs and for which payment is included in that for other procedures. The requested procedures are currently assigned the following HCPCS codes:

- 36100–(Establish access to artery)
- 36120–(Establish access to artery)
- 36140–(Establish access to artery)
- 6145–(Artery to vein shunt)
- 6200–(Place catheter in aorta)
- 6215–(Place catheter in artery)
- 6216–(Place catheter in artery)
- 36217–(Place catheter in artery)
- 36218–(Place catheter in artery)
- 36245–(Place catheter in artery)
- 36246–(Place catheter in artery)
- 36247–(Place catheter in artery)
- 36248–(Place catheter in artery)
- 38792–(Identify sentinel node)
- 62290–(Inject spine disk x-ray)
- 62291-(Inject spine disk x-ray)
- 66990–(Ophthalmic endoscope add-on)
- G0289–(Arthro, loose body + chondo)

The commenters believed that these procedures were appropriate for addition to the ASC list so that the facilities could receive separate payment for them.

Response: Many of the requested procedures for addition to the list are procedures that are typically performed as minor services that are integrally related to the provision of the primary surgical procedure. Our policy in the ASC payment system is not necessarily to pay separately for each associated component of procedures, even if it is described by a separate HCPCS code, but rather to bundle payment for those components together into the payment for the primary surgical procedure. Many of those minor procedures that commenters requested we add to the ASC list are paid as part of the payment for the primary surgical service. For instance, Medicare does not make a separate facility payment for CPT code 36145, Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft). The introduction of the needle or intracatheter described here is performed as an integral step that is part of the primary procedure, and it is not associated with any particular procedure but may be used in many different ones. Presumably, the primary procedure could not be performed unless the needle or intracatheter were first placed to provide access to the site for treatment.

Therefore, we are not adding to the ASC list for CY 2007 any procedure that we have identified as a minor service that is integrally related to the provision of the primary surgical procedure.

7. Requests for Payment Increases for Procedures on the Current ASC List

Comment: A few commenters requested that we assign CPT code 57288 (Sling operation for stress incontinence (eg, fascia or synthetic)) to a higher ASC payment level. The commenters stated that because

Medicare does not allow separate payment for the synthetic mesh required for performing the procedure, payment at the current level is inadequate to cover the cost of the service. They reported that the costs for the synthetic mesh are between $700 and $850 and that the $717 payment made to the ASC does not cover the costs of providing the service. They stated that if CMS considers the sling material to be bundled into the ASC facility fee, then CPT code 57288 should be assigned to payment group 9.

Response: As we explained in our response to comments in the proposed rule related to CPT code 51992 (Laparoscopy, surgical; sling operation for stress incontinence (eg, fascia or synthetic)) (71 FR 49630), we realize that the synthetic material for the sling may be costly, but there is no identifiable HCPCS code available for use in ASCs to report the material, and such material is not eligible for separate payment from Medicare in the ASC or in any other setting. Further, CPT code 57288, like CPT code 51992, describes a procedure that may be performed using synthetic material or fascia. As such, we cannot know whether the more costly synthetic material is used in any specific procedure and do not believe it is appropriate to fully incorporate the synthetic supply costs into the payment for all of the procedures performed. We continue to believe that ASC payment group 5 is an appropriate assignment for the procedure, and therefore, as we proposed, we are not changing that assignment.

Comment: One commenter requested that CMS assign CPT codes 58353 (Endometrial ablation, thermal; without hysteroscopic guidance) and 58563 (Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)) to payment group 9 instead of to group 4 to which they are currently assigned. They stated that because CMS assigned CPT code 58565 (Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) to payment group 9 because we believed that it was more resource-intensive than other procedures assigned to group 4, that CPT codes 58353 and 58563 should also be assigned to group 9. The commenters indicated that those two procedures use transcervical, single use devices and have similar resource intensity to CPT code 58565. The commenters did not provide any cost information for either of the procedures.

Response: We examined cost data available to us regarding the facility or office costs associated with performing those procedures in other outpatient settings (physician offices and hospital outpatient departments). These are the best data available to us because we have no cost data for those procedures in ASCs. We agree with the commenters that payment in group 4 may not be adequate for either of the procedures, and we believe that the costs for CPT code 58563 are higher than those for CPT code 58353 due to the expensive guidance equipment used in the procedure. Therefore, we are assigning CPT code 58353 to payment group 7 for CY 2007 and CPT code 58563 to payment group 9 for CY 2007.

8. Other Comments on the May 4, 2005 Interim Final Rule

In the May 4, 2005 interim final rule (70 FR 23690), we invited public comments on the payment assignments for specific procedure codes that we added to the ASC list in that rule that had not been proposed for addition to the ASC list in the November 26, 2004 proposed rule (69 FR 69178). We received comments on 14 of those newly-added procedures. A summary of those comments and our treatment of them for CY 2007 is discussed below.

Comment: Several commenters requested that we delay adding to the ASC list CPT codes 33212 (Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular), 33213 (Insertion or replacement of pacemaker pulse generator only; dual chamber), and 33233 (Removal of permanent pacemaker pulse generator) until we implement the new ASC payment system.

Response: We added these procedures to the ASC list in response to a request from a commenter. Our medical advisors evaluated the request and determined that these were appropriate procedures for performance in the ASC setting. We continued to believe that the procedures were appropriate for performance in the ASC and saw no reason to remove them from the list at this time.

We proposed in the CY 2007 OPPS proposed rule to retain CPT codes 33212, 33214, and 33233 on the ASC list, with their current payment level assignments.

We received no further comments on this proposal and, therefore, as we proposed, in this final rule with comment period, we are not making any changes to the ASC assignments for CPT codes 33212, 33213, and 33233.

Comment: Two commenters requested that we reassign CPT codes 57155 (Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy) and 58346 (Insertion of Heyman capsules for clinical brachytherapy) to the highest ASC payment group. The commenters believed that payment at a higher level was necessary in order to cover the costs of the equipment and supplies used in performing the procedures.

Response: We reviewed the OPPS cost data for the procedures as the best indicator available to us of facility costs and found that the median costs for CPT codes 57155 and 58346 when furnished in the hospital outpatient department were $506 and $364, respectively. We do not have median cost data for the procedures performed in the ASC but the ASC payment amount for both services is $446, which is within the range of the procedures' median costs in the generally more costly hospital outpatient setting. This led us to believe that the $446 payment in the ASC is quite adequate.

We proposed in the CY 2007 OPPS proposed rule to retain CPT codes 57155 and 58346 in ASC payment group 2.

We received no comments on this proposal and, therefore, as we proposed, in this final rule with comment period, we are not assigning the procedures to higher ASC payment groups.

Comment: Several commenters requested that CMS remove from the list CPT codes 36475 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein); 36476 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins in single extremity, each through separate access sites); 36478 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein); and 36479 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites). The commenters suggested that if we were unwilling to remove them from the list, that we assign the procedures to a higher payment group. They believed that the procedures required significantly more facility resources than other procedures with which they are currently grouped in payment level 3. The commenters explained that if the procedures were excluded from the list, more adequate payments would be made to physicians under the MPFS for the required resources.

Response: We added these procedures to the list in response to public comments, because we believe they met all the criteria for addition to the ASC list. We initially assigned the codes to ASC payment group 3, consistent with other procedures with similar clinical indications. We continued to believe that these procedures were appropriate for performance in the ASC setting and did not propose to remove them from the list. However, we agreed with the commenters' point that the procedures require significantly more facility resources than traditional vein removal procedures, and proposed to assign them for CY 2007 to payment group 9 in the preamble of the CY 2007 OPPS proposed rule. We note that these codes mistakenly were published in Addendum AA of the proposed rule with assignment to payment group 8, and in the supporting public data files for the CY 2007 proposed rule as assigned to payment group 8.

Comment: Many commenters also expressed their concerns about the lack of clarity of the proposed payment group assignments for CPT codes 36475, 36476, 36478, and 36479 for CY 2007. Commenters noted the high cost of the procedures, which were assigned to payment group 3, and stated their belief that payment at level three is so low that that ASCs could not afford to provide the services at that rate. Commenters requested that CMS confirm that these CPT codes were assigned to payment group 9, and finalize our proposal for their CY 2007 treatment.

Response: We proposed that all four of these procedures be assigned to payment group 9 for CY 2007. We recognize that our data files caused confusion, and we appreciate the commenters bringing the inconsistencies to our attention. We continue to believe that these services should be assigned to payment group 9 for CY 2007.

Therefore, we are finalizing our proposal to retain these procedures on the ASC list and assigning them to ASC payment group 9 for CY 2007.

Comment: Two comments requested that we assign CPT code 46947 (Hemorrhoidopexy by stapling) to a higher ASC payment group. The commenters stated that due to the cost of the stapler used in the procedure, the resources required for this procedure are not similar to the other surgical procedures for the treatment of hemorrhoids that are also assigned to ASC payment group 3. The commenters suggested that it would be more appropriate to assign this procedure to ASC payment group 7.

Response: We agreed with the commenters and proposed in the CY 2007 proposed rule to assign the procedure to ASC payment group 7 for CY 2007. We received no comments on this proposal and, therefore, are finalizing our assignment of CPT code 46947 to ASC payment group 7 for CY 2007.

Comment: One commenter requested that we allow separate payment for the material used as the sling in the procedure described by CPT code 51992 (Laparoscopy, surgical; sling operation for stress incontinence (e.g. fascia or synthetic)). The commenter stated that without separate payment for the sling material, the Medicare payment for performing the procedure is inadequate to cover the service. The commenter also stated that there is no specific HCPCS code to use for billing the synthetic sling material.

Response: We added CPT code 51992 to the ASC list in the last update in response to comments. We assigned CPT code 51992 to ASC payment group 5, the same ASC payment group to which other procedures to treat stress incontinence are assigned. As discussed previously, we realize that the synthetic material for the sling may be costly, but there is no identifiable HCPCS code available for use in ASCs to report the material, and such material is not eligible for separate payment from Medicare in the ASC or in any other setting. Further, CPT code 51992 describes a procedure that may be performed using synthetic material or fascia. As such, we cannot know whether the more costly synthetic material is used in any specific procedure and do not believe it is appropriate to fully incorporate the synthetic supply costs into the payment for all of the procedures performed. We continue to believe that ASC payment group 5 is an appropriate assignment for the procedure, and therefore, as we proposed, we are not changing that assignment.

Comment: One commenter requested that we make separate payment for the microinserts that are used in performing CPT code 58565 (Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants). The commenter stated that there is no specific HCPCS Level II code to describe the microinserts and, thus, separate billing for them currently is not possible.

Response: We added CPT code 58565 to the ASC list in the last update in response to public comment. We assigned the procedure to ASC payment group 4 with other procedures with similar clinical indications. After further review, we were convinced that the procedure described by CPT code 58565 was significantly more resource-intensive than the other procedures in ASC payment group 4 and, therefore, proposed to reassign the procedure to ASC payment group 9 for CY 2007.

We received no comments to this proposal and therefore are making final our proposal to assign CPT code 58565 to ASC payment group 9 for CY 2007.

Comment: Several comments requested that CMS issue instructions to permit separate payment for the catheters that are inserted during the procedures described by CPT codes 19296 (Placement of radiotherapy after loading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy) and 19298 (Placement of radiotherapy after loading brachytherapy catheters into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance).

One commenter supported our inclusion of CPT code 19296 on the ASC list in payment group 9, but asserted that separate payment should also be provided for the balloon catheter inserted during the procedure. With regard to CPT code 19298, other commenters also stated that the payment level is inadequate and that separate payment should be allowed for the catheters inserted during the procedure. One of the commenters explained that the catheters used to perform the procedure described by CPT code 19298 are not high cost items (about $18.50 each) but these procedures typically use 30 catheters which makes the catheters a significant cost factor in performing the procedure.

Response: In the CY 2007 proposed rule, we noted that the catheters used in these procedures are classified as surgical supplies and, as such, are not included on the DMEPOS fee schedule and are, therefore, not eligible for separate payment in the ASC. Payments for the costs of the catheters are packaged into the payments for performing the procedures. Currently CPT code 19298 is assigned to ASC payment group 1. Based on the information provided by the commenters, we were persuaded that reassignment to a higher ASC payment group was warranted and proposed to reassign the CPT code 19298 to ASC payment group 9 for CY 2007.

We received no comments about this proposal and, therefore, as we proposed, we are reassigning CPT code 19298 to ASC payment group 9 and will retain

CPT code 19296 in payment group 9 and payment for the balloon catheter will continue to be included in that rate.

C. Regulatory Changes for CY 2007

As stated earlier, in the CY 2007 proposed rule, we proposed a revised payment system for ASCs to be implemented effective January 1, 2008, including revisions to the ASC list for CY 2008, the ratesetting method, and the applicable ASC regulations to incorporate the requirements and payments for ASC facility services under the proposed revised ASC system. We expect that a final rule implementing the revised ASC payment system will be published separately in the spring of 2007. The revised ASC payment system would not take effect until January 1, 2008. However, we need to revise our current regulations at part 416, subparts D and E to ensure that the rules governing our current system are clearly distinguishable from those that will apply to the revised system beginning January 1, 2008. Therefore, as we proposed, we are revising Subparts D and E of Part 416 of the regulations to reflect that these are the rules governing the APC payment system prior to January 1, 2008, and redesignating the existing Subpart F as Subpart G under Part 416 to codify the rules governing the ASC payment adjustment for NTIOLs. In addition, we are revising existing—

- § 416.1 (a)(2) and (a)(3) (under Basis and scope) and the definition of ''Facility'' under § 416.2 to remove the obsolete reference to ''a hospital outpatient department,'' to add provisions of section 5103 of Public Law 109–171, and applicable provisions of Public Law 108–173.
- § 416.65 (Covered surgical procedures) to modify the introductory text to clearly denote the section s application to covered surgical procedures furnished before January 1, 2008. In addition, we are removing the obsolete cross-reference in paragraph (a)(4) to § 405.310 and replacing it with the correct cross-reference to § 411.15.
- § 416.125 (ASC facility services payment rate) to incorporate the limitation on payment imposed by section 5103 of Public Law 109–171.
- § 488.1 (Definitions) to correct a longstanding error by adding ambulatory surgical centers to the definition of a supplier in conformance with section 1861(d) of the Act.

We also are revising the headings of Subparts D and E and adding new §§ 416.76 and 416.121 to Subparts D and E, respectively, to clearly state that the provisions of Subparts D and E apply to services furnished before January 1, 2008.

In addition, we are making two technical changes: revising § 416.120 to replace the incorrect cross-reference to ''Part 413'' with the correct cross-reference to ''Part 419''; and deleting § 416.150 (Beneficiary appeals) because it does not conform with the appeals process provisions of 42 CFR Part 405, subparts H and I.

We received no comments on these proposed revisions and are finalizing them as proposed without modification.

D. Implementation of Section 1834(d) of the Act

Sections 1834(d)(2) and (3) of the Act require that the computed beneficiary coinsurance amount for screening flexible sigmoidoscopy and screening colonoscopy services provided in hospital outpatient departments and ASCs be equal to 25 percent of the payment amount. They also require Medicare to pay the lesser of the ASC or OPPS payment amount for those screening services in each geographic area.

For CY 2007, the OPPS payment amount will be limited to the lesser ASC payment amount for screening colonoscopies. Medicare payment for screening flexible sigmoidoscopies will not be affected in CY 2007 because those services are not currently paid for in ASCs. There will be no effect on the payment amount to ASCs for screening colonoscopies. However, beginning in CY 2007, beneficiaries will be responsible for paying a 25-percent coinsurance for screening colonoscopies when provided in ASCs. Beneficiaries have been paying a 25-percent coinsurance for such services when provided in hospital outpatient departments.

Although the provision is not new, it has not been implemented for ASCs due to ongoing instability in that payment system and uncertainty regarding plans for a revised payment system. There was uncertainty for several years about whether data gathered in a 1994 CMS-sponsored survey of ASC costs would be used to develop new rates for ASCs and, if so, how best to configure the payment methodology.

The MMA requires the implementation of a revised system no later than January 1, 2008. However, section 5103 of the Deficit Reduction Act of 2005 (DRA) requires CMS to make some substantial payment rate changes for ASCs in CY 2007. Implementation of section 5103 of the DRA requires that carriers and ASCs make significant claims processing system changes. Since passage of the MMA, we have generally followed a policy of making as few changes to the current ASC payment system as possible prior to implementation of the MMA-mandated revised payment system, in order to minimize the administrative burden on ASCs. However, because changes to the system are being made for CY 2007 to comply with the DRA, we believe that we should also implement the requirements of section 1834(d) of the Act at the same time.

We are confident that implementation of the coinsurance change required by section 1834(d) of the Act, in addition to changes required to comply with the DRA, will not interfere with ASCs' ability to provide services as usual.

Currently, Medicare provides an ASC facility payment for two screening colonoscopy procedures reported by HCPCS codes G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) and G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk), and not for any screening flexible sigmoidoscopies. Those are the only procedures that will be affected by the higher coinsurance amounts in ASCs in CY 2007. Beginning January 1, 2007, beneficiaries receiving services described by G0105 or G0121 in ASCs are responsible for a 25-percent coinsurance rather than the current 20 percent.

Sections 1834(d)(2) and (d)(3) of the Act also require Medicare to pay the lesser of the ASC or OPPS payment amount for screening flexible sigmoidoscopies and screening colonoscopies. Medicare will not make payment to ASCs for screening sigmoidoscopies in CY 2007, so there is no payment comparison to be made for those services. This requirement will not impact ASC payments for the above listed screening colonoscopies in CY 2007, because the ASC amount will be lower than the OPPS payment calculated according to the standard OPPS methodology, prior to application of this requirement.

E. Implementation of Section 5103 of Public Law 109–171 (DRA)

As noted in section XVII.A.1. of this preamble, section 5103 of Public Law 109–171 requires us to substitute the OPPS payment amount for the ASC standard overhead amount for surgical procedures performed at an ASC on or after January 1, 2007, but prior to the revised payment system when the ASC standard overhead amount exceeds the OPPS payment amount for the procedure. In Addendum AA of this final rule with comment period, we identify the HCPCS codes that we

believe will be subject to section 5103 based on a comparison of the final CY 2007 OPPS payment rates and the ASC standard overhead amounts that are effective in CY 2007. In addition, as we proposed, we are adding paragraph (c) to § 416.125 to reflect this change.

Comment: A few commenters asked that CMS not implement the payment limits because, in some cases, those payment decreases would result in payments that would be inadequate to cover the costs of the procedures.

Response: Implementation of the payment limitations required by the DRA is a statutory requirement. Therefore, we are finalizing the payment limits as required and as presented in our proposed rule without modification.

F. Modification of the Current ASC Process for Adjusting Payment for New Technology Intraocular Lenses (NTIOLs)

1. Background

At the inception of the ASC benefit on September 7, 1982, Medicare paid 80 percent of the reasonable charge for IOLs supplied for insertion concurrent with or following cataract surgery performed in an ASC (47 FR 34082, August 5, 1982). Section 4063(b) of OBRA 1987, Public Law 100–203, amended the Act to mandate that we include payment for an IOL furnished by an ASC for insertion during or following cataract surgery as part of the ASC facility fee for insertion of the IOL, and that the facility fee include payment that is reasonable and related to the cost of acquiring the class of lens involved in the procedure.

Section 4151(c)(3) of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), Public Law 101–508, froze the IOL payment amount at $200 for IOLs furnished by ASCs in conjunction with surgery performed during the period beginning November 5, 1990, and ending December 31, 1992. We continued paying an IOL allowance of $200 from January 1, 1993, through December 31, 1993.

Section 13533 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), Public Law 103–66, mandated that payment for an IOL furnished by an ASC be equal to $150 beginning January 1, 1994, through December 31, 1998.

Section 141(b)(1) of the Social Security Act Amendments of 1994 (SSAA 1994), Public Law 103–432, required us to develop and implement a process under which interested parties may request a review of the appropriateness of the payment amount for insertion of an IOL, to ensure that the facility fee for the procedure includes payment that is reasonable and related to the cost of acquiring a lens that belongs to a class of NTIOLs.

In the February 8, 1990 **Federal Register** (55 FR 4526), we published a final notice entitled ''Revision of Ambulatory Surgery Center Payment Rate Methodology,'' which implemented Medicare payment for an IOL furnished at an ASC as part of the ASC facility fee for insertion of the IOL.

In the June 16, 1999 **Federal Register** (64 FR 32198), we published a final rule entitled ''Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers,'' to add Subpart F (§§ 416.180 through 416.200) to 42 CFR Part 416, which established a process for adjusting payment amounts for insertion of a class of NTIOLs furnished by ASCs.

Our current regulations at §§ 416.180 through 416.200 define the terms relevant to the process, establish the payment review process, and establish $50 as the payment adjustment amount that is added to the ASC facility fee for insertion of a lens that CMS determines is an NTIOL. Section 416.200 provides that the payment adjustment applies for a 5-year period that begins when we recognize the first lens that establishes a class of NTIOLs. In accordance with § 416.200(b), insertion of a lens that we subsequently recognize as belonging to an existing NTIOL class would receive the payment adjustment for the remainder of the 5-year period established for the class. Section 416.185(f)(2) provides that after July 16, 2002, we have the option of changing the $50 adjustment amount through proposed and final rulemaking in connection with ASC services.

Since June 16, 1999, we have issued a series of **Federal Register** notices to list lenses for which we received requests for a 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 to NTIOLs on April 28, 2006 (71 FR 25176).

a. Current ASC Payment for Insertion of IOLs

The current ASC payment groups, payment rates and procedural HCPCS codes for cataract extraction with IOL insertion are as follows:

Payment Group 6—$826 ($676 + $150 IOL Allowance)

- CPT code 66985, Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
- CPT code 66986, Exchange of intraocular lens

Payment Group 8—$973 ($823 + $150 IOL allowance)

- CPT code 66982, Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (for example, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (for example, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage
- CPT code 66983, Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)
- CPT code 66984, Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (for example, irrigation and aspiration or phacoemulsification)

b. 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 Table 51 below:

TABLE 51.—CLASSES OF NTIOLS APPROVED FOR PAYMENT ADJUSTMENT

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.

TABLE 51.—CLASSES OF NTIOLS APPROVED FOR PAYMENT ADJUSTMENT—Continued

NTIOL category	HCPCS code	$50 Approved for services furnished on or after	NTIOL characteristic	IOLs eligible for adjustment
2	Q1002	May 18, 2000, through May 18, 2005 ..	Reduction in Preexisting Astigmatism ..	STAAR Surgical Elastic Ultraviolet-Absorbing Silicone Posterior Chamber IOL with Toric Optic, models AA4203T, AA4203TF, and AA4203TL.
3	Q1003	February 27, 2006, through February 26, 2011.	Reduced Spherical Aberration	Advanced Medical Optics (AMO) Tecnis® IOL models Z9000, Z9001, and ZA9003; Alcon Acrysof IQ Model SN60WF.

2. Proposed and Final Changes

a. Process for Recognizing IOLs as Belonging to an Active NTIOL Class

Currently, we accept and review applications for inclusion in an active NTIOL class on a continuous basis throughout the year in accordance with §§ 416.180 through 416.200 of the regulations. As we proposed in the CY 2007 OPPS proposed rule, we are continuing this established process and updating and streamlining it, as discussed below, to specify the request and comment review process, the information that a request must include to be accepted for review, the specific factors to be considered in evaluating requests, and the process to provide notification of determinations. As stated in section XVII.C. of this preamble, we are redesignating existing Subpart F of Part 416 as Subpart G, which will include the regulations pertaining to the ASC payment adjustment for NTIOLs. In addition, we are revising redesignated Subpart G to include revisions to existing § 416.180, § 416.185, § 416.190, § 416.195, and § 416.200 to reflect the changes that we are making to this process.

One of the regulatory changes that we are making is to revise existing § 416.180 to establish the basis and scope for this ASC payment adjustment. This revision eliminates the definitions currently included in that section for ''Class of new technology intraocular lenses (IOLs),'' ''Interested party,'' ''New technology IOL,'' and ''New technology subset.'' We do not believe that we need to retain these definitions because additional revisions that we are making to the regulations at Part 416 will eliminate the term ''interested party'' from §§ 416.185(c) and 416.190 and the term ''new technology subset'' from §§ 416.185(g), 416.200(a), (b), and (c) and further clarify the terms ''new technology IOL'' and ''class of new technology intraocular lenses (IOLs).'' We received no comments on the changes we proposed to § 416.180. Accordingly, we are revising § 416.180 as we proposed, to reflect the Basis and Scope of Subpart G of Part 416.

The other changes that we are making to Part 416, pertaining to the ASC payment adjustment for NTIOLs, are discussed below.

b. Public Notice and Comment Regarding Adjustments of NTIOL Payment Amounts

As we proposed, we are updating and streamlining the process for determining whether an IOL that is to be inserted during or subsequent to cataract extraction qualifies for payment adjustment as a NTIOL, as set forth in existing § 416.185 of our regulations. The basis for the current NTIOL payment review process was enacted in 1994 and has been implemented through a series of separate **Federal Register** notices specific to NTIOLs. We are modifying the current process of using separate **Federal Register** notices to notify the public of requests to review lenses for membership in new NTIOL classes, to solicit public comment on requests, and to notify the public of CMS determinations concerning new classes of NTIOLs for which an ASC payment adjustment would be made. We are specifying that these NTIOL–related notifications will be fully integrated into the annual notice and comment rulemaking for updating the ASC payment rates, the specific payment system in which NTIOL payment adjustments are made. Given that the NTIOL payment adjustments are applicable to ASC services and that our proposal for updating the new ASC payment system to be implemented in January 2008 anticipates an annual update process in coordination with notice and comment rulemaking on 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 are establishing 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.

We note that we did not receive any review requests in response to the specific NTIOL April 28, 2006 notice (71 FR 25176) soliciting CY 2006 requests for review of the appropriateness of the payment amount for particular NTIOLs furnished in ASCs.

Comment: Most commenters supported in principle our proposal to incorporate NTIOL requests and approvals within the annual ASC notice and comment rulemaking cycle to promote greater coordination and efficiency. However, several commenters urged CMS to review NTIOLs on a quarterly rather than an annual basis. These commenters expressed concern about delays in beneficiary access to NTIOLs that could be avoided by quarterly reviews, which, the commenters noted, would also be more consistent with the CMS review cycle for OPPS pass-through device categories and new technology services. One commenter urged quarterly reviews so that lenses that belong to an active NTIOL class would not be competitively disadvantaged by having to wait for months or nearly a year to be recognized. Another commenter

recommended a 60-day comment period following issuance of the list of requests for NTIOL status rather than the 30-day comment period that we proposed.

Response: We appreciate the commenters' support for our proposal to coordinate the public notice and comment process regarding requests to establish new NTIOL classes with the update of ASC payment rates. We understand and share the commenters' concerns about facilitating beneficiary access to technology with demonstrated clinical improvement over existing technology. However, section 141(b)(3) of the Social Security Act Amendments of 1994 (SSAA 1994), Public Law 103–432, requires us both to implement the payment adjustment for new classes of NTIOLs through notice and comment rulemaking in the **Federal Register** and to provide for a 30-day comment period on the lenses that are the subjects of the requests contained in the notice. We are not bound by the same prescriptive statutory requirements with regard to approval of applications for pass-through and new technology status under the OPPS, which is why we are able to implement updates of those provisions as part of the quarterly updates of the OPPS OCE and PRICER.

However, we have 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*.

The guidance document provides details regarding requests for recognition of IOLs as belonging to an existing, active NTIOL category or subset, the review process, and information required for a request to review. Currently, there is one active NTIOL subset 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 subset of NTIOLs. That is, review of candidate lenses for an existing, active NTIOL subset is ongoing and not limited to the annual review process that applies to new NTIOL classes. We ordinarily would complete the review of a request within 90 days of receipt, and upon completion of our review, we would notify the requestor of our determination and post on the CMS Web site notification of a lens newly approved for a payment adjustment as an NTIOL belonging to an active NTIOL class when furnished at an ASC.

We believe that consolidating the request, review, and approval process for new classes of NTIOLs as part of the annual ASC payment update cycle and accepting and reviewing requests for addition to an active NTIOL class on an ongoing basis will result in more timely access to improved health technologies for Medicare beneficiaries. Accordingly, we are revising § 416.185 to reflect the changes that we proposed to the current process for publishing separate **Federal Register** notices specific to NTIOLs.

c. Factors CMS Considers in Determining Whether an Adjustment of Payment for Insertion of a New Class of NTIOL Is Appropriate

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 were identified for each class. We proposed 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.

In order to assess the clinical performance of a candidate IOL to establish a new NTIOL class, outcomes from use of the candidate lens would be compared with outcomes of use of currently available IOLs. Due to the rapid evolution of medical technology, we expect that the baseline of currently available IOLs for comparison would change from year to year.

Comment: Most commenters expressed general agreement with the criteria that we proposed as the factors we would consider in determining whether an adjustment of payment is appropriate for insertion of a new class of NTIOL. One commenter suggested amending § 416.195(a)(4) to make it clear that the list of superior outcomes are examples and not an all-inclusive list.

Response: We appreciate the commenter's concern that we not be overly prescriptive in what constitutes ''superior outcomes.'' However, we believe that § 416.195(a)(4)(vi), ''Other comparable clinical advantages,'' has the same effect as the revision suggested by the commenter. In other words, the superior outcomes cited in §§ 416.195(a)(4)(i)–(v) are not all-inclusive, and extend to other comparable (but unspecified) clinical advantages. In the preamble of the proposed rule (71 FR 49633), we suggest several ''comparable clinical advantages'' for the purpose of illustration. These suggestions were intended to be examples but not an all-inclusive list.

Comment: One commenter recommended removing ''Reduced dependence on other eyewear (for example, spectacles, contact lenses, and reading glasses)'' from the list of factors (71 FR 49633) because there should not be an NTIOL class for which the class-defining clinical advantage falls outside the scope of Medicare benefits.

Response: We appreciate the comment. To avoid unnecessary confusion, we will remove ''reduced dependence on other eyewear'' from the list of illustrative improved clinical outcomes.

Comment: The same commenter recommended that CMS clarify that when a requestor seeks to establish a new NTIOL category for a candidate IOL that bears the class-defining characteristic of an existing or expired NTIOL category but also offers an additional, new technological characteristic for which a new category is being sought that is distinguishable from the class-defining characteristic of an active or expired class, the lens should be eligible for consideration for NTIOL status as long as the characteristic and associated benefit of the active or expired class is not the basis of the request for a new class.

Response: The commenter makes an excellent point. Revised § 416.195(a)(3) does not preclude from consideration as a member of a new class of NTIOL a lens that includes as one of its characteristics a class-defining characteristic associated with members of an active or expired class. Only if that shared characteristic were the predominant characteristic of the lens would it be precluded from approval as a new class of NTIOL. However, if the lens featured other characteristics, one or more of which predominated, that were clearly tied with improved clinical outcomes, the lens would not be disqualified from consideration as an NTIOL just because it also shared a characteristic with members of an active or expired class.

Comment: One commenter recommended that if an IOL's label includes a claim of superiority, that CMS take that into account, but not require having the claim of superiority in FDA-approved labeling. The same commenter disagrees that FDA-approved labeling must include a statement of specific clinical benefits that would be the basis of an NTIOL request. A second commenter took the opposite position and commended CMS for requiring a copy of the labeling claims approved by the FDA for the IOL. The second commenter believed that this requirement (§ 416.195(a)(2)) is at the heart of an NTIOL application and that the FDA claims are of paramount importance in determining whether a lens is worthy of NTIOL status.

Response: We appreciate both commenters points of view. However, we are not persuaded by the first commenter's arguments that FDA approval of claims made in the labeling for the IOL is of incidental significance. Therefore, we are not modifying § 416.195(a)(2) as one of the factors that CMS will use to determine whether an IOL qualifies for a payment adjustment as a member of a new class of NTIOL when furnished at an ASC.

In the proposed rule, we sought public comments on the desirability of further interpreting the phrase ''currently available lenses'' for purposes of comparison and specific approaches to providing such clarifications. We believe that further interpretation could be helpful to requestors seeking to provide the most relevant, authoritative evidence concerning the clinical benefits of their lenses in comparison with those currently available lenses and to us as we review the information provided in requests to establish new NTIOL classes. However, we also believe that any clarifications should incorporate our expectations for technological progression of the baseline comparison lenses over time as we make future annual determinations regarding the establishment of new NTIOL classes. Therefore, we believe that the public comments regarding practical and meaningful approaches to elaborating on the phrase ''currently available lenses'' would facilitate both requestors' submission of complete requests for review and appropriate determinations by CMS regarding new NTIOL classes to receive the ASC payment adjustment.

Comment: Several commenters presented thoughtful, illuminating discussions of what might constitute the ''currently available lenses'' with which a candidate NTIOL would be compared. A couple of commenters suggested establishing a threshold of sales in the market to delineate currently available lenses. Other suggestions for ascertaining benchmark lenses included solicitation of comments from the ophthalmic medical community and IOL industry, and consideration of whether the class-defining characteristic of IOLs in an active or expired NTIOL class has become a medically-accepted baseline technology upon which future technologies will be added. One commenter suggested that the best approach to addressing the questions we posed in the proposed rule would be through a Town Hall meeting or other forum that would bring stakeholders and CMS staff together to further deliberate on the process of how to determine whether a lens qualifies for NTIOL status and the appropriateness of a payment adjustment for such lenses. Most commenters who addressed this issue recommended that CMS not attempt to define ''currently available lenses'' with too much specificity. These commenters stressed that it was important for CMS to maintain sufficient flexibility to account for evolving IOL standards and to allow a variety of appropriate lenses to serve as relevant benchmarks. One commenter noted that while foldable spherical monofocal IOLs represent the current state-of-the-art against which candidate NTIOLs ought to be compared at this time, future advances would create new standards and require flexibility on the part of CMS. Another commenter asserted that, in general, the next IOL technological advancement worthy of NTIOL status should build upon the state of technology that is current at the time. The same commenter further recommended that CMS, in addition to being flexible, consider each request for NTIOL review on an individual, case-by-case basis.

Response: We appreciate commenters taking the time to formulate and communicate their views regarding the notion of ''currently available lenses.'' A number of thought-provoking suggestions were advanced. We agree with commenters that flexibility is critical, and that too much specificity would quickly become outdated by advancing technology. The commenters have presented a number of options for establishing baseline technology that we will carefully consider and evaluate during the course of future review of NTIOL applications. We look forward to continuing to work with stakeholders to ensure that our criteria and the NTIOL process generally are reasonable, are supportive of ongoing development of new IOL technology, and are geared to improved clinical outcomes for Medicare beneficiaries.

In summary, after carefully considering the comments we received regarding the criteria we proposed as factors to be considered to determine whether an IOL qualifies for a payment adjustment as a member of a new class of NTIOL when furnished at an ASC, we are adopting as final, without modification, our proposed revision of § 416.195.

d. Revision of Content of a Request To Review

To enable us to make a determination that the criteria for a payment adjustment for a new NTIOL class are met, we proposed to require that a request include certain specific information, which is listed below. We made this proposal to revise the content of a request, which is currently set forth in § 416.195(a), on the basis of our experience in evaluating applications for OPPS pass-through status for new device categories over the past 6 years. We have found that the additional information allows our medical advisors to complete a more comprehensive evaluation, which would ensure that a payment adjustment is appropriate. We

also have found that such information must be updated in a timely manner to ensure its relevancy to advancing technologies. Therefore, we also proposed to post the information that we require on the CMS Web site at: *http://www.cms.hhs.gov/center/asc/asp* to provide quick and easy access for updating rather than codifying the items required in the application.

In addition, we proposed to require a separate request for each NTIOL for which a payment review as member of a new class is sought. We also proposed to consider a request that does not include all of the following information as incomplete and we proposed not to accept an incomplete request for review until all information is furnished. We proposed to require the following information:

• Proposed name or description of a new class of NTIOLs.

• Trade/brand name, manufacturer, and model number of the IOL for which the request to establish a new NTIOL class is being made. (Applications must include the name and description of at least one marketed IOL that would be placed in the proposed new NTIOL class.)

• A list of all active or expired NTIOL classes that describe similar IOLs. For each active or expired class, provide a detailed explanation as to why that class would not describe the candidate IOL.

• Detailed description of the FDA approved clinical indications for the candidate IOL.

• Description of the IOL—

+ What is it? Provide a complete physical description of the IOL, including its components, for example, its composition; coating or covering; haptics; material; and construction.

+ What does it do?

+ How is it used?

+ What makes it different from other currently available IOLs?

+ What makes it superior to other currently available IOLs used for similar indications?

+ What are its clinical characteristics, for example, is it used for treatment of specific pathology; what is its life span; what are the complications associated with its use; and for what patient populations is it intended?

+ Submit relevant booklets, pamphlets, brochures, product catalogues, price lists, and/or package inserts that further describe and illuminate the nature of the IOL.

• If the candidate IOL replaces or improves upon an existing IOL, identify the trade/brand name and model of the existing IOL(s).

• Full discussion of the clinically meaningful, improved outcomes that result from use of the candidate IOL compared to use of other currently available IOLs. This discussion must include evidence to demonstrate that use of the IOL results in measurable, clinically significant improvement over currently available IOLs in one or more of the following areas:

+ 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; and

++ Decreased blurred vision, glare or other quantifiable symptom or vision deficiency.

• Provide the following information for the IOL(s) for which a new class is proposed:

+ Dates the candidate IOL was first marketed, reporting inside the United States and outside the United States separately.

+ Dates of sale of the first unit of the IOL, reporting inside the United States and outside the United States separately.

+ Number of IOLs that have been sold up to the date of the application.

+ A copy of the FDA's original approval notification.

• A copy of the labeling claims approved by the FDA for the IOL, indicating its clinical advantages and/or the lens characteristics with clinical relevance.

• A copy of the FDA's summary of the IOL's safety and effectiveness.

• Reports of modifications made after the original FDA approval.

We stated in the proposed rule that we strongly encourage and may give greater consideration for the submission of published, peer-reviewed literature and other materials that demonstrate substantial clinical improvement with use of the candidate IOL over use of currently available IOLs.

In our proposed § 416.190(d), we provided that, in order for CMS to invoke the protection allowed under Exemption 4 of the Freedom of Information Act (5 U.S.C. 552(b)(4)) and, with respect to trade secrets, the Trade Secrets Act (18 U.S.C. 1905), the requestor must clearly identify all information that is to be characterized as confidential.

Comment: Several commenters objected to our proposal to post on the CMS Web site the information required in a request for review of a potential new class of NTIOL rather than codifying it. Several commenters expressed concern that lags in Web site updates may compromise an NTIOL sponsor's ability to design and implement requisite studies and generate data that will adequately support timely consideration and approval of an application. Another commenter urged that there be sufficient stability in the requirements so that a manufacturer does not invest several months or years in conducting a comparative clinical study, only to learn when it is ready to submit an NTIOL request that the criteria have changed. Several commenters suggested that requestors have the opportunity to meet with CMS to discuss the study design and application processes to ensure that the agency's demands for documentation of an IOL's benefits are fully understood by applicants and are met upon submission of the application.

Response: We have received hundreds of applications for pass-through payment for devices and drugs and payment for new technology services under the OPPS using a format and process similar to that proposed for NTIOLs. The format for pass-through and new technology requests under the OPPS as well as the details of the application process are posted on the CMS Web site, but they are not codified. As a matter of policy and practice, we are available to meet with anyone with an interest in developing a request for consideration of a new class of NTIOLs at any time, to ensure that our requirements are clear and thoroughly understood by the requestor, and also to give CMS an opportunity to preview a potential applicant for NTIOL status. The application process is an interactive collaboration between CMS and the requestor that continues until CMS has all of the information it needs to be able to make a determination.

We are concerned that commenters may also be confusing the factors that we are implementing in revised § 416.195, which are the criteria that CMS will consider to determine whether an IOL qualifies for a payment adjustment as a member of a new NTIOL class, with the items of information listed in the proposed rule in section XVII.E.2.d of the preamble, which comprise a list of the information that CMS needs in order to determine whether a lens meets the criteria in § 416.195.

Finally, we are confused about commenters' apprehension regarding the potential for research studies being undermined in some manner if the information required for a request for NTIOL eligibility is not codified. The information required for a request for NTIOL eligibility is mostly descriptive and explanatory; it is not information required for a research study.

Comment: One commenter recommended that any information concerning NTIOLs be made available for public review and comment. Another commenter contended that the APA requires that the content requirements for an NTIOL payment request be subject to notice and comment rulemaking and subsequently published in the Code of Federal Regulations and also that any future revisions be subject to notice and comment rulemaking.

Response: We disagree with the commenters' contention that the points of information we proposed to require in a request to review a lens must be enumerated in the Code of Federal Regulations. We note that the information listed in current § 416.195(a)(1) through (5) is included in the list of information in section XVII.E.2.d. of the proposed rule (71 FR 49634). The additional points of information that we proposed to require in section XVII.E.2.d. of the preamble are simply an explicit itemization of ''other information that CMS finds necessary for identification of the IOL'' (see § 416.195(a)(6) of the current regulations). Instead of requiring requestors to use a pre-printed, prescribed application form, we simply list the individual items of information that have to be supplied, which we accept in whatever format the requestor finds most convenient. Moreover, the CY 2007 OPPS proposed rule has provided an opportunity for public comment on the information required in a request for NTIOL consideration. The few comments that we received are addressed below. The criteria for determining whether or not a lens qualifies as belonging to a new class of NTIOL are what require public comment, not the list of information needed to apply the criteria.

Comment: One commenter believed that the mere fact that scientific evidence has been published in a peer-reviewed journal should not impact whether CMS determines the evidence is credible. The commenter further believed that a study that has been accepted or published in a peer-reviewed journal should not be given greater weight simply because it has been published.

Response: We agree with the commenter's assertion that there are a variety of forms in which credible evidence can be presented, in addition to publication in a peer-reviewed journal. We encourage the submission of all credible evidence, published or not. However, we believe that published, peer-reviewed literature has particular value in that it is the product of a rigorous process of thorough scrutiny and standards that are acknowledged and recognized throughout the academic and scientific community.

For reasons stated above, as we proposed, we are revising § 416.190 to reflect the specified changes to the content of a request for payment review of an IOL, to clarify when a request can be submitted and who may submit, and to also clarify the process for maintaining confidentiality of information included in a request. As stated earlier, we are not incorporating the list of information required with each request in the regulations, but are posting it on the CMS Web site to ensure that such information is updated in a timely manner and relevant to advancing IOL technologies. We are revising § 416.190 to require that the content of each request for an IOL review must include all information as specified on the CMS Web site for the request to be considered complete.

e. Notice of CMS Determination

In the CY 2007 OPPS proposed rule, we proposed three possible outcomes from 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 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 proposed to summarize briefly in the ASC final rule the evidence that was reviewed, the public comments, and the basis for our determination. When a new NTIOL class is established, we proposed to identify the predominant characteristic of NTIOLs in that class that sets them apart from other IOLs (including those previously approved as members of other expired or active NTIOL classes) and is associated with improved clinical outcomes. The date of implementation of a payment adjustment in the case of approval of an IOL as a member of a new NTIOL class would be set prospectively as of 30 days after publication of the ASC payment update final rule, consistent with the statutory requirement. The date of implementation of a payment adjustment in the case of approval of a lens as a member of an active NTIOL class would be set prospectively as of the publication date of the ASC payment update final rule.

We received no comments on these proposals. Therefore, we are making final, without modification, the process and timelines that we proposed.

f. 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 proposed rule, we did not propose to revise this payment adjustment for CY 2007.

For CY 2007, we proposed to revise § 416.200(a) through (c) to clarify how the IOL payment adjustment would be made and how a NTIOL would be paid after expiration of the payment adjustment. We also proposed minor editorial changes to § 416.200(d).

Comment: Several commenters expressed concern that the $50 payment adjustment for a new NTIOL class is inadequate, has not been adjusted for inflation since it was initially implemented, and is out of step with the rising costs of innovative research. One commenter objected to a flat $50 adjustment for all NTIOLs on the grounds that research, development and production costs vary from lens to lens. Several commenters recommended that manufacturers be given the opportunity to present a request, supported by appropriate documentation, for a higher payment adjustment for NTIOLs for which it is warranted.

Response: In January 2008, as discussed elsewhere in this final rule with comment period, we plan to implement a significantly revised payment system for ASC facility services, which will affect payment for all ASC services, including payment for IOLs and their insertion and payment for cataract surgery. Only after we have implemented the revised ASC payment system in CY 2008 will we be able to evaluate whether or not the ASC facility fee established for cataract surgery with IOL insertion is appropriate when a lens determined to be an NTIOL is furnished. Therefore, we are retaining for now the current $50 payment adjustment for a new NTIOL class. In addition, we are

adopting as final without modification our proposal to revise § 416.200(a) through (c) to clarify how the IOL payment adjustment will be made and how a NTIOL will be paid after expiration of the payment adjustment; and to make minor editorial changes to § 416.200(d).

In summary, after careful consideration of the public comments we received timely regarding our proposed changes, we are adopting as final without modification, with the exception of a few technical edits, the provisions of proposed new Subpart G under Part 416 to codify the rules governing the ASC payment adjustment for NTIOLs.

G. Announcement of CY 2007 Deadline for Submitting Requests for CMS Review of Appropriateness of ASC Payment for Insertion Following Cataract Surgery of an NTIOL

In accordance with § 416.185(a) of our regulations, as revised by this final rule with comment period, CMS announces that, in order to be considered for payment effective January 1, 2008, requests for a review of an application for a new class of new technology IOLs must be received at CMS by COB, April 1, 2007. 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.*

XVIII. Medicare Contracting Reform Mandate

A. Background

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, amended Title XVIII of the Act to add section 1874A, Contracts with Medicare Administrative Contractors (MACs). Section 1874A of the Act replaces the prior Medicare intermediary and carrier contracting authorities formerly found in sections 1816 and 1842 of the Act, respectively. This reform (commonly referred to as ''Medicare contracting reform'' for Medicare fee-for-service) is intended to improve Medicare's administrative services to beneficiaries and health care providers and to bring standard contracting principles to Medicare, such as competition and performance incentives, which the government has long applied to other Federal programs under the Federal Acquisition Regulation (FAR). For Department of Health and Human Services acquisitions, the FAR is supplemented by the Department of Health and Human Services Acquisition Regulation (HHSAR) at 48 CFR chapter 3. Using competitive procedures, CMS will replace its current claims payment contractors (intermediaries and carriers) with new contract entities, MACs. Section 911(d)(1)(C) of Public Law 108–173 requires that CMS compete and transition all Medicare claims processing workloads to MACs by October 1, 2011.

In accordance with section 911(e) of Public Law 108–173, on or after October 1, 2005, any reference to an ''intermediary'' or ''carrier'' in a regulation shall be deemed a reference to a MAC. The process of transition from intermediaries and carriers to MACs is not a single point-in-time occurrence, but rather necessarily happens over a multiyear period due to the size and nature of the claims workloads involved. Therefore, for the purposes of clarity, the term ''intermediary'' is used throughout this final rule with comment period to describe a Medicare contractor, pursuant to the authority of section 1816 of the Act, that has not yet transitioned to a MAC. In addition, for the purpose of clarity, the term ''carrier'' is used throughout this final rule with comment period to describe a Medicare contractor, pursuant to the authority of section 1842 of the Act, that has not yet transitioned to a MAC.

B. CMS' Vision for Medicare Fee-for-Service and Medicare Administrative Contractors (MAC)

CMS' vision for the Medicare fee-for-service (FFS) program is that of a premier health plan that allows for comprehensive, quality care and world-class beneficiary and provider services. Achieving this vision requires substantial improvement of CMS' current FFS administrative structure. Further information on CMS' plans to improve Medicare FFS may be obtained through the Medicare Contracting Reform Web site: *http://www.cms.hhs.gov/medicarereform/contractingreform/.*

As of November 1, 2006, there are 20 intermediaries and 18 carriers that process FFS claims. Intermediaries process claims for Medicare Parts A and B relating to services furnished by health care facilities, including hospitals and SNFs. Carriers process claims for Medicare Part B, in particular, for physician, laboratory, and other nonfacility services. Four intermediaries serve as regional home health intermediaries (RHHIs) and process Medicare claims for home health services and hospice services. (Section 1816 of the Act was amended in 1977 to allow the Secretary to designate regional or national intermediaries, which we refer to as RHHIs, to process claims for home health services. We have designated these RHHIs to serve both the home health agency (HHA) and the hospice provider communities.) Four Durable Medical Equipment Regional Carriers (DMERCs) process claims for durable medical equipment, prosthetics, and orthotics. For a complete listing of the current Medicare intermediaries and carriers, refer to the CMS Web site: *http://www.cms.hhs.gov/contacts/incardir.asp.*

Although health care delivery in the United States has evolved with advances in modern technology, the contracting authorities relating to the Medicare FFS administrative structure did not substantially evolve between the enactment of the Medicare statute in 1965 and the enactment of Public Law 108–173.

Prior to passage of Public Law 108–173, intermediary and carrier acquisition authorities did not require full and open competition or unified processing of Medicare Part A and Part B claims. Medicare contracting was significantly hampered by absence of competition and cumbersome termination procedures. In an effort to achieve Congress' goal of a more efficient and effective Medicare operation, CMS developed a plan for most current Medicare Part A and Part B intermediary and carrier responsibilities to be integrated into a single contract entity to be administered by a single contractor in each area of the country. These new MACs will handle claims processing and related activities traditionally performed by intermediaries and carriers.

Under Medicare contracting reform, the MACs will perform all the core claims processing operations for both Medicare Part A and Part B. CMS will ensure that MACs focus on providing a high level of customer service to providers and beneficiaries. MACs will be the providers' primary contact with Medicare, and CMS will hold the MACs accountable for overall provider and beneficiary satisfaction and correct claims payment.

With respect to financial management, as was required of intermediaries and carriers, MACs will promote the fiscal integrity of the program and be accountable stewards of the Medicare Trust Fund dollars. The MACs will be required to pay claims

timely, accurately, and in a reliable manner while promoting cost efficiency and the delivery of maximum value to the program.

We recognize the potential for improving the efficiency and effectiveness of services to Medicare beneficiaries and providers through the Medicare contracting reform provisions contained in section 1874A of the Act. Through our implementation of these provisions, we expect to realize significant performance improvements. The future environment is designed to generate substantial savings both from an administrative and programmatic standpoint and will safeguard CMS' mission.

C. Provider Nomination and the Former Medicare Acquisition Authorities

As originally enacted in 1965 and until the enactment of Public Law 108–173, section 1816 of the Act afforded groups or associations and individual providers of services (as defined at section 1861(a) of the Act) the right to nominate (appoint) their intermediary. The intermediary agreements were governed by Medicare laws that diverge from the FAR in a number of important respects. Prior to Public Law 108–173, section 1816 of the Act precluded the Medicare program from competing intermediary functions on a full and open basis. Rather, institutional providers of services, such as hospitals and nursing facilities, nominated a particular intermediary to process and pay their Medicare Part A claims.

In a significant historical development that took place shortly after Medicare's enactment in 1965, the American Hospital Association and other provider trade associations nominated the Blue Cross Association (BCA) to serve as the intermediary for their membership. The BCA merged with the Blue Shield Association in the 1970s to form today's Blue Cross and Blue Shield Association (BCBSA.) CMS and the BCBSA then entered into a prime contract, which continues to currently exist through the annual renewal process. In turn, the BCBSA subcontracted most operational intermediary functions to its member plans. The BCBSA assigned the majority of the nation's hospitals to its local Blue Cross plans. Some providers of services nominated commercial insurers to serve as their intermediaries.

Most recently, section 911(b) of Public Law 108–173 amended section 1816 of the Act to remove the provider nomination authority. The section has been renamed: ''Provisions Relating to the Administration of Part A.'' Section 1816(a) of the Act, which authorized providers to select a contractor to perform claims payment and audit functions, has been amended. It now contains one sentence mandating the use of contracts with MACs to administer section 1816 of the Act. Sections 1816(e), (f), and (g) of the Act, which authorized the Secretary to develop standards, criteria, and procedures for the assignment of providers to intermediaries and to reassign providers periodically, have been repealed.

Section 911(d) of Public Law 108–173 permits the Secretary to transition the current intermediary and carrier functions to the MACs. More information about CMS' plans to implement Medicare contracting reform, including the Report to the Congress on this subject, can be obtained at the CMS Web site: *http://www.cms.hhs.gov/medicarereform/contractingreform/*. MACs will perform all core claims processing operations for both Medicare Part A and Part B. The Part A and Part B MACs will operate in distinct, nonoverlapping geographic jurisdictions, which will form the basis of the Medicare claims processing operations. A transitional period runs between October 1, 2005, and October 1, 2011. During this period, any existing intermediary and carrier contracts could be maintained until replaced by a MAC contract. The statute requires that all intermediary and carrier contracts are to be competed and awarded as MAC contracts by October 1, 2011.

D. Summary of Changes Made to Section 1816 of the Act

Substantial changes to section 1816 of the Act that were required by sections 911(b) and 911(c) of Public Law 108–173 took effect on October 1, 2005. The changes that we proposed and are finalizing in this final rule with comment period to the regulations under 42 CFR Part 421, Subpart B (discussed under section XVIII.E. of this preamble) are intended to conform the regulations to these statutory changes.

Prior to the statutory developments directed by Public Law 108–173, section 1816 of the Act provided the foundation acquisition authority for agreements between CMS, acting for the Secretary, and intermediaries, for the purpose of administering benefits under Medicare Part A and making payments to providers of services.

In particular, section 1816(a) of the Act formerly gave groups and associations of providers of services (which, under section 1861(u) of the Act, includes hospitals, CAHs, SNFs, CORFs, HHAs, hospices, and, for the purposes of sections 1814(g) and 1835(e) of the Act, funds) the power to nominate their servicing intermediary to determine and make Medicare payments to their members. Under this provision, an intermediary could be a ''national, state, or other public or private agency or organization.'' As previously stated, under this provision, the American Hospital Association nominated the national Blue Cross Association to serve as the prime Medicare intermediary for its membership in 1965, an arrangement that will continue to exist until full implementation of MACs.

Moreover, prior to the enactment of Public Law 108–173, section 1816(d) of the Act allowed individual providers and groups of providers to—

- Part with their group or association and nominate another entity to serve as their intermediary; and
- Withdraw its/their nomination from an intermediary, and obtain services from another intermediary that had an agreement with the Secretary.

Finally, section 1816(e) of the Act, as it formerly read, specified the substantial procedural requirements to be followed by the Secretary in the event that the Secretary desired to assign or reassign individual providers of services to any intermediary other than the nominated entity. This provision also gave limited authority to the Secretary to designate a regional or national intermediary for a particular ''class'' of providers of services. However, this authority was subject to substantial procedural requirements. Among these procedural requirements were:

- The Secretary had to promulgate standards, criteria, and procedures for evaluating the performance of intermediaries under section 1816(f) of the Act;
- The Secretary had to make a finding, after applying such standards, criteria, and procedures, that the reassignment of the individual provider and/or the designation of the regional or national intermediary would result in more efficient and effective administration of the Medicare program;
- The Secretary had to provide a full explanation of the reasons for determining that the intermediary change would result in more efficient and effective administration; and
- Affected agencies and organizations were given the right to a hearing, and any determinations of the Secretary on nominations and provider assignments were subject to judicial review.

In the former sections 1816(e)(4) and 1816(e)(5) of the Act, the Secretary was given authority to establish regional intermediaries with respect to HHAs and hospice providers, although certain

procedural requirements still had to be met.

In summary, while, under section 1816 of the Act, the Secretary was not required to accept all Medicare intermediary nominations, the Secretary had no independent authority to contract with any entity for Medicare intermediary services outside the nomination process. Moreover, while providers of services were given the opportunity to seek a reassignment to a new intermediary, the Secretary could not assign or reassign individual providers or classes of providers unless substantial procedural requirements were followed.

The existing Medicare regulations under 42 CFR Part 421, particularly those within Subparts A and B, were substantially shaped by this statutory framework relating to provider nominations and the assignment or reassignment of providers of services to intermediaries. In particular, the following regulatory provisions have their basis in the statutory provisions of sections 1816(a), (d), and (e) of the Act (all are located within 42 CFR Part 421):

- § 421.1(c), which discusses criteria to be used in assigning and reassigning providers;
- § 421.3, which provides exceptions to definitions to accommodate the designation of regional intermediaries for HHAs and intermediaries for hospices;
- § 421.103, which identifies options available to providers for receiving Medicare payments;
- § 421.104, which provides the procedural framework governing the administration of provider nominations for intermediaries;
- § 421.105, which obligates CMS to provide notice as to its action on nominations;
- § 421.106, which specifies the process to be used by a provider desiring a change of intermediary;
- § 421.112, which provides the considerations to be taken into account by CMS when, among other things, it desires to assign or reassign a provider to an intermediary or designate a regional or national intermediary for a class of providers;
- § 421.114, which governs the assignment or reassignment of individual providers;
- § 421.116, which specifies the requirements for designating national or regional intermediaries consistent with sections 1816(e)(1) through (e)(3) of the Act; and
- § 421.117, which specifies the parameters for assigning HHAs and hospice providers to regional intermediaries consistent with sections 1816(e)(4) and (e)(5) of the Act.

In addition to the provisions discussed above that relate to provider nominations, prior to the enactment of Public Law 108–173, section 1816 of the Act also contained other provisions governing agreements with Medicare intermediaries that were not consistent with the mainstream of Federal acquisition and procurement authorities, as this mainstream is reflected in the FAR. For instance—

- Section 1816(b) of the Act contains provisions that limited payment under all intermediary agreements to a cost-reimbursement basis only;
- Section 1816(f) of the Act required the Secretary to publish the performance criteria and standards for intermediary agreements in the **Federal Register**, and specified requirements relating to the application of such criteria and standards; and
- Section 1816(g) afforded intermediaries the right to terminate their agreements with CMS, but limited the right of the Secretary to terminate an agreement; in particular, no provision was made for the normal right of the government to terminate for convenience.

In section 911(b) of Public Law 108–173, Congress reiterated the requirement that CMS begin to move beyond the legacy nomination-based intermediary agreements during FY 2006. This was done by repealing outright or substantially modifying many of the provisions of section 1816 of the Act, effective October 1, 2005. In particular, section 911(b) of Public Law 108–173—

- Repealed the prior language of section 1816(a) of the Act, including the basic provider nomination provision, and replaced it with a statement indicating that Medicare Part A administrative functions would be contracted through section 1874A of the Act;
- Repealed section 1816(b) of the Act in full, including its provisions limiting payment to cost reimbursement;
- Repealed the contract-related provisions of section 1816(c) of the Act;
- Repealed sections 1816(d), (e), (f), (g), (h), (i), and (l) of the Act; and
- Made conforming changes to sections 1816(c), (j), and (k) of the Act.

With these changes, section 1816 of the Act is no longer an acquisition authority, and there is no vestige of the former provider nomination provisions or the partial exceptions to those provisions relating to HHAs and hospice providers.

While section 911(d)(1)(B) of Public Law 108–173 allows the Secretary to continue intermediary and carrier contracts in effect prior to October 1, 2005, under their terms and conditions until October 1, 2011, there was no similar extension for existing nomination arrangements. Section 911(d)(2)(A) of Public Law 108–173 provides the Secretary with authority to enter into intermediary agreements outside of the provider nomination process starting with the date of enactment of Public Law 108–173 (December 8, 2003). Therefore, while Congress specified that the Secretary should submit a plan for implementing section 911 at the start of FY 2005, the Secretary was authorized to contract outside of the section 1816 nomination provisions immediately and in advance of delivery of the report to Congress. This analysis requires that similar, conforming changes be made in our regulations as set forth in the proposed rule and as finalized in this final rule with comment period.

E. Provisions of the Proposed and Final Regulations

As discussed under section XVIII.A. of this preamble, based on the authority provided in sections 1874A(a) through (d) of the Act, as established by section 911(a)(1) of Public Law 108–173, we are finalizing our proposed rules to establish regulations pertaining to MACs in a new Subpart E of 42 CFR Part 421. Moreover, based on the substantial changes to section 1816 of the Act, including the repeal of all of the section 1816 provisions relating to the ability of providers to nominate their servicing intermediary, as enacted by section 911(b) of Public Law 108–173, we also are making a number of changes to Subparts A and B of 42 CFR Part 421. In addition, we are changing the title of Part 421 from ''Intermediaries and Carriers'' to ''Medicare Contracting'' and making conforming revisions to Subpart B of Part 421.

As discussed earlier, section 911(b) of Public Law 108–173 either repealed outright or substantially modified sections 1816(a), (b), (c), (d), (e), (f), (g), (h), (i), and (l) of the Act, and made clear that the acquisition authority for Part A claims processing would, after October 1, 2005, be found in section 1874A of the Act. Among all these changes, each of the former ''provider nomination'' provisions within section 1816 of the Act was repealed. In addition, section 911(d)(2)(A) of Public Law 108–173 gave the Secretary authority to disregard the provider nomination provisions in this contracting, even prior to October 1, 2005. In accordance with these statutory changes, we are finalizing our proposal to substantially modify or delete §§ 421.1(c), 421.3, 421.103, 421.104,

421.105, 421.106, 421.112, 421.114, 421.116, and 421.117 of the regulations.

As discussed earlier, the amendment to title XVIII of the Act (to allow for the new section 1874A: ''Contracts with Medicare Administrative Contractors'') requires CMS to contract with eligible entities to perform Medicare functions using the FAR. We are adding regulations pertaining to MAC contracts in a new subpart E (Medicare Administrative Contractors) under Part 421 as follows: § 421.400 (Basis and scope), § 421.401 (Definitions), and § 421.404 (Assignment of providers and suppliers to MACs).

1. Definitions

As we proposed under proposed § 421.401, in this final rule with comment period, we are defining a ''Medicare administrative contractor (MAC)'' as an agency, organization, or other person with a contract to perform any or all of the functions set forth under section 1874A of the Act. With respect to the performance of a particular function in relation to an individual entitled to benefits under Medicare Part A or enrolled under Medicare Part B, or both, or a specific provider of services or supplier (or class of such providers of services or suppliers), we are defining an ''appropriate MAC'' as a MAC that has a contract to perform a Medicare administrative function in relation to a particular individual, provider of services, or supplier, or a particular class of providers.

2. Assignment of Providers and Suppliers to MACs

As we proposed, in this final rule with comment period, we are establishing a new § 421.404 to incorporate the rules governing the processing of claims submitted by providers and suppliers that enroll with and receive Medicare payment and other Medicare services. As a general rule, Medicare providers and suppliers will be assigned to the MAC that is contracted to administer the types of services (benefits) billed by the provider or supplier within the geographic locale in which the provider or supplier is physically located or furnishes health care services, respectively. One significant exception to this general rule pertains to suppliers of durable medical equipment, prosthetics, orthotics, and supplies. These suppliers will bill the MAC covering the area where the beneficiary resides—a continuation of existing policy.

In the past, under the provider nomination provisions that were repealed by section 911 of Public Law 108–173, CMS had considered (and occasionally approved) requests from certain classes of institutional providers covered by these section 1816 provisions, primarily, hospitals, SNFs, and CAHs, to bill an intermediary other than the one servicing providers in the geographic locale of the provider. The process and criteria for making these determinations are set forth in detail in the existing regulations under 42 CFR Part 421, Subpart B (which we are removing in accordance with the changes effectuated by section 911(b) of Public Law 108–173).

In particular, not automatically but on a fairly frequent basis, CMS approved requests from large multi-State groups of such providers under common ownership and control, called ''chain providers,'' to bill a single intermediary on behalf of all the individual providers in the chain through the headquarters office, or ''home office,'' of the chain provider. These chain providers were granted ''single intermediary'' status.

The premise behind granting privileges to bill a single intermediary to such large multi-State chain providers was that this might reduce administrative billing expenses for the chain and reduce the administrative expenses of the Medicare program. In particular, assigning a large multi-State chain provider to a single intermediary facilitated the Medicare cost report audit and reimbursement functions, because findings with respect to the cost report of the chain's home office could affect the individual provider's cost report. Otherwise, these audit and reimbursement issues would need to be coordinated among multiple intermediaries.

In addition to applying the relevant regulatory requirements in 42 CFR Part 421, Subpart B in our review of chain provider requests for single intermediary status, we applied additional criteria to focus our analysis and to ensure that the exception to our normal practice of assigning providers to their ''local'' intermediary was warranted. We advised the chain provider that it would have to demonstrate that having a single intermediary would be consistent with efficient and effective administration of the Medicare program, and that the intermediary would need to have sufficient capacity to effectively serve the chain (these elements were restatements of the regulatory criteria). In addition, we required the chain to meet the following requirements:

- Size—The provider chain had to be comprised of 10 participating facilities or 500 certified beds, or 5 facilities or 300 certified beds spread across 3 or more contiguous States.
- Central Controls—The provider chain had to demonstrate that it exercised central controls, assuring substantial uniformity in operating procedures, utilization controls, personnel administration, and fiscal operations among the individual providers.

The administrative efficiencies gained by both the large multi-State chain providers and the Medicare program by allowing single intermediary relationships to exist may not be as significant as they were formerly. Prior to the implementation of the Administration Simplification provisions of Part C of Title XI of the Act, the various intermediaries required providers to use somewhat divergent transaction and formatting standards in their electronic claims processing systems. A provider chain with centralized billing processes could make a good business case that it should be permitted to bill only one intermediary. Moreover, prior to the implementation of the many prospective payment systems required by the Balanced Budget Act of 1997 and subsequent public laws, a greater percentage of Medicare program payments hinged on the Medicare cost report audit and reimbursement process. In such an environment, there was potential benefit to both a chain provider and the government to minimize coordination issues. Finally, the former Medicare environment involved many intermediaries, so there were naturally more geographic boundaries among contractors that a multi-State chain could cross.

We understand the provisions of section 1874A of the Act and, more particularly, the revisions to section 1816 of the Act made by section 911(b) of Public Law 108–173 to authorize the Secretary to assign all providers and suppliers, even the members of multi-State entities, to the geographically based MACs based on their physical location. This action is consistent with CMS' vision, as articulated in the Secretary's Report to Congress on Medicare Contracting, of establishing a claims processing environment where most Medicare Part A and Part B claims involving a particular beneficiary are administered by the same contractor.

However, as indicated in that Report (page V–4), we recognize that there may still be some legitimate business value to allowing large multi-State chains of providers that formerly were able to nominate their intermediary to bill on a consolidated basis to one MAC. While section 911(d)(1)(C) of Public Law 108–

173 abolished the former provider nomination framework, we believe that allowing the practice of consolidated billing by large chains is within the discretion of the Secretary under section 911 of Public Law 108–173. Accordingly, in this final rule with comment period, we are finalizing our proposal under § 421.404 that—

- Providers (as defined in 42 CFR 400.202) will generally be assigned to the MAC with claims processing jurisdiction over the geographic locale in which the provider is physically located.
- Large chain providers comprised of individual providers that were formerly permitted by CMS to ''nominate'' an intermediary, which we refer to as ''qualified chain providers,'' will be permitted to request opportunity to consolidate their Medicare billing activities to the MAC with jurisdiction over the geographic locale in which the chain's home office is located.
- Qualified chain providers that were formerly granted single intermediary status do not need to re-request such privileges on behalf of the entire chain.
- CMS may grant other exceptions to the general rule for assigning providers to MACs, but only based on a finding that such an exception will support the implementation of the MACs or if CMS deems the exception to be in the compelling interest of the Medicare program.

We are incorporating a definition of ''qualified chain provider.'' The criteria that constitute the definition of a ''qualified chain provider'' mirror the elements that were historically applied. We believe these are appropriate criteria to employ in reviewing whether a chain provider should even be considered for consolidated billing. Less stringent criteria would clearly cut against the statutory mandate to establish MACs and end the provider nomination process. More stringent criteria might disrupt the operations of many entities that formerly were approved for single intermediary handling under the old criteria.

Smaller chains of otherwise eligible providers (for example, hospitals, SNFs, and CAHs) might also desire consolidated billing, as well as other types of providers (for example, HHAs and hospices). In the latter case, the other types of providers (termed ''ineligible providers'' in this final rule with comment period) did not have the opportunity to request assignment to (nominate) a particular intermediary prior to October 1, 2005. In some cases, these other types of providers were assigned to regional intermediaries based on a nexus of statutory and administrative actions. In other cases, assignments were made through administrative action. In the case of smaller chains of otherwise eligible providers, we note that section 911(d)(1)(C) of Public Law 108–173 abolished the provider nomination framework and appears to us to anticipate the use of regional contractors.

We believe that our establishment of MACs that, in most cases, will administer claims from multiple States will largely resolve the concerns these other providers may have. Under our approach, for instance, we believe that few chain providers will have to bill more than two MACs even if they fail to meet the tests for being a ''qualified chain provider.''

Finally, with respect to suppliers (as also defined in 42 CFR 400.202 of our regulations), we are assigning suppliers (including physicians and nonphysician practitioners) to MACs based on the geographic jurisdiction in which they operate and furnish services. These requirements mirror the various Part B claims jurisdiction rules that have been in place. CMS may grant an exception to this policy only if CMS finds the exception will support the implementation of MACs or will serve some compelling interest of the Medicare program. However, we do incorporate the current special billing requirements relating to DMEPOS suppliers in § 421.210 and § 421.212.

We indicated in the proposed rule that as we move forward to implement MAC contracting in keeping with the statutory mandate of section 911 of Public Law 108–173 and the Secretary's Report to Congress, we were inviting public comments on these specified issues, including our proposed definitions and criteria. (Once the MACs are initially implemented, we indicated that we may propose more stringent criteria for consolidated billing status, in keeping with the overall thrust of section 911 of Public Law 108–173.)

Comment: One commenter supported the approach CMS is taking to consolidate the Medicare Part A and Part B claims processing functions into one MAC covering several States. The commenter was encouraged that this consolidation will promote greater consistency across geographic regions. The commenter requested that CMS instruct MACs to review local coverage determinations (LCDs) and other policies to ensure consistency in coverage between settings of care and to align payment policy and incentives between physicians and hospitals.

Response: As is our current practice, MACs will be required to develop LCDs in accordance with Chapter 13 of the CMS Program Integrity Manual. As the MACs commence operations in their jurisdictions, each MAC will consolidate all of the LCDs for its jurisdiction. CMS will continue to issue national coverage determinations (NCDs).

Comment: Several commenters share the commitment of CMS to implement the Medicare contracting reform provisions that are mandated by section 911 of the MMA. They requested that CMS grant exceptions to the general rule to permit large chain providers to choose an appropriate MAC. They believed that allowing providers to choose their MAC will ensure maximum efficiency. Another commenter asked if a ''large chain'' with ''multiple national offices'' could request that a specific ''chain office'' be used for consolidation to one MAC geographic locale.

Response: As specified in proposed new § 421.404(b)(3), a qualified chain provider approved by CMS to bill a single intermediary on behalf of its member providers prior to October 1, 2005, would be assigned at an appropriate time to the MAC contracted by CMS to administer claims for the applicable Medicare benefit category for the geographic locale in which the chain provider's home office is physically located. The qualified chain provider would not need to request an exception to § 421.404(b)(1). Accordingly, if the commenter's reference is to one ''large,'' previously approved, qualified chain organization, the qualified chain organization would be assigned to the MAC serving the geographic area where the qualified chain organization's home office is located. If the commenter's reference is to several distinct, previously approved, qualified chain organizations that have recently merged, the several distinct legacy chains would have to request status as a single qualified chain organization in accordance with § 421.404(b)(1); and as part of this process, the newly emerged chain organization will be required to establish the location of its home office. If CMS approves the request, the new qualified chain organization will bill and receive Medicare payment from the MAC that covers the geographic locale in which the qualified chain organization's home office is located.

Comment: Several commenters requested that CMS maintain maximum flexibility for all parties involved in Medicare contracting reform (that is, providers and contractors) during the transitional phases to the MACs. They suggested that CMS allow large chain providers the ability to maintain their existing relationships with

intermediaries until all MAC transitions are complete.

Response: We cannot allow large chain providers to maintain their existing relationships with intermediaries until all MAC transitions are complete because as intermediary functions are transitioned over time to MACs, those intermediaries will no longer be processing claims. Those claims will be processed by the ''replacement'' MAC.

Comment: One commenter requested that CMS provide a mechanism for a chain provider that has facilities in many Medicare Part A and Part B MAC jurisdictions to consolidate into a smaller number of MACs instead of a single MAC in the chain provider's home office jurisdiction.

Response: The policy announced in proposed § 421.404 allows chain providers that meet the requirements for qualified chain organization status to request single MAC billing status on behalf of its member providers. The process for submitting the request, together with the types of documentation the qualified chain organization must submit in support of its request, will be set forth in detail in a future CMS program manual. A chain provider may make the business decision to identify a segment of its organization as a distinct qualified chain organization with a regional management office that will fall appropriately within one MAC jurisdiction. Our current policy does not require that all member providers within the qualified chain organization bill through the chain provider's home office MAC. However, the future CMS program manual may require that a qualified chain organization make clear, in its centralized MAC billing request, the identity of each member provider, and which member providers are included within the request for centralized billing through the home office MAC. The future CMS program manual may require each such requesting qualified chain organization, if approved, to maintain that centralized billing configuration until a request for another change is approved by CMS.

Comment: Several commenters asked if an existing chain hospital that is in a jurisdiction that is transitioning to a MAC, but the existing chain provider's home office is not in that jurisdiction, will be allowed to continue to bill the intermediary it has been using, or must it transition to the contracted MAC in its jurisdiction. The commenters also wanted to know whether a chain organization may convert to a single MAC to avoid the need for multiple transitions.

Response: Up until the date a MAC commences operations in the jurisdiction where the existing chain provider's home office is located, the existing chain provider will be served by the current intermediary serving the State in which the existing chain provider's home office is located, provided the current intermediary does not end its contract prior to the time that the new MAC commences operations. Current intermediaries and carriers will complete their contract obligations, including serving the existing chain provider's home offices. In the event that the servicing intermediary does choose to end its contract, CMS will apply § 421.104 in reassigning the existing chain provider to another CMS contractor. Our overriding goal is to ensure continuity of operations during the period of time current contractors are transitioning to MACs.

Comment: One commenter asked CMS to allow a qualified chain organization to select either the MAC that covers the jurisdiction where its home office is located, or another MAC that covers the jurisdiction where the chain's billing office is located (if different), when deciding to consolidate Medicare billing activities.

Response: For the reasons set forth in the preamble to the proposed rule, it is CMS' policy that each qualified chain organization may request permission from CMS to bill centrally to one MAC. Further, our requirement is that the qualified chain organization must bill the MAC responsible for the geographic area where the qualified chain provider's home office is located. At this time, we will not allow the qualified chain organization to bill based on the location of its billing office (if different). Our policy protects the Medicare program against chain providers that might seek less restrictive MACs by relocating their billing offices. The process for submitting the request, together with the types of documentation the qualified chain organization must submit in support of its request, will be set forth in detail in a future CMS program manual. As we gain experience with the MAC environment, we may broaden the centralized billing alternatives to support options suggested by the commenter.

Comment: Several commenters requested that CMS have a clear notification and a transition process for notifying providers of potential reassignments deemed necessary by the Agency. They requested that a full explanation be given for the reasons for determining that the change would result in a more efficient and effective administration of services.

Response: We will ensure that providers affected by a transition from a legacy Medicare contractor to a MAC are notified in advance of the transition. This will be a significant activity within the implementation plan for each MAC as the MAC and the provider will need to work together on a number of issues (for example, test electronic billing arrangements). We have substantial experience in overseeing Medicare claims transitions and have refined these processes over many years. The reasons for the transition to MACs were set forth in the preamble to the rule.

Comment: Several commenters requested that CMS consider the potential impact on providers of delayed claims processing during the implementation of the Medicare contracting reform provisions under section 911 of the MMA.

Response: We note that Medicare claims processing timeframes are set elsewhere in statute and CMS' program requirements will not be affected by the transition to MACs. We will review all MAC contract proposals to verify that companies desiring to serve as MACs can meet these requirements, and we will closely monitor all transitions to ensure that strong program performance is maintained.

Comment: One commenter commended CMS for requiring MACs to pay claims timely. However, the commenter strongly requested that CMS not allow a MAC to move to a less frequent payment schedule, believing that Medicare claims volumes continue to warrant the most frequent payment schedule. The commenter also urged CMS to consider the ability and availability of the MAC to meet the needs of the providers assigned to the MAC. The commenter believed the MAC should be available during a provider's normal business hours, regardless of the provider's location within the MAC jurisdiction.

Response: The commenter raised issues that are outside the scope of the proposed rule. In this final rule with comment period, we are not responding to those comments. We note that Medicare claims processing timeframes are set elsewhere in statute and will not be affected by the transition to MACs. We will review the other comments and consider whether to take other actions, such as revising or clarifying the MAC contracts or CMS' operating instructions or procedures, based on the information or recommendations provided in the comments.

Comment: Several commenters had concerns that newly appointed MACs

may not have the expertise or familiarity needed to process specialized claims such as those for end stage renal disease (ESRD).

Response: These commenters raised issues that are outside the scope of the proposed rule. In this final rule with comment period, we are not responding to those comments. We note that we are requiring MACs that will administer specialized workloads to demonstrate their capability to do so in their contract proposals.

Comment: Several commenters requested that CMS allow ESRD providers the option of having their claims handled by multi-state, regional MACs.

Response: All of the MACs will serve multi-state areas, for example one will serve New York and Connecticut. ESRD suppliers will generally be assigned to MACs based on § 421.404(c)(1). However, a group of ESRD suppliers under common control and common ownership may obtain a § 421.404(c)(3) exception if CMS finds the request for centralized billing through the home office MAC will support the implementation of MACs or will serve some other compelling interest of the Medicare program, or both.

Comment: One commenter cautioned that if a chain were to consolidate to just one MAC, there is the potential for an excessive workload for a MAC that may have in its jurisdiction many home offices for large chain organizations.

Response: We believe that the MACs will be fully capable of administering their chains' workload, but we will monitor the concentration of qualified chain organization claims across the 15 Medicare Part A and Part B MACs.

Comment: One commenter recommended that CMS permit all of a qualified chain organization's member providers within a particular area to bill their local, geographically assigned MACs, even if the remainder of the qualified chain organization has requested and been approved for centralized, home office MAC billing. The commenter believed that some local MACs may be better suited to serve a chain's providers because LCDs vary across jurisdictions. Specifically, the commenter was concerned about a scenario where the home office MAC's LCD policy might not cover a hospitalization, even were the local MAC's policies might allow a physician to bill under the same clinical circumstances. The commenter stated that the typical chain often operates a variety of providers and suppliers such as hospitals, freestanding imaging centers, and physician offices.

Response: During the post-award/pre-commencement period, as an intermediary or carrier transitions to the selected MAC, the selected MAC's medical director will consolidate all the LCDs for the States in the MAC's jurisdiction by identifying and implementing the least restrictive LCD. This process will alleviate a certain percentage of LCD conflict across States. However, a given MAC will apply only the LCDs in force in its own jurisdiction. MACs will not be required to apply the LCDs of other MACs.

The choice to request centralized, home office billing is a business decision for each qualified chain provider to weigh. We are providing this option under § 421.404(b)(2) of the regulations, but are not mandating that chains avail themselves of it. We will not routinely provide alternatives (other than the general alternative provided by § 421.404(b)(1)) because doing so is not generally in CMS' administrative interest and could devolve to the former ''provider nomination'' environment.

We note that moving from 20 intermediaries and 18 carriers to 15 Medicare Part A and Part B MACs has been widely received as a step in the right direction by most segments of the Medicare provider community and a substantial accomplishment to support the contracting reform goal of improving the efficiency and effectiveness of delivering services to Medicare beneficiaries and providers.

Comment: One commenter requested clarification of CMS policy on how often qualified chain organization member providers can move in and out of centralized billing status. The commenter stated that chains frequently change in size and scope of operations, such as the establishment of a regional central billing office, and determine that it is more efficient to change the billing status for all or some member providers. The commenter suggested the status change be permitted each fiscal year with a minimum required notice of 120 days before the start of the next home office cost reporting period.

Response: We appreciate the industry's input on workable notice requirements. This is a policy detail we will address in the future CMS program manual. However, we wish to point out that no provider will be allowed to centralize (or decentralize) its billing without CMS approval, and we do not anticipate allowing chains to change their process frequently. There is a cost to the Medicare Program associated with moving providers from one contractor to another, and the lead time required will be more than 120 days in many cases.

Comment: Several commenters recommended that CMS allow companies with more than one legal entity, and currently assigned to a single intermediary, to continue to bill centrally. They also recommended that CMS allow companies with more than one legal entity to apply for single MAC status.

Response: Existing chain providers, including those with more than one legal entity, assigned to a single intermediary prior to October 1, 2005, will be assigned to a single MAC at an appropriate time in accordance with § 421.404(b)(3). If a chain provider with more than one legal entity, that is assigned to a single MAC, subsequently comes to CMS with a request to change the MAC assignment for one of the legal entities because of a change in the corporate structure of the overall chain, such as spinning off a downstream affiliate, then CMS may require the entire chain to reapply for single MAC status, applying the then-current CMS qualified chain organization program manual.

Comment: One commenter recommended that CMS expand the field of § 421.404(a) ''eligible providers'' that are entitled to be counted among the qualified chain provider's members. The commenter argued that allowing otherwise ineligible providers to join in centralized billing status would facilitate integration of important functions such as coverage rules, provider education, and support for beneficiaries.

Response: The group of ''eligible providers'' under § 421.404(a) was established by reference to the provider types that have traditionally been eligible to consolidate their billing. At this time, we do not intend to extend centralized billing beyond these provider types. However, we believe that § 421.404(b)(4) provides CMS the discretion to make exceptions if circumstances warrant.

Comment: Several commenters requested that CMS clarify what is meant by the term ''best interest of the program''.

Response: ''Best interest of the program'' means that which the responsible CMS personnel (acting in their official capacity, or capacities) determine on a nonarbitrary and noncapricious basis, using reasonable judgment and information known to them, to be most advantageous to the Medicare program. In making such a determination, CMS personnel may balance competing factors and options. The factors considered may change over time; for instance, as the Medicare program's requirements change,

technology evolves, and the MACs are implemented.

Comment: One commenter offered input on the MAC procurement process and asked CMS to consider certain performance-related information in the awarding of a future MAC contract. Several commenters requested that CMS include providers in the contractor selection and renewal process. They requested CMS to allow providers to give mid-contract reviews of the MACs' performance. One commenter requested that CMS ensure that MACs are required to maintain a significant local presence inasmuch as each jurisdiction includes several States.

Response: These commenters raised issues that are outside the scope of the provisions of the proposed rule. In this final rule with comment period, we are not responding to those comments. However, we will review the comments and consider whether to take other actions, such as revising or clarifying the MAC contracts or the CMS operating instructions or procedures that are issued, based on the information or recommendations provided in the comments. We note that the Medicare contracting reform statute requires us to measure providers' satisfaction with the MACs, and that we will be periodically surveying providers for this information.

Comment: One commenter made an individual-case-specific request. One of its ''health care systems'' supposedly was granted centralized billing privileges by CMS but the transition to a single intermediary was never completed for various reasons. The commenter asked CMS to complete the centralized billing transition through the finalization of this rule.

Response: Through a series of ''Medlearn Matters'' articles published on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/2005MMA/List.asp#TopOfPage* and distributed via Listserves and communications with CMS components and affiliated contractors in September and October of 2005, CMS notified the Medicare community that no requests for provider nomination would be accepted beyond October 1, 2005. The public comment and response process connected with a notice of proposed rulemaking is not the forum in which the Agency treats case-specific requests for qualified chain provider or centralized billing status. Chain organizations that have experienced a delay in conversion to centralized billing in connection with a pre-October 1, 2005 CMS decision to authorize centralized billing should contact the CMS component where the original request was made and provide documentation of CMS authorization for centralized billing. Without the proper documentation, a qualified chain organization must wait for CMS to open the period for single-MAC billing status. A forthcoming program manual that outlines the process for such requests will provide the appropriate instructions.

After considering the public comments received, we are adopting as final, without modification, the proposed provisions of Subpart E of 42 CFR Part 421 (§§ 421.400, 421.401, and 421.404) governing MACs.

3. Other Technical and Conforming Changes

a. Definition of ''Intermediary'' (§ 421.3)

We did not receive any public comments on our proposal to revise the definition of the term ''intermediary'' under existing § 421.3 to delete reference to ''alternative regional intermediaries,'' and, therefore, are finalizing it in this final rule with comment period. CMS no longer allows HHAs and hospice care providers to select an alternative regional intermediary. Over the years, as the number of intermediaries in the program has decreased, the availability of alternative intermediaries for HHAs and hospices has declined. We have implemented the policy that all HHAs and hospice care facilities are to be assigned to the designated regional intermediary that serves their geographic jurisdiction. This is required for the efficient and effective administration of the Medicare program as the agency moves forward to implement the MACs.

b. Intermediary Functions (§ 421.100)

Section 1816(a) of the Act, which allowed providers to nominate an intermediary, required that only nominated intermediaries perform the functions of determining payment amounts and making payments to providers. Section 1874A of the Act, as added by section 911 of Public Law 108–173, eliminates the intermediary nomination process. All activities carried out under intermediary agreements will be transitioned to MAC contracts by September 30, 2011.

During the transition period, CMS will still require regulations to support its intermediary agreements. In the proposed rule, we proposed to amend § 421.100, concerning functions to be included in intermediary agreements, to address the dual intermediary responsibilities. We also proposed to revise existing § 421.100(i), Dual intermediary responsibilities, to delete the reference to § 421.117 from this section, as the statutory provision that made this necessary was repealed by Public Law 108–173.

We did not receive any public comments on these proposed technical and conforming changes and, therefore, are finalizing them in this final rule with comment period without modification.

c. Options Available to Providers and CMS (§ 421.103)

As we proposed, we are finalizing our change of the title of § 421.103 to ''Payment to Providers'' and revising the contents of § 421.103 to clarify that all providers must receive payments for covered services furnished to Medicare beneficiaries through an intermediary (under § 421.404) and eventually through a MAC (under § 421.404). We are specifying that this function must remain with the intermediaries. We will no longer allow providers to receive payments directly from CMS, nor will we allow providers to receive payments from alternative regional intermediaries. We believe the inclusion of this function is consistent with the effective and efficient administration of the Medicare program.

We did not receive any public comments on our proposed technical changes.

d. Nomination for Intermediary (§ 421.104)

As we proposed, we are finalizing our change of the title of § 421.104 to ''Assignment of Providers of Services to Intermediaries During Transition to Medicare Administrative Contractors (MACs)'' and revising the contents of the section to provide that new providers that enter the Medicare program during the transition period will be assigned to the local designated intermediary that serves the jurisdiction in which the provider is located. We did not receive any public comments on the proposed technical change. We believe this change is necessary as we prepare to transition from intermediary agreements and carrier contracts to contracts with the MACs. In the MAC environment, providers will be assigned based on their geographic location to the MAC that has jurisdiction for their provider type.

e. Notification of Actions on Nominations, Changes to Another Intermediary or to Direct Payment, and Requirements for Approval of an Agreement (§ 421.105 and § 421.106)

We did not receive any public comments on our proposal to remove

§ 421.105 and § 421.106 from the regulations; the sections will no longer be applicable with implementation of the new Subpart E of Part 421. Therefore, we are finalizing the removal in this final rule with comment period.

f. Considerations Relating to the Effective and Efficient Administration of the Medicare Program (§ 421.112)

We are finalizing our proposal to revise § 421.112 (a). As stated previously in this final rule with comment period, provider requests to be assigned or reassigned to a particular intermediary will no longer be considered. However, we may deem it necessary to reassign providers if we find it is necessary for the efficient and effective administration of the program. In addition, there will no longer be a national intermediary to serve a class of providers.

We did not receive any specific public comments on this technical change.

g. Assignment and Reassignment of Providers by CMS (§ 421.114)

We are finalizing our proposal to revise § 421.114 to specify that we may consider it necessary to assign and reassign providers if the assignment or reassignment is in the best interest of the program. Before making these determinations, we will no longer review provider requests to be reassigned to another intermediary. This is consistent with the proposed policy to eliminate a provider request to change to another intermediary or to direct payment. Under Medicare contracting reform, we require increased flexibility to realign providers to geographical jurisdictions for effective implementation of the MACs. We reserve the right to reassign providers to other jurisdictions if we deem it to be in the best interest of the program.

We did not receive any specific public comments on this proposed technical change.

h. Designation of National or Regional Intermediaries (§ 421.116) and Designation of Regional and Alternative Designated Regional Intermediaries for Home Health Agencies and Hospices (§ 421.117)

We are finalizing our proposal to delete § 421.116, Designation of national or regional intermediaries, and § 421.117, Designation of regional and alternative designated regional intermediaries for HHAs and hospices. The statutory provisions that made these regulations necessary were repealed by Public Law 108–173. Therefore, we no longer need these regulations. All providers will receive payment for covered services as described in § 421.103.

We did not receive any public comments on this proposed technical change.

i. Awarding of Experimental Contracts (§ 421.118)

We are finalizing our proposal to delete § 421.118, which specifies the provisions under which CMS may award a fixed price or performance incentive contract under the experimental authority contained in 42 U.S.C. 1395b–1 for performance of intermediary functions under § 421.100. The provisions of this section became obsolete with the enactment of section 911 of Public Law 108–173.

We did not receive any public comments on this proposed technical change.

XIX. Reporting Quality Data for Improved Quality and Costs Under the OPPS

As noted previously, CMS' Office of the Actuary currently projects that Medicare Part B expenditures will continue to grow at a significant rate, as a result of rapid growth in the use of both physician-related services and hospital outpatient services in the original Medicare fee-for-service program. Specifically, the actuaries project that the expenditures under the OPPS in CY 2007 will be approximately $32.540 billion. This represents approximately a 9.2 percent increase over our estimated expenditure of $29.809 billion for the OPPS in CY 2006, and reflects even more rapid spending growth in recent years. As the following table shows, implementation of the OPPS has not slowed outpatient spending growth; in fact, double-digit spending growth has been occurring.

TABLE 52.—GROWTH IN EXPENDITURES UNDER OPPS FROM CY 2001 THROUGH CY 2007 (PROJECTED EXPENDITURES FOR CY 2006 AND CY 2007) IN BILLIONS

OPPS Growth	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007
Incurred Cost	17.702	19.158	20.8102	23.702	26.518	29.809	32.540
Percent Increase	.....	8.2	8.6	13.9	11.9	12.4	9.2

Source: FY 2007 Mid-Session Review, Budget of the U.S. Government.

As we indicated in the CY 2007 OPPS proposed rule, the current rate of growth in expenditures for hospital outpatient services is of great concern to us. 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 primary reason for the current rate of growth in the OPPS, rather than general price or enrollment changes. The table below illustrates the increases in the volume and intensity of outpatient hospital services over the last several years.

TABLE 53.—PERCENT INCREASE IN VOLUME/INTENSITY OF HOSPITAL OUTPATIENT SERVICES

	CY 2002	CY 2003	CY 2004	CY 2005 (Est.)	CY 2006 (Est.)
Percent Increase	3.5	2.4	7.8	7.8	9.7

Source: FY 2007 Mid-Session Review, Budget of the U.S. Government

For outpatient hospital services, the volume and intensity of services for CY 2005 are estimated to continue to increase significantly at a rate of 7.8 percent, in excess of the long-term trend. This increase follows the 7.8 percent increase in CY 2004, and the growth is projected to be 9.7 percent in CY 2006.

As we have stated repeatedly, this rapid growth in utilization of services in

the OPPS shows that Medicare is paying mainly for more services each year, regardless of their quality or impact on beneficiary health. The program should promote higher quality services, so that Medicare spending is directed in the most efficient manner toward higher quality services. Medicare payments should encourage doctors and other providers in their efforts to achieve better health outcomes for Medicare beneficiaries at a lower cost. Therefore, we have been examining the concept of ''value-based purchasing'' in a number of payment systems. ''Value-based purchasing'' may use a range of incentives to achieve identified quality and efficiency goals, as a means of promoting better quality of care and more effective resource use in the Medicare payment systems. In developing the concept of value-based purchasing, we have been working closely with stakeholder partners, including health professionals and providers.

In the CY 2007 OPPS proposed rule, we sought public comment on value-based purchasing as related specifically to hospital outpatient departments. As part of our overall goal of promoting value-based purchasing in outpatient payment, we also made one specific proposal for the CY 2007 OPPS.

Section 1833(t)(2)(E) of the statute permits the Secretary to ''establish, in a budget neutral manner, * * * adjustments as determined to be necessary to ensure equitable payments'' under the OPPS. The absence of OPPS measures to promote high quality in the provision of services to Medicare beneficiaries creates an issue of payment equity. In general, payments to providers in Medicare's payment systems do not vary on the basis of quality or efficiency differences among the providers of services. As a result, Medicare's payment systems may direct additional resources to hospitals that deliver care that is not of the highest quality. For that reason, each Medicare dollar spent does not result in the same quality and efficiency of care for Medicare beneficiaries.

We believe that the collection and submission of performance data and the public reporting of comparative information about hospital performance can provide a strong incentive to encourage hospital accountability in general and quality improvement in particular. 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 actual health care delivery. Hospital performance measures may also provide a foundation for performance-based rather than volume-based payments, which are used in the OPPS today.

We have obtained some evidence of the potential for improving quality of care in hospitals by means of the collection and submission of performance data from the Premier Hospital Quality Incentive Demonstration.[1] This demonstration was designed to test whether the quality of inpatient care for Medicare beneficiaries can improve when financial incentives are provided. Under the demonstration, about 270 hospitals of Premier, Inc., a nationwide alliance of not-for-profit hospitals, have been voluntarily providing data on 34 quality measures related to five clinical conditions: heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. Using the quality measures, CMS identifies hospitals with the highest quality performance in each of the five clinical areas. Hospitals scoring in the top 10 percent in each clinical area receive a two percent bonus payment in addition to the regular Medicare DRG payment for the measured condition. Hospitals in the second highest 10 percent receive a one percent bonus payment. In the third year of the demonstration, if hospitals do not achieve absolute improvements above the demonstration's first year composite score baseline (the lowest 20 percent) for that condition, they will have their DRG payments reduced by one or two percent, depending on how far their performance is below the baseline.

Following the first year of the demonstration (FY 2004), CMS awarded a total of $8.85 million to participating hospitals in the top two deciles for each clinical area. In the aggregate, quality of care improved in all five clinical areas that were measured. Preliminary information from the second year of the demonstration indicates that quality is continuing to improve, particularly for the hospitals that were initially poorest performing.[2] We believe that these results indicate that reporting of quality data may in and of itself lead to improved outcomes for Medicare beneficiaries.

Since 2003, we have operated the Hospital Quality Initiative,[3] which is designed to stimulate improvements in inpatient hospital care by standardizing hospital performance measures and data transmission to ensure that all payers, hospitals, and oversight and accrediting entities use the same measures when publicly reporting on hospital performance. Section 501(b) of Public Law 108–173 authorized us to link the collection of data for an initial starter set of 10 quality measures to the hospital IPPS annual payment update. In order to implement this provision, we created the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. For FYs 2005 and 2006, hospitals that met the RHQDAPU program's requirements received the full IPPS annual payment update, while hospitals that did not comply received an update that was reduced by 0.4 percentage points. For FY 2005, virtually every hospital in the country that was eligible to participate submitted data (98.3 percent), and approximately 96 percent of all participating hospitals met the requirements to receive the full update. The data regarding the starter set of 10 quality measures, as well as additional, voluntarily reported data on other quality measures, are available to the public through the Hospital Compare Web site at: *http://www.hospitalcompare.hhs.gov.*

The starter set of 10 quality measures that was established for the IPPS RHQDAPU as of November 1, 2003, are:

Heart Attack (Acute Myocardial Infarction/AMI)

- Was aspirin given to the patient upon arrival to the hospital?
- Was aspirin prescribed when the patient was discharged?
- Was a beta-blocker given to the patient upon arrival to the hospital?
- Was a beta-blocker prescribed when the patient was discharged?
- Was an ACE inhibitor given for the patient with heart failure?

Heart Failure (HF)

- Did the patient get an assessment of his or her heart function?
- Was an ACE inhibitor given to the patient?

Pneumonia (PNE)

- Was an antibiotic given to the patient in a timely way?

[1] The Premier Hospital Quality Incentive Demonstration was authorized under section 402 of Pub. L. 90–248, Social Security Amendments of 1967 (42 U.S.C. 1395b–1). This section authorizes certain types of demonstration projects that waive compliance with the regular payment methods used in the Medicare program.

[2] Additional information on the Premier Hospital Quality Incentive Demonstration is available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalQualityInits/35_HospitalPremier.asp.*

[3] Additional information on CMS' Hospital Quality Initiative is available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalQualityInits/.*

• Had the patient received a pneumococcal vaccination?

• Was the patient's oxygen level assessed?

For FY 2007 and each subsequent year, section 5001(a) of Public Law 109–171 amended section 1886(b)(3)(B) of the Act and made changes to the program established under section 501(b) of Public Law 108–173. These changes require us to expand the number of measures for which data must be submitted, and to change the percentage point reduction in the annual payment update from 0.4 percentage points to 2.0 percentage points for IPPS hospitals that do not report the required quality measures in a form and manner, and at a time, specified by the Secretary.

Effective for payments beginning with FY 2007, new section 1886(b)(3)(B)(viii)(IV) of the Act requires the Secretary to begin to adopt the expanded set of performance measures set forth in the IOM's 2005 report entitled, ''Performance Measurement: Accelerating Improvement.'' [4] Those measures include the HQA measures and the HCAHPS patient perspective survey. Effective for payments beginning with FY 2008, the Secretary must add other measures that reflect consensus among affected parties and may replace existing measures as appropriate. New section 1886(b)(3)(B)(viii)(VII) of the Act requires the Secretary to post hospital quality data on these measures on the CMS Web site. The expanded set of 21 quality measures for the FY 2007 update that was included in the FY 2007 IPPS final rule (71 FR 48033) is outlined below:

Heart Failure (Acute Myocardial Infarction/AMI)

• 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

• Thrombolytic agent received within 30 minutes of hospital arrival

• Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival

• Adult smoking cessation advice/counseling

Heart Failure (HF)

• Left ventricular function assessment

• ACE inhibitor (ACE–1) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction

• Discharge instructions

• Adult smoking cessation advice/counseling

Pneumonia (PNE)

• Initial antibiotic received within 4 hours of hospital arrival

• Oxygenation assessment

• Pneumococcal vaccination status

• Blood culture performed before first antibiotic received in hospital

• Adult smoking cessation advice/counseling

• Appropriate initial antibiotic selection

• Influenza vaccination status

Surgical Care Improvement Project (SCIP)

• Prophylactic antibiotic received within 1 hour prior to surgical incision

• Prophylactic antibiotics discontinued within 24 hours after surgery end time

In order to receive the full FY 2007 IPPS update, hospitals are required to continue to collect data for all 10 starter set quality measures (or begin collecting such data, if newly participating in the program) and are required to provide a written pledge to submit data on the set of 21 expanded quality measures, in addition to completing several administrative tasks regarding quality reporting. All of the measures for the IPPS RHQDAPU program are to be reported on inpatient hospital discharges.

In the CY 2007 OPPS proposed rule, we proposed to employ our equitable adjustment authority under section 1833(t)(2)(E) of the Act to adapt the quality improvement mechanism provided by the IPPS RHQDAPU program for use in the OPPS. As we have discussed above, failure to account at all for quality in payment systems raises a fundamental issue of payment equity. In the absence of mechanisms that provide incentives for higher quality care, Medicare's payment systems can direct more resources to hospitals that do not deliver high quality care to Medicare beneficiaries.

In the proposed rule, we proposed to initiate a Reporting Hospital Quality Data for Annual Payment Update under the OPPS (OPPS RHQDAPU program), effective for payments beginning January 1, 2007. We proposed to add a new § 419.43(h) to our regulations to implement this proposal. Under proposed new § 419.43(h)(1), we would initially implement an OPPS RHQDAPU program by reducing the OPPS conversion factor update in CY 2007 for those hospitals that are required to report quality data under the IPPS RHQDAPU program in order to receive the FY 2007 update, and fail to meet the requirements for receiving the full FY 2007 IPPS payment update. These hospitals would receive an update to the CY 2007 OPPS conversion factor that is reduced by 2.0 percentage points. Under proposed § 419.43(h)(2), any reduction would not affect a hospital's OPPS update in a subsequent calendar year. Hospitals that meet the IPPS RHQDAPU program's requirements for FY 2007 and receive the full IPPS annual payment update would also receive the full update to the conversion factor used to determine payments for CY 2007 under the OPPS.

In the proposed rule, we indicated that, for this initial phase of implementing an OPPS RHQDAPU program in CY 2007, it would be necessary to provide an exception for certain hospital outpatient departments to the requirement that quality data be submitted under the IPPS RHQDAPU program in order to receive the full OPPS update. The quality data submission requirements of the IPPS RHQDAPU program apply only to ''subsection (d)'' hospitals. ''Subsection (d)'' hospitals are 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. In other words, the provision does not apply to hospitals and hospital units excluded from the IPPS, or to hospitals located in Puerto Rico or the U.S. territories. For the initial stage of implementing the OPPS RHQDAPU program in CY 2007, hospitals that are paid under the OPPS but that do not qualify as ''subsection (d)'' hospitals would continue to receive the full update to the OPPS conversion factor. However, as we explained in the proposed rule, our intention was to expand the OPPS RHQDAPU in the future program by requiring all hospitals that receive payment under the OPPS to participate in the program in order to receive a full update, by appropriate expansion, adaptation, and/or extension of quality performance measures and quality reporting mechanisms.

In the proposed rule, we explained that we believe that it is fair and appropriate, for purposes of the initial phase of implementing an OPPS RHQDAPU program, to take timely and accurate reporting of IPPS RHQDAPU program quality measures into account

[4] Institute of Medicine, ''Performance Measurement: Accelerating Improvement,'' December 1, 2005, available at *http://www.iom.edu/CMS/3809/19805/31310.aspx.*

under our equitable adjustment authority. We believe that the 10 original quality measures and the expanded set of 21 process measures as reported for inpatient discharges for heart attack, heart failure, pneumonia, and surgical care reflect the quality of care in the outpatient department as well as the inpatient hospital, so they are appropriate for initial use in the OPPS as specific measures are being developed to reflect the quality of care for hospital outpatients. We believe that hospitals generally function as integrated systems that provide health care services to patients in both inpatient and outpatient settings for many of the same clinical conditions, while recognizing the different typical levels of acuity in the two settings. Hospital quality measures for multiple conditions reflect, in part, the systems of care established by hospitals in the outpatient setting such as the emergency department. Therefore, the well-developed quality measures reported for the FY 2007 IPPS regarding inpatient hospital discharges should reasonably represent the quality of care provided to hospital outpatients, so we proposed their interim use for the CY 2007 OPPS while quality measures specific to hospital outpatients are being developed and refined. This use of multiple measures for several clinical conditions serves as a proxy for the quality of the systems of care established by hospitals. As we expand quality measurement for the hospital outpatient setting, we intend to move from measures that serve as proxies for the quality of care to actual performance measures for the outpatient setting. The discussion below focuses on the expanded list of 21 quality of care measures, as the 10 original measures continue to be included in the quality measurement expansion.

There are seven quality measures assessing the processes of care for patients presenting to the hospital with an acute myocardial infarction, focused on the care on arrival, the promptness of interventions, and discharge care. As we noted in the proposed rule, for the common urgent condition of a patient presenting to the hospital with chest pain that results in a clinical suspicion of acute myocardial infarction, in their effort to provide consistent, high quality care that is founded on evidence-based guidelines, hospitals often utilize clinical care pathways that are standardized for such patients presenting to the emergency room of the hospital. Such care pathways generally apply to patients with specific medical conditions who present to the hospital initially as outpatients, regardless of their eventual discharge home from the outpatient department or inpatient admission. Thus, we believe that all seven of these measures likely serve as reasonable proxies for the quality of care for patients presenting to the hospital outpatient department with chest pain related to a myocardial infarction, who commonly receive care along the continuum from outpatient to inpatient services in a hospital that provides such care in an integrated system.

Similarly, there are seven process measures related to the care of patients with pneumonia, who often present urgently to the hospital's emergency room with symptoms suggestive of the diagnosis of pneumonia. Because of the established clinical evidence regarding assessment and treatment activities that improve the quality of care for patients with pneumonia, most of the interventions that are measured, including oxygenation assessment, drawing of blood cultures, assessment of the patient's pneumococcal and influenza vaccine status, and selection and provision of an initial antibiotic in a timely manner, would generally be performed in the outpatient department, sometimes prior to a clinical decision about the patient's ultimate need for inpatient admission. In particular, the measures of vaccine status are quality measures that may be especially appropriate as hospital outpatient prevention measures. Their use in the hospital setting provides an opportunity for quality improvement in the hospital by encouraging assessment of immunization status and appropriate provision of immunizations, so we see no reason why their reporting on hospital inpatients is not also reflective of the quality of hospital outpatient care. While we acknowledge that, in general, the clinical picture of patients who are admitted to the hospital with pneumonia differs from that of patients who are not hospitalized, we expect there to be many common elements in their assessment, treatment, and counseling regarding the significance of smoking as the hospital provides their initial and subsequent care in the outpatient and/or inpatient settings. Therefore, we believe that all seven of the measures related to the treatment of pneumonia are likely appropriately reflective of the quality of the care systems established by hospitals for outpatients with a diagnosis of pneumonia.

There are four quality measures related to the treatment of patients with heart failure, including assessment of their cardiac function, use of certain medications in their treatment, counseling regarding smoking cessation, and provision of discharge instructions. Patients with heart failure, a common chronic medical condition, are seen frequently in hospital clinics and emergency departments with exacerbations of their symptoms. Once again, their initial treatment is often standardized and provided in the outpatient setting without consideration of their eventual discharge from the outpatient department or inpatient admission, a decision that ultimately depends on clinical considerations, including their response to treatment. Thus, we believe that all four of the inpatient quality measures regarding the treatment of patients with heart failure are reasonable surrogates for the quality of hospital systems of care for outpatients with heart failure.

Likewise, under the expanded list of quality measures for the FY 2007 IPPS the surgical infection prevention quality measures indicating the provision of a prophylactic antibiotic within 1 hour prior to surgical incision and prophylactic antibiotics discontinued within 24 hours after surgery end time likely serve as a reasonable representation of the quality of surgical care for hospital outpatients. Many of the same surgical procedures are commonly performed on both hospital outpatients and inpatients, sometimes in the same operating room suites with attendance by the same clinical staff. Hospitals often have standardized protocols for providing antibiotics prior to surgery and postoperatively based on the types of procedures performed, rather than on the inpatient or outpatient status of the patient, and a decision to admit a patient may not even be made until after the completion of a procedure. Thus, we have no reason to believe that the preoperative and postoperative antibiotic experiences of a patient undergoing outpatient surgery would systemically vary from that of a hospital inpatient.

In summary, in the CY 2007 OPPS proposed rule we concluded that we believe that quality improvement is usually a function of the entire institution as an integrated system that provides both inpatient and outpatient services to patients with an overlapping range of medical conditions. Quality improvement in a hospital inpatient department is likely to correlate with, and indeed to promote, similar quality improvement in the hospital's outpatient department and other sectors of the institution. Conversely, hospitals that fail to promote quality improvement in key sectors such as inpatient care are also unlikely to improve quality in the hospital

outpatient department. We believe that the FY 2007 IPPS quality measures for multiple clinical conditions reflect the quality of hospitals' systems of care that customarily include key outpatient settings such as the emergency department. Therefore, as an interim step while specific quality measures are being developed and refined for reporting on the quality of care to hospital outpatients, we proposed that the initial CY 2007 OPPS RHQDAPU incorporate all of the quality measures that are applicable to the IPPS during FY 2007.

In the proposed rule, we welcomed public comments on the applicability to the OPPS of the various FY 2007 IPPS quality measures as proxies for the quality of care in hospital systems that include outpatient departments, with consideration of both the 10 starter set measures and the 11 new measures in the expanded set for FY 2007.

In the proposed rule, we also discussed our proposed additional quality measures for hospital reporting of quality data for the FY 2008 IPPS. The proposed areas of expansion for the FY 2008 IPPS include the HCAHPS survey, which incorporates questions measuring patients' perspectives of their hospital experiences; 3 additional measures related to the processes of surgical care to supplement the 2 initial Surgical Care Improvement Project (SCIP) measures to be implemented in FY 2007; and 3 risk-adjusted assessments of mortality within 30 days of hospital admission for acute myocardial infarction, heart failure, and pneumonia. For the same reasons detailed above for the FY 2007 IPPS SCIP measures, in the proposed rule we explained that we believe that the additional surgical process of care measures are a reasonable interim proxy for the quality of surgical care for hospital outpatients.

In addition, the questions on the hospital HCAHPS survey assess aspects of the patient's hospital experience, including communication with doctors and nurses, responsiveness of the staff, pain management, and discharge information. These areas of questioning are all relevant to a hospital's care for its outpatients, who may be treated in the hospital outpatient department for an extended period of time, particularly if they are in observation status or recovering from a significant surgical procedure. As described above, because hospitals generally function as integrated systems, with both inpatients and outpatients with related medical conditions passing through the same departments and interacting with similar staff, we believe that this survey of patients who have been admitted to the hospital may reasonably reflect hospital outpatients' perspectives on their care experiences as well.

Finally, with respect to the 30-day mortality measures, these measures are linked to the same three medical conditions for which quality process measures have already been implemented in the IPPS RHQDAPU program, in order to expand the quality data to more fully reflect the true outcomes of care. These mortality measures are risk-adjusted based on historical medical care use, including inpatient and outpatient hospital care and physician office visits, and reflect outcomes of care specifically for Medicare patients. Because we proposed that the full set of FY 2007 IPPS process of care quality measures are acceptable proxies for the quality of care to hospital outpatients as previously discussed, and we believe that some of the value of health care process measures is their relative ease of measurement and their ultimate relationship to health outcomes, we believe that the 30-day mortality measures for inpatients may also reflect the quality of care to hospital outpatients with the same medical conditions. In addition, in view of the common clinical courses of acute myocardial infarction, heart failure, and pneumonia in Medicare beneficiaries, it is highly likely that hospital outpatient services may be provided to previously hospitalized patients within the measures' timeframe of 30 days after hospital discharge, thereby contributing to their care and health outcomes.

Therefore, in the CY 2007 OPPS proposed rule we stated our intention to adopt the full set of FY 2008 IPPS quality measures as proposed for the CY 2008 OPPS RHQDAPU program, while we continue to develop a set of specific quality measures for hospital outpatient care.

In the CY 2007 OPPS proposed rule, we welcomed public comments on the applicability of the FY 2008 IPPS additional quality measures that we proposed to the care of hospital outpatients. We also welcomed public comments on alternative measures of quality of care, including measures of the cost or efficiency of care, that are suitable for adoption to reduce the incidence of lower-quality and high-cost outpatient hospital care for Medicare beneficiaries. We indicated that we would formalize our proposal regarding the CY 2008 OPPS RHQDAPU program in the CY 2008 OPPS proposed rule, which may include proposing to adopt none, some, or all of the FY 2008 IPPS RHQDAPU measures, and may also reflect quality measures that are discussed in comments on this proposed rule.

For purposes of computing the update to the conversion factor under the OPPS in CY 2007, we proposed to reduce the update to the OPPS conversion factor by 2.0 percentage points for any hospital that is eligible to participate in the IPPS RHQDAPU program, but that has had its IPPS payment update reduced because it failed to comply with that program's requirements. Under this proposal, hospitals that fail to qualify for the full CY 2007 OPPS update would receive payments based on a proposed conversion factor of $60.36, reflecting an update of 1.4 percent, in place of the proposed conversion factor of $61.551 reflecting the full update of 3.4 percent.

We proposed to add a new § 419.43(h) to incorporate our proposal. Under proposed § 419.43(h)(1), in order to avoid reduction to the CY 2007 OPPS update, hospitals that are eligible to participate in the IPPS RHQDAPU program must meet the requirements for receiving the full IPPS update for FY 2007. Updated procedures and requirements for the IPPS RHQDAPU program are included in the FY 2007 IPPS final rule. In addition to publication in the final rule, all revised procedures will be added to the ''Reporting Hospital Quality Data for Annual Payment Update Reference Checklist'' section of the QualityNet Exchange Web site (*http://www.qnetexchange.org*). For purposes of determining which hospitals have not qualified to receive the full update under the OPPS for CY 2007, we indicated in the proposed rule that we would follow the determination for FY 2007 full IPPS payment update eligibility under the IPPS RHQDAPU program. Since publication of the CY 2007 OPPS proposed rule, CMS has determined that 171 hospitals are not eligible to receive the full FY 2007 IPPS payment update. As we noted above, we proposed this initiative under the authority granted by section 1833(t)(2)(E) of the Act, which authorizes the Secretary to ''establish, in a budget neutral manner, * * * adjustments as determined to be necessary to ensure equitable payments'' under the OPPS. Proposed § 419.43(h)(3) provided that the reduction to the CY 2007 update that we will implement for hospitals that fail to meet the requirements described above will be implemented in a budget neutral manner. Therefore, if we determine that some hospitals would receive a reduced update for CY 2007 as a result of failure to meet the requirements established under this initial phase of the OPPS RHQDAPU program, we would also

make an adjustment to the OPPS conversion factor, so that estimated aggregate payments under the OPPS for CY 2007, taking into account the reduced update for some hospitals, equal the aggregate payments that we estimate would have been made in CY 2007 if all hospitals received the full update to the conversion factor. As we noted above, determinations concerning which hospitals failed to meet the requirements for receiving the full update to the OPPS conversion factor in CY 2007 were available in September 2006. During the development of the proposed rule, we were unable to determine how many hospitals would receive a reduced update in CY 2007, or to determine the budget neutrality adjustment factor that would be necessary to ensure that estimated aggregate payments under the OPPS for CY 2007 did not change as a result of implementing the proposed OPPS RHQDAPU program. However, we noted that very few hospitals had previously failed to qualify for the full annual updates under the IPPS RHQDAPU program. Therefore, we anticipated that any further adjustment to the CY 2007 conversion factor to satisfy the budget neutrality requirement under section 1833(t)(2)(E) of the Act would be negligible. Our projections were correct, as only a few hospitals were not eligible to receive the full FY 2007 IPPS update.

We explained in the proposed rule that it was not our intention to maintain the specific requirements described above beyond a short initial phase of implementing an OPPS RHQDAPU program. Rather, our intention is to develop this program beyond its initial stage in at least two ways. As we have stated previously, we believe that it is appropriate and fair during this initial phase of the OPPS RHQDAPU program to take quality data reporting under the IPPS RHQDAPU program into consideration for purposes of determining the update for hospitals under the OPPS. However, it would be important for a fully developed OPPS RHQDAPU program to be based on reporting measures that are defined in terms of the quality considerations that are most appropriate and applicable in the hospital outpatient setting. In collaboration with health care stakeholders, we indicated in the proposed rule that we intend to begin work on a set of quality and cost of care measures specific to hospital outpatient departments for implementation in a later phase of the OPPS RHQDAPU program. We said that we intend to implement a hospital outpatient-specific set of such quality and cost of care measures at the earliest possible date. Reporting of a more fully developed, outpatient-specific set of quality and cost of care measures may be effective for purposes of determining the update as early as CY 2009. However, in implementing the system, we explained that we would allow adequate time for development of the appropriate measures; announcement of the quality and cost of care measures we have selected; consideration of comments from the hospital community, patient advocates, and other stakeholders; establishment of the requisite mechanisms for reporting the measure; and initiation of actual reporting of the measures by hospitals. As we begin to develop such a set of hospital outpatient-specific quality and cost of care measures, in the proposed rule we welcomed comments on this issue.

Specifically, in the CY 2007 OPPS proposed rule, we invited comments on the following (and related) questions: Which current quality and cost of care measures, such as IPPS quality measures (especially the measure set as expanded under the DRA), physician practice measures, HCAHPS/ACAHPS® etc., are most applicable in the hospital outpatient setting? What would be the characteristics of an ideal measure set of quality and cost of care measures for the outpatient setting? What quality and cost of care measures are currently available for the outpatient setting? What privately-led organizations or alliances are best suited to conduct needed development and consensus endorsement of outpatient quality measures?

As we discussed above and we proposed for the initial stage of implementing the OPPS RHQDAPU program in CY 2007, hospitals that are paid under the OPPS but that do not qualify as ''subsection (d)'' hospitals would receive the full update to the OPPS conversion factor. However, we believe that it is essential to expand the requirements of the OPPS RHQDAPU program that we proposed to all hospital outpatient departments paid under the OPPS. Therefore, we indicated that we would also undertake to study, for CYs 2008 and beyond, approaches to adapting and expanding the current quality and cost of care measures under the IPPS RHQDAPU program for use in reporting on the quality of outpatient care in hospitals that are paid under the OPPS but that do not qualify as ''subsection (d)'' hospitals. We explained that we would also begin development of mechanisms by which these hospitals could report the requisite quality data in a timely and effective manner. In the proposed rule, we welcomed comments on ways in which we could expand the proposed OPPS RHQDAPU program to all hospital outpatient departments that are paid under the OPPS, and on quality and cost of care measures that are specifically appropriate for reporting by hospital outpatient departments paid under the OPPS but that do not qualify as ''subsection (d)'' hospitals.

In the proposed rule, we explained that our ultimate goal is implementation of an OPPS RHQDAPU program that extends to all hospital outpatient departments that are paid under the OPPS, that is based on a set of quality and cost of care reporting measures that are specific to the hospital outpatient setting, and that is appropriately aligned with developments in quality reporting and value-based purchasing in other payment systems such as the IPPS. We noted that we would take into consideration issues related to the appropriate alignment of quality and cost of care reporting and value-based purchasing under the IPPS and OPPS during the planning process mandated by section 5001(b) of the DRA for implementation of inpatient value-based purchasing by FY 2009. We explained that we plan to include all hospital services, whether inpatient or outpatient, in the report on implementation of value-based purchasing. We have often heard from stakeholders that a more comprehensive, systematic approach to quality should be our focus. Quality reporting of inpatient and outpatient services is consistent with such comments, and would provide more comprehensive information about the quality of services provided by hospitals. In the proposed rule, we requested comments on the alignment of scope and other issues that should be considered during this planning process, including quality and cost of care reporting measures, data and program infrastructure, incentives, and public reporting of quality and cost of care measures under value-based purchasing.

Finally, in the CY 2007 OPPS proposed rule, we requested comments on the most effective use of our authority under section 1833(t)(2)(E) of the Act, in light of the concerning evidence of rapid and uneven payment growth in the OPPS with limited evidence of patient benefit. In particular, we indicated that commenters who believe that the proposed quality reporting initiative is not the most effective use of this authority should consider submitting comments on alternative, more effective approaches to using this and related

authorities available to CMS under the Act to promote higher quality, more equitable care. We stressed that we did not believe that the status quo, with rapid and uneven growth in spending and limited evidence of its value, was consistent with an efficient hospital outpatient payment program and value-driven health care for Medicare beneficiaries, and we expect to take further steps to address this important concern. In addition, we sought comment on whether section 1833(t)(2)(F) of the Act also supports the proposed use of quality reporting to determine a hospital's update under the OPPS.

Comment: Some commenters generally supported the proposal to reduce the update to the OPPS conversion factor for CY 2007 for those hospitals that are required to report quality data under the IPPS RHQDAPU program in order to receive the FY 2007 update and fail to meet the requirements for receiving the full FY 2007 IPPS payment update. One commenter characterized the proposal as ''an important and laudable project.'' However, this commenter also expressed concern that the projected expansion of reporting to additional, outpatient-specific measures would require significant increases in hospital resources, including additional staff and increased vendor workload. Another commenter agreed with the agency's goals of adopting value-based purchasing and promoting higher quality services. This commenter expressed concern, however, that the adoption of the IPPS standards might delay development of standards that are appropriate to outpatient care. Another commenter supported the proposal as an interim step toward development and reporting of quality measures that are most appropriate to the hospital outpatient department setting. This commenter noted that the proposed reduction to a hospital's outpatient payment update would provide an additional incentive to spur the submission of the inpatient quality data. Commenters also recommended that CMS evaluate the effectiveness of reporting quality data and consider increasing the reduction or shifting the application of the reduction to reflect actual performance rather than mere reporting.

Another commenter supported the effort to improve the quality of care in hospital outpatient departments. This commenter offered specific suggestions for revising the proposed list of quality measures for use in the hospital outpatient department setting. For example, the commenter recommender that the heart attack (Acute Myocardial Infarction/AMI) measures be expanded to reflect current standards of care, which include provision of both aspirin and clopidogrel bisulfate to patients with Acute Coronary Syndrome on discharge.

One commenter said that it was not clear whether CMS was proposing: (1) That hospitals must report the IPPS measures for outpatient services to prevent a 2.0 percent reduction on their FY 2007 conversion factor update, or (2) that hospitals that report all of the IPPS measures will automatically receive the full OPPS update. The commenter strongly objected to the application of the IPPS measures to outpatient hospital services and said that CMS should consolidate the various silos of measures into a single set of quality measures that promote patient-centeredness, episodes of care, the continuum of care, and disease management. The commenter also stated that there needs to be a national measurement framework for establishing the priorities for outpatient measures and that when outpatient measures are constructed, there should be testing prior to public reporting of the findings. However, the commenter also expressed support for a policy that CMS ''use the evidence of IPPS reporting to influence the OPPS conversion factor update for CY 2007 * * *.'' This commenter supported this ''extra incentive for hospital quality reporting,'' on the grounds that it ''is imperative that all hospitals participate in this avenue for accountability and quality improvement. Thus, basing a portion of OPPS payment on whether hospitals report their IPPS measures is warranted.''

One commenter noted that some hospitals are still attempting to master the original inpatient measures. The commenter suggested the most appropriate time to add outpatient quality indicators would be that when this task has been mastered. The commenter also suggested the non-inpatient indicators should be added for all entities at the same time, noting that the CMS proposal under the OPPS does not apply to ambulatory surgical centers.

Finally, one commenter agreed that there is some correlation between outpatient and inpatient care for the specific diagnoses included in the current IPPS reporting measures, but expressed some concern about the use of the IPPS measures as a proxy for the quality of hospital outpatient services. The commenter suggested that modification of some current inpatient measures to include outpatients could provide an interim methodology. However, the commenter also stated that there should not be a rush to put outpatient measures into place without prior review of such modifications by all stakeholders.

A number of other commenters strongly opposed our proposal. Several commenters objected that the proposal was unfair because it would take into account reporting that hospitals had already performed before they became aware of the additional payment reduction proposed under the OPPS for failure to report the measures. Some of these commenters expressed the view that, in this respect, the proposal amounted to retroactive rulemaking, since hospitals could now take no action to avoid a potential reduction to their CY 2007 payments if the proposal is adopted. Other commenters objected that the proposal exceeds CMS' statutory authority.

Some of these commenters argued that the congressional mandate of quality reporting in the hospital inpatient and home health settings precludes CMS from extending reporting into the hospital outpatient setting without such specific statutory authority. These and other commenters also objected that section 1833(t)(2)(E) of the Act, which allows the Secretary to establish ''other adjustments as determined to be necessary to ensure equitable payments,'' does not provide adequate statutory authority to tie hospital outpatient payments to quality reporting. In addition, some commenters noted that unlike other adjustments proposed for the CY 2007 OPPS, there appeared to be no provision for the amounts not spent in the full update for hospitals that did not meet the IPPS quality reporting standards to be returned to other providers through increases in payment. They believe that this proposal appeared to be a penalty, rather than an equitable adjustment.

Some commenters also objected to the proposed linkage of outpatient payment to inpatient measures of quality. Several commenters stated that the IPPS quality measures have no documented validity for outpatient care and services. Other commenters stated that the inpatient measures are not appropriate proxies for hospital outpatient care measures, for a variety of reasons. For example, one commenter pointed out that there is evidence that patients diagnosed with AMI, and who have no contraindications for receiving particular medications, have a better outcome if they receive aspirin and beta blockers within a short time of presenting to the hospital. However, there is no evidence of better outcomes

for patients who receive aspirin when they present in an emergency department with chest pain, but are diagnosed with some condition other than heart attack and are sent home. Therefore, these commenters believe that CMS should proceed with care in taking these measures into account in the outpatient setting only after a thorough, scientific review to establish the application of the measures to outpatient care. One commenter specifically recommended that CMS should not proceed with expanding quality reporting into the hospital outpatient setting in any manner without a thorough scientific review conducted by such organizations as the National Quality Forum (NQF). The commenter noted that the NQF has endorsed the 21 hospital-based inpatient quality measures only for assessing quality of care in the inpatient setting, not for use in the hospital outpatient setting. Some commenters were concerned that additional outpatient hospital-specific measures could result in a greatly increased administrative burden, due to the volume of services in the outpatient setting that is much greater than the inpatient setting. Other commenters asked that outpatient quality and cost of care measures conform to standards of clinically appropriate care as established by peer-reviewed literature or professional consensus, be sufficiently flexible to allow access to new technology and devices, and be reviewed and updated periodically. They thought that when providers met a particular measure, it should be removed to reduce the reporting burden.

MedPAC agreed that certain of the IPPS measures, such as provision of aspirin on arrival to a patient with AMI, could conceptually be employed for evaluating outpatient quality. However, MedPAC also advised that additional analysis may be necessary in order to ensure that these measures apply in the outpatient hospital setting. MedPAC also expressed a preference that CMS seek the authority to move beyond pay-for-reporting toward pay-for-performance, so that payment updates depend on empirical evidence of outcomes from the quality data, not merely on whether the data are submitted.

Response: We appreciate the many thoughtful comments that we received on our proposal. We continue to believe that the statute permits us to provide a differential payment adjustment under the OPPS for quality reporting, consistent with our broad authority under section 1833(t)(2)(E) of the Act to provide an adjustment to ensure that payments are equitable. As we explained in the proposed rule, it is inequitable for hospitals providing poorer quality care that may result in the provision of more health services to Medicare beneficiaries in the hospital outpatient department to be in a position to receive higher payments from the OPPS for that episode of care, a result more in keeping with a fee-for-service payment system that provides payments for services without a focus on quality. The rapid spending growth in the OPPS is primarily due to brisk growth in the intensity and utilization of services, rather than general price or enrollment changes. This growth has occurred in an OPPS payment environment that has not yet focused on accounting for high quality care that improves the health of Medicare beneficiaries. We believe that the OPPS must look forward, and that future OPPS spending should be directed in the most efficient manner possible toward higher quality services. A continued lack of focus on the quality and value is not desirable for the program over the upcoming years. Specifically, we believe we have the statutory authority to provide a differential update based on quality reporting in the OPPS as we proposed. While we acknowledge that the IPPS RHQDAPU program is based in part on a DRA provision, the law does not preclude the Secretary from using his other statutory authorities to ensure that other services paid by Medicare, such as the outpatient hospital services paid under the OPPS, are of appropriately high quality.

CMS' shift across payment systems to quality-based payment reform is an evolutionary process. On the hospital inpatient side, we began with linking the IPPS annual payment update to reporting on 10 quality measures, and we now have expanded the measure set for inpatient hospital reporting in FY 2007. In the DRA, Congress mandated that DHHS develop a plan for implementation of hospital value-based purchasing beginning with FY 2009. While the plan specifically focuses on the inpatient setting, moving toward pay for reporting in the hospital outpatient setting as we proposed is a logical next step. We believe it is very valuable for hospitals and CMS to gain as much experience as possible with all aspects of quality reporting with a focus on ultimately enhancing value for Medicare.

As we discussed in detail in our proposal, we proposed as an initial step in the program's movement toward value-based purchasing to reduce the update to the CY 2007 OPPS conversion factor by 2.0 percentage points for those hospitals that are required to report quality data under the IPPS RHQDAPU quality reporting program and fail to meet the requirements for receiving the full FY 2007 IPPS payment update. We appreciate the perspective of the commenters who acknowledged that this initial step was a sensible progression and agreed that the proposal would provide an extra incentive for hospital quality reporting that is an effective avenue to hospital accountability and quality improvement. We also explained that this proposal was only the first phase of implementing a quality reporting program in the OPPS, which would eventually expand to encompass reporting by all hospitals paid under the OPPS and refinement of quality measures to include those specific to hospital outpatient services.

In contrast, however, we acknowledge that many commenters expressed their belief that quality performance in the outpatient setting could only be fairly and accurately assessed through the reporting of quality measures that are specific to outpatient hospital care by all hospitals paid under the OPPS. We agree that the current inpatient quality measures have some limitations as proxies for the quality of outpatient hospital care, in particular, their use to assess what constitutes effective treatment for different patient populations. The inpatient measures have been developed and refined for those patients who are admitted as hospital inpatients, and those patients may differ in several ways, including the severity of their illnesses, from hospital outpatients. We agree with commenters who believe that hospitals should be held accountable for the quality of their outpatient hospital services through measures that are specific to that care. Throughout the development of the IPPS quality measures, we have highly valued stakeholder input in the measure selection and refinement processes. We hope they continue to contribute vital input into the OPPS RHQDAPU quality reporting program, as we seek to create a bridge based on quality in the OPPS between the care setting and the payment setting. We do not intend to implement a quality reporting program linked to the OPPS annual update that is based on quality reporting that does not conceptually and practically reflect this vital link.

While the DRA-mandated hospital value-based purchasing plan only requires CMS to design a plan for the inpatient hospital setting, as part of that work we are also considering issues

related to the implementation of quality reporting in the hospital outpatient setting. We see extension of the focus on quality to outpatient hospital services, many of which were inpatient services until recently, as a logical progression. Most importantly, we believe that implementing a payment adjustment would serve as an important milestone to signal the program's emerging focus on quality services that provide significant benefits to the health of Medicare beneficiaries.

We agree 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. Public reporting of specific outpatient hospital quality measures requires not only having developed, accepted measures, but also having in place the infrastructure for data collection and reporting. To reach the point where an outpatient hospital measure is collected and reported, based on our experience with developing the IPPS measures, multiple steps are involved. For a single measure, these steps include developing the measure, obtaining stakeholder endorsement, vetting the measure with appropriate organizations, engaging vendors and providing a vehicle for chart reviews to support reporting, testing of the Web site display, and then beginning data collection. From the start of actual data collection, given the time period allowed for submission of data and the time it takes to preview and ultimately generate a usable report, it would take at least one year before the measure could be reported.

CMS has built strong and productive working relationships with many organizations, including the Joint Commission on Accreditation of Healthcare Organizations, the NQF, Hospital Quality Alliance, and others through our IPPS measure development experience. We would hope these relationships continue in our move to develop outpatient hospital quality measures for reporting. We also would seek to minimize the reporting burden on hospitals through close collaboration with the hospital industry to develop appropriate measures and an efficient data collection methodology. Some commenters recommended that some of the current inpatient hospital measures could be adapted to provide information specifically regarding outpatient hospital care. However, whether we adapt existing measures or develop new ones, we would need to engage in the same development and infrastructure activities. We have already begun to take a more systematic approach to the development of hospital outpatient measures, and we plan to accelerate our timetable significantly during CY 2007. We appreciate the specific suggestions of commenters regarding measure development for hospital outpatient care, and we welcome ongoing public input in this area.

We have concluded that the most appropriate course at this point is to implement the OPPS quality update reporting program based on measures specifically developed to characterize the quality of hospital outpatient care. We believe the process will require 2 years before quality measure data are available. Given our concerns about the increasing growth in OPPS spending without concern for the value of the services, we do not believe it would be appropriate to delay focusing on the quality of hospital outpatient services beyond the minimum of 2 years required for the development and implementation of these measures.

We agree with those commenters who pointed out that implementation of the OPPS RHQDAPU program as proposed for CY 2007 would mean that hospitals could not have made decisions regarding their participation in the IPPS quality reporting program with full knowledge of the effects of their participation on their OPPS update. While implementation of the OPPS RHQDAPU program in CY 2008 based on hospitals' participation in the IPPS RHQDAPU would be possible because hospitals would have the opportunity to make decisions knowing the consequences of their participation, we believe 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. Therefore, we are delaying implementation of the OPPS RHQDAPU program until CY 2009, when we will implement a 2.0 point reduction to the OPPS conversion factor update for those hospitals that do not meet the specific requirements of the CY 2009 OPPS RHQDAPU program. The CY 2009 program will be based upon CY 2008 hospital reporting of 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.

We have revised proposed § 419.43(h) to reflect this new effective date and we are adopting it as revised in this final rule with comment period. We also note that in the CY 2008 OPPS proposed rule, we may further refine our approach under the OPPS RHQDAPU program.

We continue to believe that it is not only appropriate but necessary to require that hospitals must fully comply with the OPPS RHQDAPU program requirements to receive OPPS payment that reflects the full CY 2009 update to the conversion factor. 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 incorporating value-based purchasing into the OPPS. We seek to encourage care that is both efficient and of high quality in the hospital outpatient department. 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.

XX. Promoting Effective Use of Health Information Technology

We recognize the potential for health information technology (HIT) to facilitate improvements in the quality and efficiency of health care services. One recent RAND study found that broad adoption of electronic health records could save more than $81 billion annually and, at the same time, improve quality of care.[5] The largest potential savings that the study identified was in the hospital setting because of shorter hospital stays promoted by better coordinated care; less nursing time spent on administrative tasks; better use of medications in hospitals; and better utilization of drugs, laboratory services, and radiology services in hospital outpatient settings. The study also identified potential quality gains through enhanced patient safety, decision support tools for evidence-based medicine, and reminder mechanisms for screening and preventive care. Despite such large potential benefits, the study found that only about 20 to 25 percent of hospitals have adopted HIT systems.

It is important to note the caveats to the RAND study. The projected savings are across the health care sector, and any Federal savings would be a portion of the total savings. In addition, there are significant assumptions made in the RAND study. National savings are projected in some cases based on one or two small studies. Also, the study assumes patient compliance, in the form

[5] RAND News Release: Rand Study Says Computerizing Medical Records Could Save $81 Billion Annually and Improve the Quality of Medical Care, September 14, 2005, available at: *http://rand.org/news/press.05/09.14.html.*

of participation in disease management programs and following medical advice. For these reasons, extreme caution should be used in interpreting these results.

In his 2004 State of the Union Address, President Bush announced a plan to ensure that most Americans have electronic health records within 10 years.[6] One part of this plan involves developing voluntary standards and promoting the adoption of interoperable HIT systems that use these standards. The 2007 Budget states that ''The Administration supports the adoption of health information technology (IT) as a normal cost of doing business to ensure patients receive high quality care.''

Over the past several years, CMS has undertaken several activities to promote the adoption and effective use of HIT in coordination with other Federal agencies and with the Office of the National Coordinator for Health Information Technology. One of those activities is promotion of data standards for clinical information, as well as for claims and administrative data. In addition, through our 8th Scope of Work contract with the QIOs, we are offering assistance to hospitals on how to adopt and redesign care processes to effectively use HIT to improve the quality of care for Medicare beneficiaries, including computerized physician order entry (CPOE) and bar coding systems. Finally, our Premier Hospital Quality Incentive Demonstration provides additional financial payments for hospitals that achieve improvements in quality, which effective HIT systems can facilitate.

We are considering the role of interoperable HIT systems in increasing the quality of hospital services while avoiding unnecessary costs. As noted above, the Administration supports the adoption of HIT as a normal cost of doing business. While payments under the OPPS do not vary depending on the adoption and use of HIT, hospitals that leverage HIT to provide better quality services may more efficiently reap the reward of any resulting cost savings. In addition, the adoption and use of HIT may contribute to improved processes and outcomes of care, including shortened hospital stays and the avoidance of adverse drug reactions.

In the proposed rule, we sought comments on our statutory authority to encourage the adoption and use of HIT. We also sought comments on the appropriate role of HIT in any value-based purchasing program, beyond the intrinsic incentives of the OPPS, to provide efficient care, encourage the avoidance of unnecessary costs, and increase quality of care. In the proposed rule, we did not propose adding adoption of HIT to the Medicare hospital conditions of participation. However, we solicited comments on promotion of the use of effective HIT through hospital conditions of participation, perhaps by adding a requirement that hospitals use HIT that is compliant with and certified in its use of the HIT standards adopted by the Secretary. We anticipate that the American Health Information Community will provide advice to the Secretary on these issues.

We received 13 responses to the proposed rule on this section. Below is a summary of the comments within each response addressing: (1) CMS' statutory authority and use of our conditions of participation to encourage adoption of effective HIT; (2) the role that HIT should play in value-based purchasing; and (3) the importance of interoperability standards in promoting the adoption of HIT. In addition to these areas in which we sought comments, we also received several comments on the challenges of implementing HIT, which were particularly focused on barriers such as the high cost of implementation.

Comments: Some commenters addressed CMS' statutory authority to encourage adoption of effective HIT. One commenter referenced CMS' previous use of statutory authority to promulgate exceptions under the physician self-referral law as an example of the agency's authority to promote the adoption of HIT. Another commenter stated that CMS does not have the statutory authority to promote adoption of HIT and, therefore, should concentrate on other mechanisms, such CMS' demonstrations authority to encourage HIT adoption.

Several commenters addressed CMS' idea of promoting the adoption of HIT through CMS conditions of participation. Some of the commenters were in favor of including adoption of HIT in conditions of participation. One commenter suggested making modifications to existing conditions of participation in lieu of creating new conditions of participation to accommodate adoption of HIT. Many commenters opposed including the adoption of HIT in the conditions of participation. Commenters opposed to including HIT implementation within conditions of participation characterized the proposal as creating an ''unfunded mandate.''

Many commenters provided feedback on the proper role of HIT within a value-based purchasing system. The majority of commenters noted that adoption of HIT can lead to improved quality, enhanced patient safety, and increased efficiency. Many commenters emphasized that HIT can reduce the burden associated with quality reporting. One commenter stated that the foundation of HIT adoption should support the aims outlined within the IOM's ''Crossing the Quality Chasm Report'': safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Another commenter suggested that CMS could advance its quality agenda by investing in the development of algorithms for the calculation of quality measure scores.

Most commenters stated that a value-based purchasing system should emphasize process and outcomes measures, rather than structural measures such as the use of HIT tools like computerized physician order entry. However, two commenters stated that use of HIT should be included as a structural measure for any value-based purchasing system.

Several commenters addressed the costs associated with HIT implementation. Several commenters stated that HIT is very costly to implement and felt strongly that implementation of HIT should be a shared expense between providers, purchasers, and payers. Some commenters felt that incentives could aid providers by reducing the cost burden and suggested that direct Medicare payment for HIT would most effectively encourage its adoption.

Several commenters addressed the importance of interoperability standards for HIT. Many commenters noted that interoperability standards are a critical component of any HIT system and must include a standard set of policies, procedures, and standards for data collection and documentation. The commenters also noted the importance of having interoperability standards that are publicly available and non-proprietary. One commenter suggested that HHS and AHIC should provide modern terminology to guide the adoption of interoperability standards, such as those identified in the Consolidated Health Informatics (CHI) and the SNOMED–CT®, adopted by CHI and approved by the National Committee on Vital and Health Statistics. In addition to interoperability standards, one commenter stated that a rigorous quality assurance process that addresses strict adherence to interoperability standards should be required by third party certification.

[6] Transforming Health Care: The President's Health Information Technology Plan, available at: *http://www.whitehouse.gov/infocus/technology/economic_policy200404/chap3.html.*

One commenter strongly supported the role of both AHIC and the Ambulatory Quality Alliance-Hospital Quality Alliance Steering Committee in promoting the adoption of HIT. Another commenter commended CMS on promoting adoption of HIT by ''promulgating regulatory protections under the physician self-referral and Anti-Kickback Statutes for donations related to electronic medical records.''

Response: We thank all commenters for their thoughtful and valuable discussion of the issues. In the HIT section of the preamble to the proposed rule, we recognized the potential for effective HIT to facilitate improvements in the quality and efficiency of health care services. We also pointed out CMS' promotion of the adoption and effective use of HIT in coordination with other Federal agencies and the Office of the National Coordinator for Health Information Technology. Here, we will discuss three initiatives that we are emphasizing to promote the effective use of HIT, in light of the comments we received: (1) Value-based purchasing, (2) the recent CMS and OIG final rules regarding the donation of certain HIT, and (3) infrastructure and interoperability standards.

We continue to explore the implementation of value-based purchasing payment system reforms because we believe that, among other advantages, value-based purchasing can encourage hospitals to invest in activities, such as effective HIT, that have the potential to improve quality and decrease unnecessary costs. However, linking a portion of Medicare payments to valid measures of quality and effective use of resources could give hospitals more direct incentives to implement innovative ideas and approaches that may result in improved value of care. We agree with the commenters that noted that the use of effective HIT could increase quality, efficiency, and patient safety. We also agree with the commenters that noted that effective use of HIT can be used to decrease the burden of reporting to value-based purchasing programs. However, we disagree with the commenters that recommended direct government funding of HIT. As stated in the President's 2007 Budget, ''the Administration supports the adoption of [HIT] as a normal cost of doing business to ensure patients receive high quality care.''

Commenters noted that multiple stakeholders in the health care system, including purchasers and payers, benefit from provider adoption and use of effective HIT and should share in the cost. CMS and OIG have recently issued final rules to allow hospitals and other health care providers under some circumstances to donate electronic prescribing and electronic health records technology to physicians and others without running afoul of the Stark (physician self-referral) and anti-kickback statutes. We believe that these rules facilitate the adoption of HIT by physicians and other health care providers who might otherwise have been unable or unwilling to invest in the technology.

We also believe that these regulatory changes help to stimulate the adoption of effective HIT, and that, as HIT use spreads, the benefits relative to the costs of implementation may increase for all stakeholders.

The majority of commenters pointed out that the current lack of HIT infrastructure, including lack of interoperability standards, is a major obstacle to adoption and effective use of HIT. To address the lack of infrastructure, the Secretary has undertaken a national strategy that calls for Federal agencies to collaborate with private stakeholders in the development of architecture, standards, certification processes, and methods of governance to facilitate the adoption of effective HIT. In September 2005, the Secretary selected 16 commissioners to serve on the American Health Information Community (AHIC or Community), which is a federally chartered collaborative forum of private and public interests charged with advising the Secretary on how to make health information digital and interoperable. The goals of the Community include immediate access to vital medical information at the point of care, privacy protection, better data for research, and overall cost savings. The work of the Community has been divided among six workgroups: (1) The Electronic Health Records Workgroup, (2) the Chronic Care Workgroup, (3) the Consumer Empowerment Workgroup, (4) the Biosurveillance Workgroup, (5) the Confidentiality, Privacy, and Security Workgroup, and (6) the Quality Workgroup. The AHIC Workgroups have made recommendations, as their initial ''breakthroughs,'' pertaining to: an electronic medication summary and registration history; secure messaging capabilities for individuals with chronic disease; biosurveillance monitoring; and, through secure means, broadening the availability and access to current and historical laboratory results and interpretations. More information about the Community is available at: *http://www.hhs.gov/healthit/ahic.html*.

In conclusion, we are not at this time requiring adoption of certified, interoperable HIT as a part of the Medicare conditions of participation. Rather, we are reserving judgment on the imposition of such a requirement and will continue to research the feasibility of doing so. We may revisit this issue in the CY 2008 OPPS proposed rule or in another rulemaking proceeding.

XXI. Health Care Information Transparency Initiative

The United States (U.S.) faces a dilemma in health care. Although the rate of increase in health care spending slowed last year, costs are still growing at an unsustainable rate. The U.S. spends $1.9 trillion on health care, or 16 percent of the gross domestic product (GDP). By 2015, projections are that health care will consume 20 percent of GDP. The Medicare program alone consumes 3.4 percent of the GDP; by 2040, it will consume 8.1 percent of the GDP, and by 2070, 14 percent of the GDP.

Part of the reason health care costs are rising so quickly is that most consumers of health care—the patients—are frequently not aware of the actual cost of their care. Health insurance shields them from the full cost of services, and they have only limited information about the quality and costs of their care. Consequently, consumers do not have the incentive or means to carefully shop for providers offering the best value. Thus, providers of care are not subject to the competitive pressures that exist in other markets for offering quality services at the best possible price. Reducing the rate of increase in health care prices and avoiding health services of little value could help to stem the growth in health care spending, and potentially reduce the number of individuals who are unable to afford health insurance. Part of the President's health care agenda is to expand Health Savings Accounts (HSAs), which would provide consumers with greater financial incentives to compare providers in terms of price and quality, and choose those that offer the best value.

In order to exercise those choices, consumers must have accessible and useful information on the price and quality of health care items and services. Typically, health care providers do not publicly quote or publish their prices. Moreover, list prices, or charges, generally differ from the actual prices negotiated and paid by different health plans. Thus, even if consumers were financially motivated to shop for the best price, it would be very difficult at the current time for them to access usable information.

For these reasons, DHHS is launching a major health care information transparency initiative in 2006. This effort builds on steps taken by CMS to make quality and price information available. For example, Medicare has provided unprecedented information about drug prices in the Medicare drug benefit, and is now adding to these efforts in other areas. We recently posted Medicare payment information for common elective procedures and other common admissions for all hospitals by county on our Web site at *http://www.cms.hhs.gov/HealthCareConInit/01_Overview.asp#TopOfPage*. We also recently posted geographically-based Medicare payment information for common elective procedures for ambulatory surgery centers on our Web site at *http://www.cms.hhs.gov/HealthCareConInit/03_ASC.asp*. We will post similar information for common hospital outpatient and physician services this fall.

In addition, a number of tools providing usable health care information are already available to Medicare beneficiaries. Consumers can access ''Compare'' Web sites through *http://www.medicare.gov* where they can evaluate important aspects of their health care options for care at a hospital, nursing home, home health agency, and dialysis facility, as well as compare their costs and coverage when choosing a prescription drug plan.

CMS is developing a transparency initiative with the goals of providing more comprehensive information on quality and costs, including more complete measures of health outcomes, satisfaction, and volume of services that matter to consumers, and more comprehensive measures of costs for entire episodes of care, not just payments for particular services and admissions. We intend for the project to combine public and private health care data to provide cost and quality of care information at the physician and hospital levels. Quality, cost, pricing, and patient information will be reported to consumers and purchasers of health care in a meaningful and transparent way. In addition, we anticipate the project will provide a national template for performance measures and a payment structure that aligns payment and performance.

The comments we received on our transparency initiative and our responses are summarized below.

Comment: All commenters supported the concept of providing useful information for consumers and patients on the price and quality of care delivered in the outpatient setting. However, many commenters also noted the complexity of such information, particularly price and cost data, and identified issues that would need to be addressed when determining what information is most helpful and the manner in which it should be given to consumers.

In particular, commenters noted that (1) the price of services varies by patient needs and services, (2) hospital costs also include their public service role, (3) physician services are not included in the hospital bill, and (4) hospital prices would vary based on the insurance status of the patient. The commenters suggested that price information should be easy to understand and use, easy to access, use common definitions and language, and explain the factors that affect prices. Several commenters also described their proposals for making such information more readily available through state and insurer mandates and hospital and Federal research efforts to identify the most useful price information. Several commenters also noted that price and quality information should be released together.

Response: We agree that price information is complex and that the factors that affect price noted by the commenters should be considered when determining what information to release and the manner in which it is provided. For inpatient services, we released Medicare payment information for common conditions, and we plan to do so for outpatient services later this fall. This type of information provides beneficiaries and their families with information on their potential out-of-pocket costs. Another useful way to describe costs may be to provide information on the total costs for a course of treatment (beyond just the inpatient stay) for an episode of care (potentially encompassing all providers and over time for a specific condition). Consumers may also want information about the quality of care across the episode. Because some services delivered in the outpatient setting are also delivered in ambulatory surgical centers and physicians' offices, we also may consider comparisons across settings in the future.

We also agree that information on price should be easy to use and access, and that it is important to continue research on the best way to provide such information to consumers. We have been posting information on the quality of care for several settings, including hospitals, nursing homes, dialysis facilities, Medicare Advantage plans, and Part D plans. Regarding the Part D information, we have created an interactive tool which provides beneficiaries an unprecedented level of detail on the availability of their drugs and potential cost liability for plans in their region. We anticipate using our experience with these tools and working with others to develop useful tools for displaying information on outpatient services.

We are grateful for the support for our efforts and will welcome proposals for providing consumers and patients useful information on price and quality.

Comment: Several commenters suggested that CMS work through the AQA and Hospital Quality Alliance efforts, along with the joint steering committee charged with harmonizing hospital and physician measurement—the Quality Alliance Steering Committee—to identify the most useful price and quality measures for the outpatient settings.

Response: We strongly support the AQA and HQA efforts, and believe that such collaboration is critical to the success of transparency. To the extent these organizations, as well as others, such as the National Quality Forum, reach consensus regarding price or quality measures for outpatient settings we would look to their efforts to inform ours.

Comment: One commenter stated that in addition to making sure the measures and the process are useful, it is critical to make sure the data, particularly claims, are consistent across settings. The commenter noted the need to update data standards to reflect the contents of 21st century health records, including moving to ICD–10–CM and using other standards endorsed by the National Committee on Vital and Health Statistics (NCVHS).

Response: We agree that it is critically important for the information underlying these price and quality measures to be as uniform and accurate as possible. As directed by the President's Executive Order, we are currently engaged in numerous department initiatives to identify and endorse terminology and messaging standards and to support a certification process for electronic health records. We also support movement towards the ICD–10–CM coding system. As consumers, patients, and providers become increasingly engaged in the use of health care price and quality information this will become ever more important.

Comment: One commenter noted that the length of time used to calculate costs and quality is critical. The commenter stated that the outcome of a service may take a long time to manifest, sometimes even longer than a year, so that the

length of time used should be considered.

Response: We recognize that the length of time in which patient outcomes manifest may vary. We believe it will be important, particularly when assessing the cost and quality of broad episodes of care to vary the episode length depending on the patterns of care specific to the condition.

XXII. Additional Quality Measures and Procedures for Hospital Reporting of Quality Data for the FY 2008 IPPS Annual Payment Update

A. Background

Section 5001(a) of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171) sets out new requirements for the IPPS Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. The IPPS RHQDAPU program was established to implement section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108–173). It builds on our ongoing voluntary Hospital Quality Initiative which is intended to empower consumers with quality of care information to make more informed decisions about their health care while also encouraging hospitals and clinicians to improve the quality of care.

Section 5001(a) of Public Law 109–171 revises the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. New sections 1886(b)(3)(B)(viii)(I) and 1886(b)(3)(B)(viii)(II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year will be reduced by 2.0 percentage points for any ''subsection (d) hospital'' that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary. Under sections 1886(b)(3)(B)(viii)(III) and 1886(b)(3)(B)(viii) (IV) of the Act, we must expand the ''starter set'' of quality measures that we have used since FY 2005, and to begin to adopt the baseline set of performance measures as set forth in a 2005 report issued by the Institute of Medicine of the National Academy of Sciences (IOM) under section 238(b) of the MMA, effective for payments beginning with FY 2007. The 2005 IOM report's ''baseline'' quality measures include Hospital Quality Alliance (HQA)-approved clinical quality measures, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient perspective survey, and three structural measures. The structural measures are: (1) Implementation of computerized provider order entry for prescriptions, (2) staffing of intensive care units with intensivists, and (3) evidence-based hospital referrals. These measures originate from the Leapfrog Group's original ''three leaps,'' and are part of the NQF's 30 safe practices.

In 2002, the Secretary of HHS initiated a partnership with several collaborators intended to promote hospital quality improvement and public reporting of hospital quality information. This collaboration is known as the Hospital Quality Alliance (HQA). The collaborators include the American Hospital Association, the Federation of American Hospitals, the Association of American Medical Colleges, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Quality Forum (NQF), the American Medical Association, the Consumer-Purchaser Disclosure Project, the AARP, the American Federation of Labor-Congress of Industrial Organizations (AFL–CIO), the Agency for Healthcare Research and Quality (AHRQ), as well as CMS, Quality Improvement Organizations (QIOs), and other stakeholders who share a common interest in reporting on hospital quality. The HQA has been proactive in making performance data on hospitals accessible to the public, thereby improving patient care.

The RHQDAPU program, however, is distinct from the HQA (formerly known as the National Voluntary Hospital Reporting Initiative). Hospitals participate in the HQA on an entirely voluntary basis. Participation in HQA has no bearing on payment under Medicare or any other Federal program. The RHQDAPU program is a CMS program that ties quality data reporting to payment under the IPPS. In some ways, the HQA can be seen as a testing ground for a quality measure before CMS adopts it for purposes of the RHQDAPU program. To date, all of the quality measures CMS has adopted for purposes of the RHQDAPU had previously been for HQA reporting. We note, however, that HQA adoption is not a legal prerequisite for CMS to adopt a measure for purposes of the RHQDAPU program.

In the FY 2007 IPPS final rule, we began to implement the new IPPS RHQDAPU program requirements by adding 11 HQA-approved measures to our 10-measure ''starter set'' of quality measures, for purposes of the FY 2007 update (71 FR 48031 through 48037).

Under section 1886(b)(3)(B)(viii)(V) of the Act, for payments beginning with FY 2008, we are required to add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, we must include measures set forth by one or more national consensus building entities.

Commenters on the FY 2007 IPPS proposed rule requested that we notify the public as far in advance as possible of any proposed expansions of the measure set and program procedures in order to encourage broad collaboration and to give hospitals time to prepare for any anticipated changes. Other commenters requested that we adopt additional quality measures and that we do so as soon as feasible. For example, several commenters urged that we adopt the HCAHPS patient survey as a part of the IPPS RHQDAPU program, while others suggested that we adopt more of the IOM measures as well as more outcome measures, including mortality measures that were not included in the 2005 IOM report's ''baseline'' quality measures. In response to these comments and as part of our continuing efforts to strengthen the IPPS RHQDAPU program, in the CY 2007 OPPS proposed rule, we sought comments on this proposal to expand, for FY 2008, the measurement set beyond those measures we adopted for purposes of the FY 2007 update. This proposed expanded set would further broaden the scope of the IPPS RHQDAPU program by including the HCAHPS patients' perspectives of care measures as well as surgical care and mortality outcome measures. We received a number of comments in response to our proposal. These comments are discussed below.

Comment: A majority of the commenters appreciated that CMS has proposed measures for FY 2008 that have already been adopted as part of the HQA's effort to promote public reporting of hospital data. Also, commenters recommended that CMS continue to work with HQA and that CMS align its choices of measures and link payment with the measures chosen by HQA to provide a public accountability for quality. The commenters suggested that this alignment will also reinforce the importance of public transparency on quality to help to focus quality improvement efforts on identified high priority care areas.

Response: We strongly value our association with the HQA, which was established as a public-private collaboration to promote voluntary hospital public reporting on quality of care. We plan to continue to work closely with HQA on the choice of measures publicly reported on Hospital Compare. Additionally, we will

continue to focus efforts on measures adopted by the HQA.

Comment: A majority of the commenters applauded and expressed support for CMS efforts to establish the measures hospitals will be expected to report under the IPPS RHQDAPU program early enough for hospitals to put the proper data collection processes in place.

Response: We appreciate these comments as we recognize the importance of communications to hospitals. CMS will continue to provide information as early as possible on the measures hospitals that will be used for the IPPS RHQDAPU program. We also look forward to commenters' continued support as we expand the set of measures for the program.

Comment: One commenter supported the expanded FY 2008 measurement set, but urged CMS to also add the structural measures that were included in the 2005 IOM report ''Performance Measurement: Accelerating Improvement.''

Response: At this time we are not adopting the three structural measures recommended by the Leapfrog Group. As we continue to expand the set of measures under the IPPS RHQDAPU program, we will further evaluate and consider these structural measures.

Comment: One commenter supported the HQA and its work to implement NQF-endorsed measures through a collaborative, public-private partnership. However, although the commenter believed that the HQA has been instrumental in advancing hospital performance reporting via the Hospital Compare Web site, the commenter did not believe that the HQA adhered to the same consensus-building process used by the NQF. The commenter viewed the roles of these two entities as distinct, though complementary.

Response: We agree that the roles of the HQA and NQF are distinct. However, the NQF is represented on the HQA and the HQA has in principle and in practice agreed to only employ NQF-endorsed measures for public reporting. Therefore, all measures advanced by the HQA for public reporting have gone through the NQF consensus building process.

Comment: One commenter suggested that there was a need to develop an infrastructure that would facilitate the efficient transmission and storage of data and to designate an oversight entity that is responsible for the infrastructure. The commenter recommended that CMS consult with healthcare stakeholders before determining where the quality data are housed.

Response: We have a centralized information technology infrastructure in place for the transmission and storage of clinical data in support of our quality improvement initiatives. Clinical data are transmitted to the QIO Clinical Warehouse via QualityNet Exchange, a secure Web site. Access to data stored in the QIO Clinical Warehouse is limited to authorized parties. We solicit input from other healthcare stakeholders to facilitate the design and enhancements to this system.

Comment: One commenter stated the current reporting of quality data is costly, the data definitions change quarterly, and it is difficult to use the validation process. The commenter recommended that because payments are based on the validation of the measures, CMS must absolutely ensure that the CDAC and QIOs interpret the data the same way.

Response: The validation and appeal processes are posted on the QualityNet Web site under the Hospital/Data Validation tab. The Specifications Manual for National Hospital Quality Measures is updated routinely to stay with current medical practices. Hospitals should continue working with their QIOs in order to keep up with the most recent updates. The CDAC utilizes this same manual during validation for the re-abstraction of medical records. Modifications or clarifications in the manual are shared with hospitals, QIOs, and the CDAC concurrently in order to maintain a common abstraction knowledge base.

We have devoted substantial resources to ensuring that the CDAC process is consistent, reliable and accurate.

Comment: Two commenters suggested that CMS create a private-sector mechanism to leverage the reporting benefit the JCAHO is providing through its vendors, especially with respect to attention to the quality of the data.

Response: CMS strongly values its collaborative relationship with the JCAHO and agrees the vendor community input is important. CMS is currently considering whether to form an advisory work group of vendors to work with our staff.

Comment: One commenter did not oppose collecting of data on the proposed measures and publishing the measures for the public. However, the commenter opposed tying payment to the quality of the data during the initial phases of data collection of new measures sets. Also, the commenter opposed the proposed implementation of the new measure set because it does not give hospitals a transition period to collect data that will affect payments.

Response: We thoroughly evaluate all measures before linking them to payment. We are using this rulemaking in addition to the IPPS rulemaking to establish additional measures in order to give hospitals advance notice and lead time to learn about the collection requirements of the new measures before linking them to payment. We note that the HQA will be collecting and reporting these new measures sets before hospitals begin reporting these measures for RHQDAPU purposes. For example, the HQA began collecting the SCIP–VTE 1 and SCIP–VTE 2 measures in fourth quarter 2006, when they were first published in the HQA Specifications Manual for National Hospital Quality Measures. This allows hospitals three months to abstract and submit these measures before the first quarter of 2007, when they become IPPS RHQDAPU measures for purposes of the FY 2008 IPPS market basket update. Collection of SCIP Infection 1 and SCIP Infection 3 as RHQDAPU program measures for FY 2008 began third quarter of 2006. CMS believes the addition of SCIP–VTE 1, SCIP–VTE 2, and SCIP Infection 2 measures to the RHQDAPU measures beginning first quarter 2007 provides reasonable advance notice for hospitals.

B. Additional Quality Measures for FY 2008

1. Introduction

In the CY 2007 OPPS proposed rule, we proposed to add the following categories to the FY 2008 IPPS RHQDAPU program measure set:

- *HCAHPS Survey*

HCAHPS is also known as Hospital CAHPS® or the CAHPS® Hospital Survey. The HCAHPS survey is composed of the following 27 questions:

+ 18 substantive questions that measure critical aspects of the hospital experience (communication with doctors; communication with nurses; responsiveness of hospital staff; cleanliness and quietness of hospital environment; pain management; communication about medicines; and discharge information).

+ 4 questions that direct patients to complete only those survey questions that apply to them.

+ 3 questions to be used to adjust the mix of patients across hospitals.

+ 2 questions that support Congressionally-mandated reports, the ''National Healthcare Disparities Report,'' and the ''National Healthcare Quality Report.''

- *Surgical Care Improvement Project (SCIP)*

+ SCIP–VTE 1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patient

+ SCIP–VTE 2: VTE prophylaxis within 24 hours pre/post surgery
+ SCIP Infection 2: Prophylactic antibiotic selection for surgical patients
• *Mortality*
+ Acute Myocardial Infarction 30-day mortality—Medicare patients
+ Heart Failure 30-day mortality—Medicare patients
+ Pneumonia 30-day mortality—Medicare patients

We discuss these proposed measures in detail below.

2. HCAHPS Survey and the Hospital Quality Initiative

We have partnered with another HHS agency, AHRQ, to develop HCAHPS. The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives of hospital care. While many hospitals currently collect information on patients' satisfaction with care, there is currently no national standard for collecting or publicly reporting this information that would enable valid comparisons to be made across hospitals. To make the appropriate comparisons to support consumer choice, we believe it is necessary to introduce a standard measurement approach. HCAHPS can be viewed as a core set of questions that can be combined with a broader, customized set of hospital-specific items. HCAHPS is intended to complement the data hospitals currently collect to support improvements in hospitals' internal customer services and quality related initiatives.

Three broad goals have shaped HCAHPS. The survey is designed to produce data on the patients' perspective of care that allows objective and meaningful comparisons among hospitals on issues that are important to consumers. In addition, public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care. Also, public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the HCAHPS initiative has taken substantial steps to assure that the survey will be credible, useful, and practical.

Throughout the HCAHPS development process, AHRQ and CMS have solicited and received a great deal of public input. AHRQ published a **Federal Register** notice that called for measures in July 2002 (67 FR 48477) and we solicited input on drafts of the HCAHPS instrument and its implementation strategy (February 2003, June 2003, and December 2003—68 FR 5889, 68 FR 38346, 68 FR 68087). In addition to the public comments received, results from a 3-State Pilot Study were used to reduce the pool of 66 survey questions to 25 questions.

In addition to the development and review processes, we submitted the 25-item version of the HCAHPS instrument to the NQF for its review and endorsement through its consensus development process. The NQF is a voluntary consensus standard-setting organization established to standardize health care quality measurement and reporting. NQF endorsement represents the consensus of numerous health care providers, consumer groups, professional associations, purchasers, Federal agencies, and research and quality organizations. Following a thorough, multi-stage review process, HCAHPS was endorsed by the NQF board in May 2005. In the process, NQF recommended a few modifications to the instrument. As a result of the recommendations of the NQF Consensus Development Process, questions regarding courtesy and respect were added to the survey. The NQF review committee believes that these questions are important to all patients, and may be particularly meaningful to patients who are members of racial and ethnic minority groups. Upon the recommendation of the NQF, we further examined the costs and benefits of the 27-item HCAHPS survey. This cost-benefit analysis of HCAHPS was conducted by Abt Associates, Inc. The report of this analysis can be found at *http://www.cms.hhs.gov/HospitalQualityInits/downloads/HCAHPSCostsBenefits200512.pdf.*

We published a **Federal Register** notice soliciting comments on the draft 27-item HCAHPS Survey in November 2005 (70 FR 67476). The HCAHPS survey received approval by the Office of Management and Budget (OMB) on December 22, 2005.

Shortly thereafter, we began final preparations for the voluntary national implementation (as a part of the Hospital Quality Initiative) with the support of the HQA. We also offered training sessions for hospitals self-administering the survey and survey vendors acting on behalf of hospitals in February and April 2006. Since HCAHPS was a new initiative, we decided that it was critical to hospitals, survey vendors, and CMS to acquire first-hand experience with data collection, including sampling and data submission to the QualityNet Exchange, before we collected data for public reporting. For hospitals participating in the national implementation of HCAHPS on October 1, 2006, we required participation in a short dry run period of at least one month. A hospital could choose to sample and survey discharges in April, May, and/or June 2006. Data from this ''dry run'' are not publicly reported.

National implementation began in October 2006 for this first set of hospitals and survey vendors that are participating in the HCAHPS voluntary initiative. The initial data collection covers 9 months of patient discharges (October 2006 through June 2007). Hospital results will be publicly reported on the CMS Hospital Compare Web site (*http://www.hospitalcompare.hhs.gov*). After the initial implementation, the Web site will contain 12 months of HCAHPS data and will be updated quarterly.

The HCAHPS survey is currently available in English and Spanish. During the HCAHPS dry run and initial national implementation (discussed more fully below), we are soliciting comments from participating hospitals and survey vendors regarding additional languages for HCAHPS. This information can be submitted to our HCAHPS mailbox, *CMSHOSPITALCAHPS@cms.hhs.gov.* From the information we receive, we will establish priorities for HCAHPS translation into additional languages.

In order for the remaining hospitals to participate in HCAHPS, future training sessions for hospital personnel and survey vendors will take place in January 2007. Hospitals may choose to self-administer HCAHPS, or may choose to hire a vendor who has completed the training. A brief dry run of March 2007 discharges will allow newly participating hospitals and vendors to get ''first-hand'' experience with all phases of the data collection and submission process. Details about the HCAHPS requirements, and the additional requirements proposed for HCAHPS under the IPPS RHQDAPU program, are included in section XXII.C. and XXII.D. of this preamble.

Comment: Commenters expressed appreciation for the iterative process that CMS engaged in with the hospital field and other Federal agencies such as AHRQ in the development and then implementation of HCAHPS.

Response: We appreciate the comments and the input we received from stakeholders during the development process.

Comment: Because HCAHPS is a new measure set for hospital data collection, one commenter opposed using HCAHPS as part of the IPPS RHQDAPU program

until at least 12 months of data have been abstracted, submitted, and validated.

Response: For FY 2008, the IPPS annual payment update under the program is tied to reporting, not performance. This gives hospitals the opportunity to use HCAHPS without tying their scores to performance.

HCAHPS has been rigorously tested and validated in collaboration with a public-private partnership (HQA) on hospital quality reporting. In addition, the National Quality Forum endorsed HCAHPS in May 2005 (see final report at *http://www.qualityforum.org*) and it has received final approval from the Federal OMB (December 2005).

In order to submit HCAHPS data, each hospital, either self-administering or through use of a vendor, must participate in at least a one month dry run. The dry run mirrors all aspects of the data collection process: Sampling, survey administration, and data submission. The dry run allows participating providers to submit data without having it publicly reported. Hospitals that did not participate in the Spring 2006 dry runs will be required to carry out a dry run in March 2007 following training. Approximately 2,500 hospitals participated in the Spring 2006 dry run. These hospitals will have used HCAHPS for at least one year by July 2007.

Unlike the clinical measures, hospitals cannot validate survey data. Therefore, our oversight focuses on ensuring vendors and hospitals are following the HCAHPS protocols. During this initial implementation prior to July 2007, CMS will begin conducting oversight activities to provide feedback to hospitals and survey vendors. We are also currently providing feedback based on the April, May and June 2006 dry run submissions and will conduct a similar process for the March 2007 dry run.

After careful consideration of the public comments received, we are adopting as final the HCAHPS measure requirements we proposed.

3. Surgical Care Improvement Project (SCIP) Quality Measures

The Surgical Care Improvement Project (SCIP) is a national quality partnership of organizations committed to improving the safety of surgical care through the reduction of post-operative complications. The primary goal of the partnership is to save lives by reducing the incidence of surgical complications by 25 percent by the year 2010.

Partners in SCIP believe that a meaningful reduction in complications requires a systems approach to our challenges, which means that surgeons, anesthesiologists, primary care physicians and internal medicine specialists, perioperative nurses, pharmacists, infection control professionals, and hospital executives must work together to make surgical care improvement a priority. SCIP partners coordinate their efforts through a steering committee that includes representatives of the American Hospital Association, the American College of Surgeons, the American Society of Anesthesiologists, the Association of Perioperative Registered Nurses, the JCAHO, the Institute of Healthcare Improvement, the Department of Veterans Affairs (VA), the AHRQ, the Centers for Disease Control and Prevention (CDC) and CMS.

SCIP is a comprehensive program, integrated into the quality improvement agenda of the CMS, JCAHO, the CDC, the American College of Surgeons, the VA's Veterans Health Administration, as well as the other organizations that comprise the SCIP Steering Committee. There are a number of activities underway from these and other partnering organizations. Hospital participation in the SCIP program is voluntary.

We received a number of comments on the SCIP measures.

Comment: One commenter applauded CMS' proposal to add SCIP–VTE 1 and SCIP–VTE 2 to the IPPS RHQDAPU program. The commenter stated that adding these measures for hospitals reporting quality data under this program will help to improve quality of care for Medicare beneficiaries, and reduce the risk of post-operative complications associated with VTE.

Response: We appreciate the comment as we recognize the importance of these measures in improving the quality of care provided to Medicare beneficiaries. We plan to continue to focus efforts on measures that will decrease the risk of surgical complications. We also look forward to the commenter's continued support as we expand the set of measures for the RHQDAPU program.

Comment: One commenter expressed concern that the CMS Medicare Quality Improvement Community (MedQIC) has delineated inappropriate cost effectiveness factors for the SCIP target areas. MedQIC's SCIP target area of ''Deep vein thrombosis'' includes a discussion of the cost of low-dose unfractionated heparin (LDUH) versus the cost of low-molecular-weight heparin (LMWH).

Response: We have reviewed the information currently posted on MedQIC and the information pertaining to cost effectiveness factors for SCIP target areas is accurate. The statement from the SCIP Education Module (developed by the Florida QIO) about the cost of low-dose unfractionated heparin (LDUH) versus the cost of low-molecular weight heparin (LMWH) is not meant to be an endorsement of the lower cost thromboprophylaxis. As evident in the VTE prophylaxis recommendation table located in the Measure Information Form for SCIP–VTE–1 (found at *http://www.QualityNet.com*, select Hospitals, then Specifications Manual from the drop-down menu), both forms of thromboprophylaxis are listed, where appropriate.

Comment: One commenter urged CMS to take the lead in developing a new VTE measure for prophylaxis of medical patients at risk for VTE. The commenter believed that this is consistent with NQF-endorsed safe practices. The commenter noted that the IPPS RHQDAPU program currently only includes measures for VTE prophylaxis in surgery patients and recommended that CMS expand the measure to include a measure for prophylactic treatment of medical patients at risk for VTE.

Response: Currently, we are supportive of JCAHO's efforts to create VTE measures for the medical community and have provided technical support to that activity in conjunction with the alignment of other measures. We will continue to take an active part in making recommendations for additional measure development.

Comment: One commenter commended CMS for the steps it has taken through the SCIP pilot to increase VTE prophylaxis in acute care hospitals. The commenter believed that the addition of the SCIP–VTE 1 and 2 to the Hospital Compare Web site is an important step to improving prophylaxis and reducing complications in surgical patients. However, the commenter believed that there are a significant number of hospitalized nonsurgical patients who are at risk for VTE. The commenter stated VTE is a hospital-wide preventable condition; while addressing prophylaxis for surgical patients in the hospital setting is a necessary step, alone it is not sufficient to reduce the overall rate of VTE across the continuum of care.

The commenter encouraged CMS to go beyond the silos of hospital setting and need based on surgery and address three critical areas:

- Continuity of prophylaxis into other treatment setting after surgery;
- Prophylaxis for the medical patients in the hospital who are high risk of VTE;

• Outcome measures for all hospitalized patients, at 90 days for re-hospitalization for symptomatic VTE and mortality.

Response: We believe that the clinical situation for non-surgical patients is very different. The NQF has endorsed surgical VTE prophylaxis measures, but has not endorsed any VTE prophylaxis measures for the non-surgical patient. We are working closely with JCAHO in its work regarding VTE prophylaxis in the non-surgical patient. That work is very time consuming and final measures will take a significant amount of time to create and then test. In the interim CMS will move ahead with those measures for surgical patients.

After careful consideration of the public comments received, we are adopting as final the SCIP requirements we proposed.

4. Mortality Outcome Measures

CMS recognizes that the current set of hospital performance measures should be expanded to more fully reflect outcomes of care. The 30-day mortality measures for patients with acute myocardial infarction (AMI), heart failure (HF) and pneumonia are three separate claims-based, risk-adjusted assessments of mortality within 30 days of admission for each of the three conditions. The measures reflect outcomes of care for Medicare patients only, and rely on Medicare patients' historical medical care use, including inpatient and physician office visits and outpatient care 1 year before their hospitalizations, for the risk adjustment calculation.

The 30-day mortality rate measures for AMI and HF were endorsed by the NQF in 2005 (see *http://www.qualityforum.org/news/tb3Hospspecsforweb02–10–06.pdf*). We anticipate that the 30-day mortality rate measure for pneumonia will also be endorsed by the NQF since it reflects the same underlying methodology as the other 30-day mortality measures.

In contrast to the HCAHPS and SCIP quality measures added to the measure set for FY 2008, no additional data collection from hospitals will be required to calculate the 30-day mortality measures. All three measures can be calculated based on Medicare inpatient and outpatient claims data that are already reported to the Medicare program for payment purposes. We anticipate that we will conduct a national dry run for the AMI and HF measures in late 2006 to test implementation and educate hospitals on the methodology. During this dry run, hospitals will be given the opportunity to examine their rates and other data associated with the measures, and to provide feedback to CMS on questions related to the calculation of the rates. The rates that will be developed for the dry run will be used for quality improvement purposes and will not be publicly reported to the Hospital Compare. More information about the dry run will be provided to hospitals through the QualityNet Exchange Web site (*http://www.qnetexchange.org*).

We proposed to calculate and publicly report 30-day mortality rates for the AMI and HF conditions in the June 2007 update of the Hospital Compare Web site. Under the proposal, rates for the 30-day pneumonia mortality measure would be posted as soon as possible after we receive NQF endorsement. As is currently the case for the other measures, hospitals would be provided a 30-day period in which they would be permitted to preview their rates before publication. As is currently the case for the ''starter set'' measures, hospitals that pledged to submit data for full annual payment update for FY 2008 would not be permitted to suppress or withhold publication of the rates on the Hospital Compare Web site, except under highly limited circumstances.

Comment: Three commenters believed that use of the 30-day risk adjusted mortality measures for acute myocardial infarction and heart failure patients did not represent the best outcome measures that could be selected by Medicare to represent the quality of care delivered to patients in hospitals. The commenters recommended that CMS identify outcome measures that better reflect the quality of hospital care.

Response: We are interested in identifying other outcome measures that reflect quality hospital care that are of importance to consumers. However, the 30-day risk adjusted mortality measures for acute myocardial infarction and heart failure complement the other AMI and HF measures already reported on Hospital Compare and will provide additional information to consumers regarding the quality of care for these two important conditions. The evidence underlying the process measures for the cardiac conditions is based on outcomes of care (usually mortality) measured at a specified time interval (most frequently 30 days). Also, length of stay varies by hospital due to local custom, efficiency and transfer policies. For these reasons we believe that 30 day risk-adjusted mortality is a better outcome measure to measure the quality of care delivered to patients in hospitals than in-patient mortality. In addition, these measures were unanimously recommended by the NQF Scientific Committee as the sole claims-based 30-day mortality measures that met the NQF's stringent scientific criteria. The measures were subsequently NQF-endorsed through its consensus development process.

Comment: One commenter believed that the use of the 30-day risk adjusted mortality for acute myocardial infarction is not congruent with the in-hospital mortality measures that are part of the JCAHO core measures for acute myocardial infarction and an outcome measure that is being used in the Premier Hospital Quality Incentive Demonstration project.

Response: It is our understanding that the once CMS begins publicly reporting these 30-day mortality measures on Hospital Compare, JCAHO will no longer independently report inpatient mortality. The 30-day mortality measures include both patients who expire while in the hospital and patients who expire after discharge. We believe that the 30-day measure is a better measure to assess hospital performance because a standardized period of time over which performance is assessed is particularly important because (1) length of stay varies by hospital due to local custom, efficiency and transfer policies, and (2) limiting reporting to in-hospital mortality would provide a strong incentive for hospitals to adopt strategies to transfer people who are dying to other facilities (other acute care hospitals or SNFs or home).

Comment: One commenter recommended that CMS publicly recognize the limitations associated with the use of the mortality measures, as every risk-adjustment methodology has limitations based on its underlying assumptions that the data is available and used in those calculations. Additionally, the commenter recommended that CMS to be open to refining the risk adjustment methodology and/or selection of alternate outcome measures based on hospital and health system recommendations.

Response: We will make the mortality measures methodology transparent to the public by posting the report on the risk adjustment methodology and measure specifications on the CMS website at *http://www.cms.hhs.gov* or *http://www.cms.hhs.gov/HospitalQualityInits/*. The limitations of the measures will be a part of the report. Furthermore, hospitals and health systems will have the opportunity to examine the methodology, review their own data, and provide feedback to CMS in a national ''dry run'' of the measures

prior to public reporting. We also plan to continue refining and updating the mortality measures in order to ensure the scientific soundness of the measure methodology.

Comment: One commenter supported the use of outcome quality measures such as the 3 mortality measures. However, the commenter believed that CMS must make its risk adjustment method completely transparent to all stakeholders prior to using these measures of quality and noted that the propose rule does not contain a transparent explanation of how risk adjustments will be made.

Response: We will make the risk adjustment methodologies and measure specifications available to the public. Furthermore, prior to publicly reporting these mortality measures on Hospital Compare, CMS will conduct a dry run with all the hospitals in the nation. CMS will not post the hospital mortality rates on the Hospital Compare Web site during the dry run. The dry run is intended to give hospitals an opportunity to have experience with the measures and the risk adjustment methodology and review their mortality rates prior to public reporting. Hospitals will also have an opportunity to send their feedback to CMS during the dry run.

After careful consideration of the public comments received, we are therefore adopting as final the AMI and heart failure mortality measure requirements we proposed. When we proposed adding the pneumonia mortality measure for the FY 2008 IPPS RHQDAPU program, we believed that it would soon be endorsed by the NQF. However, the NQF has not yet endorsed the pneumonia mortality measure. Therefore, we are not adopting the pneumonia mortality measure in this final rule. We intend to adopt this measure after the NQF endorses it. At the time we determine to adopt the measure, we would finalize our proposal to adopt the pneumonia mortality measure in a notice published in the **Federal Register**.

C. General Procedures and Participation Requirements for the FY 2008 IPPS RHQDAPU Program

All revised procedures for FY 2008 also will be added to the ''Reporting Hospital Quality Data for Annual Payment Update Reference Checklist'' section of the QualityNet Exchange Web site. This checklist also links to all of the forms to be completed by hospitals participating in the program.

To participate in the RHQDAPU program, as we proposed, we are requiring that hospitals must follow these steps:

- Complete all registration steps; this information can be found on ''Reporting Hospital Quality Data for Annual Payment Update Reference Checklist'' located on the QualityNet Exchange Web site.
- Continue to collect data for all clinical quality measures that are currently part of the RHQDAPU program, and submit the data to the QIO Clinical Warehouse either using the CMS Abstraction & Reporting Tool (CART), the JCAHO ORYX® Core Measures Performance Measurement System, or another third-party vendor tool that has met specification requirements for data transmission to QualityNet Exchange. For HCAHPS, the submission needs to be in the required XML formats or through the online data submission tool. The submission must be done through QualityNet Exchange. Because the information in the QIO Clinical Warehouse is considered QIO information, it is subject to the stringent QIO confidentiality regulations in 42 CFR Part 480.

In addition, for purposes of the annual payment update, we will continue to require hospitals to pass our validation requirements for the clinical quality measures. We originally set forth these requirements in the FY 2006 IPPS final rule (70 FR 47421), and we will continue to require that hospitals achieve an 80-percent reliability. We will also continue to post information related to validation requirements on the QualityNet Exchange Web site.

In addition to these general procedures, the specific procedures below apply to these additional measures.

D. HCAHPS Procedures and Participation Requirements for the FY 2008 IPPS RHQDAPU Program

1. Introduction

Under sections 1886(b)(3)(viii)(III) and 1886(b)(3)(B)(viii)(IV) of the Act, CMS must begin to adopt the baseline set of performance measurements as set forth in a 2005 report issued by the Institute of Medicine (IOM) of the National Academy of Sciences under section 238(b) of Public Law 108–173, effective for payments beginning with FY 2007. CMS is expanding the set of IOM measures that hospitals will be required to report to receive the full IPPS market basket update for FY 2008. In accordance with the recommendation of the 2005 IOM report, CMS is expanding the ''starter'' measures by including the HCAHPS patient perspective survey. In accordance with section 1886(b)(3)(B)(viii)(V) of the Act, CMS is also adding ''other measures that reflect consensus among affected parties and, to the extent feasible and practicable,'' and include ''measures set forth by one or more national consensus building entities.'' Accordingly, CMS will add additional SCIP quality measures and two 30-day mortality measures, as discussed in section XXII.E. of this preamble.

2. HCAHPS Hospital Pledge and Beginning Date for Data Collection

We proposed that hospitals will need to submit HCAHPS data to the QIO Clinical Warehouse beginning with discharges that occur in the third calendar quarter of 2007 (July through September discharges) in order to be eligible for the full FY 2008 IPPS market basket update. In order to meet HCAHPS requirements for the RHQDAPU program, we proposed that all hospitals, including hospitals new to HCAHPS and hospitals that have been collecting data since October 1, 2006, must submit a formal pledge to CMS by July 1, 2007 stating that they will collect and submit HCAHPS data to the QIO Clinical Warehouse starting with July 2007 discharges. We proposed that to meet HCAHPS requirements for the RHQDAPU program for FY 2008, all hospitals must submit this pledge to CMS.

Comment: One commenter wanted clarification as to whether all hospitals need to submit the pledge or just hospitals eligible for the RHQDAPU program.

Response: The pledge form referenced in the rule is for participation in the RHQDAPU program, so only hospitals eligible for the RHQDAPU program need to submit it.

Comment: One commenter recommended that CMS include HCAHPS in the annual formal pledge form for participation in the RHQDAPU program.

Response: We agree that it will be less confusing to hospitals to have one pledge form for both the clinical measures and HCAHPS. We will be combining all of the measures, including HCAHPS, into the RHQDAPU Notice of Participation form that hospitals fill out and submit to their QIO each summer.

Comment: One commenter requested that the RHQDAPU participation form be made available to submit electronically.

Response: The RHQDAPU Notice of Participation form is available electronically on *http://www.qualitynet.org*. Submitters must mail or fax their signed forms to the

QIOs. The QIOs then enter the information into the Program Resource System (PRS).

We are finalizing our proposal to require that, in order to be eligible for the full FY 2008 IPPS market basket update, hospitals must submit a pledge stating that they will collect and submit HCAHPS data to the QIO Clinical Warehouse starting with July 2007 discharges. This pledge will be part of the RHQDAPU Notice of Participation form for FY 2008 that will include the clinical measures, HCAHPS, and the mortality measures. We will announce the deadline for the RHQDAPU Notice of Participation form at a future date.

3. HCAHPS Dry Run

We are finalizing our proposal to require hospitals that have not had experience collecting and submitting HCAHPS data to the QIO Clinical Warehouse as a result of participating in the 2006 voluntary initiative must participate in a dry run of the survey in March 2007. We proposed to require the submission of March 2007 dry run data to the QIO Clinical Warehouse by July 13, 2007 from those hospitals not yet collecting and submitting HCAHPS data. We received no comments on this proposal.

4. HCAHPS Data Collection Requirements

We also are finalizing our proposal that, to collect HCAHPS data, a hospital can either contract with an approved HCAHPS survey vendor that will conduct the survey and submit data on the hospital's behalf to the QIO Clinical Warehouse, or a hospital can self-administer the survey without using a survey vendor provided that the hospital meets Minimum Survey Requirements as specified at (*http://www.HCAHPSonline.org/programapplication.asp*). A current list of approved HCAHPS survey vendors can be found at *http://www.HCAHPSonline.org/app_vendor.asp*. We received no comments on this proposal.

5. HCAHPS Registration Requirements

We are adopting as final our proposal that HCAHPS registration requirements for the IPPS RHQDAPU program will include the following:

The hospital must be a registered user of QualityNet Exchange. Hospitals that are self-administering HCAHPS or survey vendors hired by the hospitals must collect and submit HCAHPS survey person-level data electronically to the QIO Clinical Warehouse via QualityNet Exchange, using prescribed file specifications that can be found at *http://www.HCAHPSonline.org/techspecs.asp*. We received no comments on this proposal.

6. Additional Steps for HCAHPS Participation

We are finalizing our proposal that, in order to participate in HCAHPS, hospitals that self-administer the survey and survey vendors that collect and submit data on behalf of client hospitals must follow these steps:

• *Attend Hospital/Survey Vendor Training.* Hospitals and survey vendors that intend to actually administer the survey must attend HCAHPS training. Hospitals contracting with a survey vendor or another hospital to administer the survey on behalf of the hospital do not need to attend training. The next training session will be offered via Webinar in late January 2007. Please see *http://www.HCAHPSonline.org* for updated information on training opportunities and registration. At a minimum, the hospital's or survey vendor's project manager must attend the HCAHPS training for administering the survey. Hospitals and survey vendors that attended training in February or April 2006 and are participating in the voluntary HCAHPS data submission beginning October 2006 do not need to participate in the January 2007 training sessions. In addition, we may hold short refresher training sessions for all hospitals self-administering the survey and survey vendors in the spring of 2007.

• *Review and follow the HCAHPS Quality Assurance Guidelines and Updates.* HCAHPS Quality Assurance Guidelines have been developed to standardize the survey data collection process and to ensure comparability of data reported through HCAHPS. They are located on *http://www.HCAHPSonline.org* and will also be presented at the HCAHPS hospital/survey vendor training.

The HCAHPS Quality Assurance Guidelines (the Guidelines) provide detailed information regarding: technical support; sampling protocols; the four allowed modes of survey administration; data specifications and coding; data preparation and submission; data reporting and the exceptions process. The Guidelines describe technical support that is available to hospitals and survey vendors administering HCAHPS by using a toll-free number or by e-mail. The Guidelines provide details regarding the protocol for sampling, which is based on drawing a simple random sample each month from the sampling frame of eligible discharges. Sampling can be done at one time after the end of the month, or continuously throughout the month, as long as a simple random sample is generated for the month. The Guidelines include very specific information about the four allowed modes of survey administration: mail only, telephone only, a mixed methodology of mail with telephone follow up, and active interactive voice response (IVR). All modes of administration require following a standardized protocol. The Guidelines describe a standardized approach for handling all data, including assigning the unique tracking number, the decision rules for capturing data, the file specifications, the file layout, the procedure for assigning disposition codes, the definition of a completed survey, and the procedure for calculating the total survey response rate. Data preparation and submission guidelines cover registration for data submission via the QualityNet Exchange, creation of data files, instructions for data submission via the QualityNet Exchange, and confirmation of accuracy of data. Data reporting covers internal and external reports; among them are the hospital preview reports and the public reports on CMS Hospital Compare. The Quality Assurance Guidelines describe the exceptions process to review requests for methodologies that vary from the standard HCAHPS protocols, and the appeals process if an exception is denied. For the initial implementation phase of the HCAHPS survey, no exceptions to the four approved modes of survey administration will be allowed.

In addition, hospitals/survey vendors must follow any updates that are posted on *http://www.HCAHPSonline.org*.

• *Develop Hospital/Survey Vendor HCAHPS Quality Assurance Plan.* Hospitals self-administering the survey and survey vendors must develop a Quality Assurance Plan for survey administration in accordance with the Quality Assurance Guidelines presented at the HCAHPS hospital/survey vendor training and posted on *http://www.HCAHPSonline.org/programapplication.asp*. The HCAHPS Quality Assurance Plan should include the following:

+ Organizational chart
+ Work plan for survey implementation
+ Description of survey procedures and quality controls
+ Plans for quality assurance oversight of on-site work and of all subcontractors' work
+ Confidentiality/Privacy and Security procedures in accordance with

the Health Insurance Portability and Accountability Act (HIPAA).

The hospital or survey vendor must make the HCAHPS Quality Assurance Plan available to the HCAHPS project team upon request. The project team includes CMS, the Health Services Advisory Group (HSAG) that is helping CMS implement HCAHPS, and HSAG's subcontractors for this project.

• *Attest to the Accuracy of the Organization's Data Collection.* Hospitals self-administering the survey and survey vendors must review and agree that the HCAHPS survey was administered in accordance with the HCAHPS Quality Assurance Guidelines.

• *Participate in HCAHPS oversight activities.* Hospitals and survey vendors must participate in a quality oversight process conducted by the HCAHPS project team. Prior to July 2007, the purpose of the oversight activities will be to provide feedback to hospitals and survey vendors on data collection procedures. Starting in July 2007, CMS may ask hospitals/survey vendors to correct any problems that are found and provide follow-up documentation of corrections for review within a defined time period. If we find that the hospital has not made these corrections, CMS may determine that the hospital is not submitting appropriate HCAHPS data for the RHQDAPU program.

As part of these activities, HCAHPS project staff will review and discuss with survey vendors and hospitals self-administering the survey their specific Quality Assurance Plans, survey management procedures, sampling and data collection protocols, and data preparation and submission. This review may take place in-person or through other means of communication.

Comment: One commenter asked how the integrity of HCAHPS survey will be protected if it is sent to a prisoner or mentally incapacitated patient. The commenter also asked how CMS will validate that the survey was actually completed by the patient.

Response: Hospitals participating in the HCAHPS survey are instructed to exclude certain categories of patients from the universe of patients to whom the survey may be administered. These excluded categories encompass, among others, both prisoners and patients admitted to hospital for psychiatric treatment. In addition, psychiatric hospitals, as defined under section 1861(f) of the Act, do not participate in the RHQDAPU program because they are excluded from the IPPS.

To ensure that the patient completes the survey, hospitals participating in HCAHPS and the survey vendors that administer the survey on their behalf must notify all patients they survey that only the patient himself or herself should complete the survey. Survey vendors conducting telephone surveys may only speak directly to the patient. If they reach a family member or someone other than the patient, that person cannot complete the survey. There are instructions on all mail surveys that only the patient may complete the survey.

Comment: Some commenters expressed concern about having yet another entity that hospitals and health systems need to be familiar with, especially since they deal primarily with the QIO regarding issues around quality measurement, submission of data to the QIO Clinical Warehouse, annual payment update, and appeals related to chart validation. These commenters asked whether the QIOs have any involvement with HCAHPS.

Response: The submission of HCAHPS data is similar to the data submission for the clinical measures. We have contracted with the Iowa Foundation of Medical Care (IFMC) for the data submission through QualityNet Exchange and the QIO Clinical Warehouse, and with the Health Services Advisory Group, Inc. (HSAG) of Arizona for all technical assistance and support for HCAHPS. HSAG is fully available to accommodate assistance needs on a national basis for HCAHPS. We believe that this carefully coordinated effort will ensure a high level of reliability of data collection, data submission and data oversight since consistency of protocols is essential to the success of this survey and to assuring quality data reporting to the public. In addition to these two QIOs (IFMC and HSAG), we anticipate that all QIOs will be involved in the preview process prior to public reporting.

7. HCAHPS Survey Completion Requirements

We also are finalizing our proposal to require hospitals to submit complete HCAHPS data in accordance with the HCAHPS Quality Assurance Guidelines located at *http://www.HCAHPSonline.org* and made available at the hospital/survey vendor training. These requirements specify that hospitals are required to survey a random sample of eligible discharges on a monthly basis. Hospitals should target to collect at least 300 completed surveys over the public reporting period. For the initial HCAHPS national implementation, the public reporting period is 9 months (October 2006 through June 2007) due to broad interest in making HCAHPS results publicly available as quickly as possible. As discussed above, participation in this initial 9 month reporting period is not a requirement under the RHQDAPU program and hospitals do not need to participate in this initial reporting period in order to receive the full FY 2008 IPPS market basket update. After this initial implementation, reporting of HCAHPS data will be required under the RHQDAPU program. The public reporting period will be 12 months and hospitals should be targeting to collect at least 300 completed HCAHPS surveys over a 12 month period. Smaller hospitals that cannot collect 300 completed HCAHPS surveys during a public reporting period will only be required to collect as many completed surveys as possible. A small hospital is defined for the purposes of HCAHPS as any hospital that cannot achieve 300 completed HCAHPS surveys during a public reporting period because of its dearth of eligible hospital discharges during that period. For hospitals that cannot collect 300 completed HCAHPS surveys, we plan to note on *http://www.hospitalcompare.hhs.gov* that the results for these hospitals are based on less than 100 completed HCAHPS surveys, or between 100 and 299 completed HCAHPS surveys.

8. HCAHPS Public Reporting

We are finalizing our proposal to display HCAHPS data on our Web site for public viewing in accordance with section 1886(b)(3)(B)(viii)(VII) of the Act, which states that the Secretary must report quality measures that relate to patients' perspectives of care on our Web site. Before we display this information, hospitals will be permitted to review their data to be made public as we have recorded it.

As discussed above, there are 27 questions included in the HCAHPS survey. The survey is comprised of substantive questions that directly pertain to seven domains of primary importance to the target audience: doctor communication; nurse communication; cleanliness and quiet of the hospital environment; responsiveness of hospital staff; pain management; communication about medicines; and discharge information. The survey also includes two overall questions that measure the patient's overall satisfaction with the hospital and willingness to recommend the hospital.

Each of the seven domains is constructed from two or three questions from the survey and is reported as a composite score. For public reporting purposes, the seven composite scores or items from within these domains and

two overall ratings will be displayed. There will be both national and state comparisons for each of the reported results. We are currently conducting testing with consumers to ensure that the HCAHPS displays on *http://www.hospitalcompare.hhs.gov* are consumer friendly. Generally, for CAHPS® measures in other settings we display bar graphs with the top response categories, such as the percent of people surveyed that gave the hospital a ''10'' for a 0 to 10 rating, or the percent that said their doctors ''always'' communicate well. Users of the site can ''drill down'' to get more detailed information regarding the distribution for the response categories underlying the survey questions.

Comment: A commenter noted that the proposed rule does not contain a transparent explanation of how risk adjustments will be made.

Response: We will adjust HCAHPS data for mode and patient-mix effects prior to public reporting. We will adjust hospital results to ''level the playing field'' by adjusting for factors not directly related to hospital performance: mode of survey administration, patient-mix, and non-response tendencies. An HCAHPS Mode Experiment was conducted for several months in 2006, and the data analyses are now underway. The adjustment algorithm will be made available prior to the public reporting of HCAHPS results. The mode experiment results, including the adjustments to be made, will be available in late 2006 on *http://www.HCAHPSonline.org*. Several questions on the HCAHPS survey, as well as some items from hospital administrative data, will be used for patient mix adjustment.

Comment: A commenter supported publicly reporting HCAHPS survey data in seven composites and two overall ratings displayed on the Hospital Compare Web site. However, the commenter suggested that CMS consider retaining the ability for consumers to drill down so that they may assess the hospital's performance related to a single question.

Response: We appreciate this sensitivity to consumers' need to assess specific information. We are currently testing and assessing various data displays for use on the Hospital Compare Web site. We will be testing drill-downs with consumers and after the testing is completed will determine the best way to display HCAHPS data. We are also testing the seven composites to ensure that they work well for the displays and are consumer friendly.

Comment: A commenter asked CMS to continue to allow private sector organizations to have full access to provider performance information from the CMS Compare Web site and that the performance information for each question (rather than just the composite scores) on the HCAHPS survey be available for download.

Response: We are considering different options for the downloadable database and will take this request into consideration as this database is developed.

9. Reporting HCAHPS Results for Multi-Campus Hospitals

Currently, hospitals that share Medicare provider numbers combine their clinical data across campuses for submission and publication of their data. We proposed to combine HCAHPS data across campuses. However, we are considering ways in which data could potentially be displayed by campus rather than by hospital system in the future. As a starting point, we are trying to determine a way to identify those hospitals that share Medicare provider numbers, which will allow CMS to denote that the measures are made up of multiple campuses on *http://www.hospitalcompare.hhs.gov.* In the future, if feasible, we would like to move towards obtaining and reporting information at the campus level. In the CY 2007 OPPPS proposed rule, we encouraged comments regarding this issue.

Comment: One commenter recommended that all hospital data be treated consistently by reporting both clinical quality and HCAHPS data by Medicare provider number or by individual hospital.

Response: We agree that data should be reported consistently for both clinical quality and HCAHPS data, either by Medicare provider number or by individual hospital.

Comment: A commenter applauded CMS' interest in determining a way to identify those hospitals that share a Medicare provider number and move toward displaying performance information by campus rather than by hospital system as it provides consumers with more information to assist in decisions about where to obtain services.

Response: We appreciate the comment and will continue to explore ways to obtain and report information at the campus level.

Currently, hospitals that share Medicare provider numbers combine their clinical data across campuses for submission and publication of their data. For purposes of the FY 2008 RHQDAPU program, we are adopting our proposal to require hospitals to combine their HCAHPS data for all campuses of a multi-campus provider. For each reporting period, which is 12 months starting in July 2007, hospitals that share a Medicare provider number need to obtain 300 survey completes across their multiple campuses. CMS will continue to explore ways to collect and report the data by campus in the future.

E. SCIP & Mortality Measure Requirements for the FY 2008 RHQDAPU Program

- We proposed that hospitals be required to complete and return a written form on which they agree to participate in the RHQDAPU program for FY 2008.
- For the SCIP measures, we proposed to require hospitals to submit data starting with discharges that occur in CY 2007. Hospitals will be required to submit data on these measures to the QIO Clinical Warehouse beginning with discharges that occur in the first calendar year quarter of 2007 (January through March discharges). We proposed that the deadline for hospitals to submit their data for first calendar quarter of 2007 will be August 15, 2007.
- For the Mortality measures, we proposed to use claims data that is already being collected for index hospitalizations to calculate the mortality rates. Therefore, no additional data will need to be submitted by hospitals for these measures. Index hospitalization is the initial hospitalization for an episode of care. Claims data submitted to CMS for index hospitalizations occurring from July 2005 through June 2006 (3rd quarter CY 2005 through 2nd quarter CY 2006) will be used to calculate the mortality rates that will be used for FY 2008 annual payment determination. These rates will be posted on Hospital Compare in June 2007.
- We proposed to display on our Web site data collected on the SCIP and Mortality measures for public viewing in accordance with section 1886(b)(3)(B)(viii)(VII) of the Act. Before we display this information, hospitals will be permitted to review their data that are to be made public as we have recorded it.

Comment: One commenter stated that, for the SCIP–VTE 1, SCIP–VTE 2, and SCIP Infection 2 measures, the proposed time frame to report these measures do not allow for hospitals to have sufficient staff on board and to make sure they are properly educated and trained to ensure a high degree of accuracy in the data abstraction. The commenter recommends that CMS require hospitals submit data for these measures

beginning with discharges in the third quarter 2007 (July through September 2007).

Response: Collection of SCIP-Infection 1 and SCIP-Infection 3 as RHQDAPU measures for FY 2008 (which we adopted for purposes of the RHQDAPU program in the FY 2007 IPPS final rule) began third calendar quarter of 2006. The data submission deadline for third calendar quarter of 2006 is February 15, 2007. For those hospitals that are already collecting and submitting data for SCIP-Inf-1 and SCIP-Inf-3, the addition of SCIP-Inf-2 would require collection of only two additional data elements (questions). These two additional data elements include Antibiotic Allergy and Vancomycin. We believe the addition of these measures to the RHQDAPU measures beginning first quarter 2007 is a reasonable expectation for hospitals.

Collection of the SCIP–VTE 1 and SCIP–VTE 2 measures began as a voluntary submission in fourth calendar quarter of 2006 (October through December discharges) under the Surgical Care Improvement Project (SCIP) discussed in section XXII.B.3. of this final rule with comment period. These measures were first published in the Specifications Manual for National Hospital Quality Measures in the October 2006 release of the manual, which was available June 9, 2006. This provided hospitals with an opportunity to abstract and submit these measures three months before the first calendar quarter of 2007, when they become RHQDAPU measures for FY2008.

SCIP–VTE–1, SCIP–VTE–2, and SCIP-Inf-2 measures can be found in the Specifications Manual for National Hospital Quality Measures that was released in June 2006. This version of the manual pertains to fourth calendar quarter of 2006 and forward (October through December discharges).

Comment: One commenter noted that, for the SCIP–VTE 1, SCIP–VTE 2, and SCIP Infection 2 measures, hospitals and health systems require time to work with their respective performance vendors to make sure that all tools are available to allow them to do the chart abstraction.

Response: The above SCIP-Inf-2 has been collected since first calendar quarter of 2005 as part of the HQA. The Specifications Manual for National Hospital Quality Measures for fourth quarter 2006 discharges has been available to Vendors since June 9, 2006. SCIP–VTE 1 and SCIP–VTE 2 have been collected since fourth quarter 2006 under SCIP. Based on their inclusion in the SCIP or HQA efforts, these measures have been incorporated in the August and October releases of the CART and ORYX® tools so there should be no concern regarding the availability of data collection tools. Hospitals may use these tools immediately.

As discussed above, after careful consideration of the public comments received, we are adopting as final the SCIP requirements we proposed.

F. Conclusion

We believe that our decision to include HCAHPS, SCIP and mortality measures as part of the FY 2008 IPPS RHQDAPU program's reporting requirements meets the requirements of section 1886(b)(3)(B)(viii)(III) of the Act. This provision states that we must expand for FY 2007 and each subsequent fiscal year, consistent with sections 1886(b)(3)(B)(viii)(IV) through 1886(b)(3)(viii)(VII) of the Act, the set of measures that the Secretary determines to be ''appropriate'' for the measurement of care furnished by hospitals in inpatient settings beyond the original 10-measure starter set of quality measures that applied in FY 2005 and FY 2006.

Section 1886(b)(3)(B)(viii)(IV) of the Act requires us to begin to adopt the baseline set of performance measures set forth in the 2005 IOM report effective for payment beginning with FY 2007. We began to adopt these measures for FY 2007 and are now adopting additional measures, including several measures from this report. HCAHPS and the SCIP Infection 2 measures are measures set forth in the 2005 IOM report. Thus, we believe our decision to expand the measure set to include HCAHPS and SCIP Infection 2 measures for the FY 2008 IPPS RHQDAPU program meets this requirement of the Act.

Section 1886(b)(3)(B)(viii)(V) of the Act states that effective for payments beginning with fiscal year 2008, we must add ''other measures that reflect consensus among affected parties and, to the extent feasible and practicable,'' and include ''measures set forth by one or more national consensus building entities.'' In addition to adding additional measures from the baseline measures found in the 2005 IOM report, we are adding additional SCIP quality measures and two 30-day mortality measures. In selecting these measures to adopt consistent with this section for the FY 2008 payment update and thereafter, CMS is adding standardized quality measures that have been adopted or endorsed by a national consensus building entity that utilizes a national consensus building process that endorses measures based on: (1) Its consideration of issues such as the validity, reliability, impact and feasibility of the measures; and (2) input from a wide variety of stakeholders including, but not limited to, health care consumers and patients, clinicians and providers, purchasers, and researchers.

We believe that adopting measures that have been endorsed as a result of this process achieves the type of consensus that Congress envisioned in enacting section 5001(a) of Public Law 109–171. The NQF is one consensus building entity that administers this process and takes these factors into account when endorsing measures. NQF is a voluntary consensus standard-setting organization established to standardize health care quality measurement and reporting, for its review and endorsement through its consensus development process. NQF endorsement, which occurs following a thorough, multi-stage review process, represents the consensus of numerous health care providers, consumer groups, professional associations, purchasers, Federal agencies, and research and quality organizations. We recognize that the 30-day Pneumonia mortality is not currently NQF-endorsed. Therefore, as discussed above, we have decided not to adopt the 30-day Pneumonia mortality measure in this final rule with comment period.

The HQA is another such consensus building entity. The HQA is a public-private collaboration of numerous stakeholder groups. One goal of HQA is to identify a robust set of standardized and easy-to-understand hospital quality measures that would be used by all stakeholders in the health care system in order to improve quality of care and the ability of consumers to make informed health care choices. We also note that HQA currently relies on the NQF process as part of its process.

CMS anticipates that other consensus building entities that take into account the issues of validity, reliability, impact and feasibility of the measures and involves a wide array of stakeholders may develop.

XXIII. Files Available to the Public Via the Internet

Addenda A and B to this final rule with comment period provide various data pertaining to the CY 2007 payments for services under the OPPS. Addendum AA to this final rule with comment period include various data pertaining to the ASC list of covered procedures and payment rates for procedures furnished in ASCs in CY 2007.

To conserve resources and to make Addendum B more relevant to the OPPS, we are including in Addendum

B of this final rule with comment period HCPCS codes (including CPT codes) for services that are assigned a payable status indicator under the OPPS and HCPCS codes for which we are making a change in status indicator and/or APC assignment for CY 2007. A list of all active HCPCS codes and those codes discontinued as of December 31, 2006, regardless of their assigned payment status or comment indicators under the OPPS, is 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. To access Addendum C and other supporting data files related to the CY 2007 update of the OPPS, go to *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage,* and select regulation number ''CMS–1506–FC''. At this same Web site is a link to all of the FY 2007 IPPS wage index related tables from the FY 2007 IPPS final notice (71 FR 59886 through 60043), as they would be used for the CY 2007 OPPS. Similarly, we are including Addendum AA on the CMS Web site at: *http://www.cms.hhs.gov/center/asc.asp.*

For additional assistance, contact Chuck Braver, (410) 786–6719.

XXIV. Collection of Information Requirements

Under the Paperwork Reduction Act (PRA) of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the 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.

The following information collection requirements are included in this final rule with comment period and their associated burdens are subject to the PRA.

Additional Quality Measures for FY 2008: Surgical Care Improvement Project (SCIP)

Section 5001(a) of the Deficit Reduction Act (DRA) of 2005 (Pub. L. 109–171) sets out new requirements for the IPPS Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. Under section 1886(b)(3)(B)(viii)(V) of the Act, for payments beginning with FY 2008, we are required to add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, must include measures set forth by one or more national consensus building entities. In this final rule with comment period, we are setting out the additional measures that we require for FY 2008.

The burden associated with this section is the time and effort associated with collecting, copying, and submitting the data. As part of the SCIP, we estimate that there will be approximately 3,700 respondents per year. All of these hospitals already were required to submit SCIP Infection 1 and 3 to be eligible to receive the full IPPS market basket update for FY 2007. Additional surgical procedures covering approximately 6,000,000 discharges annually will be sampled at a 10-percent rate per hospital; therefore, an additional 600,000 discharges will be abstracted and submitted by hospitals for the additional SCIP measures (SCIP Infection 2 and VTE 1, 2). The 10-percent sampling rate is a minimum threshold specified in the most current version of the joint CMS/JCAHO Hospital Quality Measures Specifications Manual. We estimate that it will take 450,000 hours (3/4 hour per sampled discharge) to abstract and submit data for these additional sampled discharges.

In addition, hospitals must abstract and submit additional information needed for the additional SCIP measures covering the surgical procedures already covered in SCIP Infection 1 and 3. We estimate that about 275,000 discharges will be sampled and abstracted covering these surgical procedures. We estimate that it will take an additional 137,500 hours (1/2 hour per sampled discharge) for hospitals to abstract and submit this additional information. Both estimates include overhead.

In total, we estimate that an additional 587,500 hours will be used by hospitals to abstract and submit the additional SCIP measures. This estimate includes overhead.

Further, we note that there is no additional burden associated with the incorporation of mortality outcome measures as this information is currently collected with claims data.

We have submitted a copy of this final rule with comment period to the OMB for its review of the aforementioned information collection requirements.

This final rule with comment period also includes associated information collections for which CMS has obtained the OMB's approval. The following is a discussion of these currently OMB approved collections.

As discussed in section XXII. of this preamble, the IPPS RHQDAPU program expands upon the Hospital Quality Initiative, which is intended to empower consumers with quality of care information to make more informed decisions about their health care while also encouraging hospitals and clinicians to improve the quality of care. The information collection associated with the IPPS RHQDAPU is the Hospital Quality Alliance (formerly known as the National Voluntary Hospital Reporting Initiative) —Hospital Quality Measures. The OMB approved this information collection under OMB control number 0938–0918, with an expiration date of December 31, 2008. As a result of the increase from 10 to 21 quality measures, CMS created a revised information collection request to include the new quality measures. CMS announced the revised information collection in a 60-day **Federal Register** notice that published on June 9, 2006 (71 FR 33458). CMS will publish a 30-day **Federal Register** notice prior to the submission of the revised information collection outlined in this final rule with comment period to OMB.

Further, as discussed in section XXII. of this preamble, for FY 2008, we are expanding the IPPS RHQDAPU program to include the HCAHPS Survey, also known as the Hospital CAHPS or the CAHPS Hospital Survey. The HCAHPS Survey is composed of 27 questions: 18 substantive questions that encompass critical aspects of the hospital experience (communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness and quietness of hospital environment, pain management, communication about medicines, and discharge information); 4 questions to skip patients to appropriate questions; 3 questions to adjust for the mix of patients across hospitals; and 2 questions to support congressionally mandated reports. As explained in section XXII. of this preamble, CMS published a **Federal Register** notice soliciting comments on the draft 27-item

HCAHPS Survey in November 2005 (70 FR 67476). The OMB approved the HCAHPS Survey under OMB control number 0938–0981, with an expiration date of December 31, 2007.

Revised § 416.190(c)—Request for Review of Payment Amount

The collection of information requirements at 5 CFR 1320 are applicable to requirements affecting 10 or more entities. Revised § 416.190(c) would require that a request for review of the ASC payment amount for insertion of an IOL must include all the information that CMS specifies on its Web site.

While this section of this final rule with comment period contains information collection requirements, we estimate that less than 10 ASCs will be affected; therefore, we believe these collection requirements are exempt from OMB for review and approval, as specified at 5 CFR 1320.3(c)(4). Consequently, this section of the final rule with comment period need not be reviewed by the OMB under the authority of the PRA.

If you comment on any of 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, Regulations Development Group, Attn.: Melissa Musotto, CMS–1506–FC, 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–1506–FC), *carolyn_lovett@omb.eop.gov.* Fax (202) 395–6974.

XXV. 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 preamble, and, when we proceed with a subsequent document(s), we will respond to those comments in the preamble to that document(s).

XXVI. 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, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate that the effects of the OPPS provisions that will be implemented by this final rule with comment period will result in expenditures exceeding $100 million in any 1 year. We estimate that adding 19 procedures to the ASC list and implementing section 5103 of Public Law 109–171 in CY 2007 will result in savings to the Medicare program of approximately $15 million. A more detailed discussion of the effects of the changes to the ASC list of procedures for CY 2007 is provided in section XXVI.C. below.

In addition, we estimate that the changes that we are making in section XVIII. of this preamble to implement Medicare contracting reform mandated by section 911 of Public Law 108–173 have no economic effect on current Medicare payments in CY 2007. This aspect of our rule amends our current Medicare contractor regulations to conform them to the statutory changes mandated by Public Law 108–173 and in and of itself does not affect in any way Medicare's coverage or payment policies for hospital outpatient services or any other covered Medicare services. Accordingly, we believe that this provision has no immediate economic effect on Medicare payments in CY 2007.

Further, we estimate that the changes that we are making in section XXII. of this preamble to implement an expanded set of quality measures for the IPPS Reporting Hospital Quality Data for the Annual Payment Update (RHQDAPU) program in accordance with sections 1886(b)(3)(B)(viii)(III) and 1886(b)(3)(B)(viii)(IV) of the Act will not have a significant economic effect on Medicare payments to hospitals in CY 2007. A more detailed discussion of the effects of this provision is included in section XXII. of this preamble and section XXVI.E. below.

However, 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 2007 compared to CY 2006 to be approximately $2.24 billion. Therefore, 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 agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year (65 FR 69432).

For purposes of the RFA, we have determined that approximately 37 percent of hospitals and 73 percent of ambulatory surgery centers would be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation, manufacturing, biological products, or medical instrument industries that would be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees and $67.6 billion in annual sales (1997 business census). For biological products (except diagnostic) (NAICS 325414), with $5.7 billion in annual sales, and medical instruments (NAICS 339112), with $18.5 billion in annual sales, the standard is 50 or fewer employees (see the standards Web site at: *http://www.sba.gov/regulations/siccodes/*). 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 2,167 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 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals. We believe that the changes to the OPPS in this 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 although the changes to the ASC payment system for CY 2007 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 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. The maximum nationwide cost to hospitals will be $16.9 million for HCAHPS (Abt Report), $58.7 million in noncapital costs for SCIP, and no cost for mortality measures. This final rule with comment period will not mandate any requirements for State, local, or tribal government, nor will it affect private sector costs.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes any rule (proposed or final) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this final rule 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 54, we estimate that OPPS payments to governmental hospitals (including State, local, and tribal governmental hospitals) will increase by 2.7 percent under this final rule with comment period. The provisions related to payments to ASCs in CY 2007 will not affect payments to government hospitals. In addition, the provisions related to MACs and HCAHPS will not affect payments to government hospitals.

B. Effects of OPPS Changes in This Final Rule With Comment Period

We are making several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this final rule with comment period, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2007, as we discuss in sections II.C. and II.D., respectively, of this preamble. We also are revising the relative APC payment weights using claims data from January 1, 2005, through December 31, 2005, 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 preamble provides greater detail on this rural adjustment. Finally, we are not removing any device categories from pass-through payment status in CY 2007.

Under this final rule with comment period, the update change to the conversion factor as provided by statute will increase total OPPS payments by 3.4 percent in CY 2007. The expiration of the one-time wage reclassification under section 508 in April 2007, which is not budget neutral, and an increase in the fixed-dollar outlier threshold to account for the underestimation of outlier payments in CY 2006, results in a net increase of 3.0 percent. The changes to the APC weights, changes to the wage indices, the continuation of a payment adjustment for rural SCHs, and the expansion of the rural adjustment to EACHs will not increase OPPS payments because these changes to the OPPS are budget neutral. However, these updates do change the distribution of payments within the budget neutral system as shown in Table 54 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 these 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 Coding and Payment Policy for Visits.

In section IX. of this preamble, we are creating five new G-codes for emergency department visits provided in Type B emergency departments and one new G-code for critical care associated with trauma response. Hospitals will continue using CPT codes to describe clinic visits and emergency department visits provided in Type A emergency departments. CMS 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. However, since the beginning of the OPPS, we have acknowledged that the CPT E/M codes do not adequately describe the facility resources required to perform the services. One alternative considered was to create G-codes to be used by hospitals to report clinic visits, Type A and Type B emergency department visits, and critical care services, which would describe hospital resource use. However, many commenters objected to creating G-codes before national guidelines were implemented. In response to this concern, we are finalizing new G-codes for visits provided in Type B emergency departments because there currently are no CPT codes that describe services in these facilities. In addition, we are creating one new G-code for critical care associated with trauma response, in response to commenters' requests that we pay differentially for critical care provided with and without trauma response.

Some hospitals have requested that they be permitted to bill emergency department visit codes under the OPPS for services furnished in a facility that meets the CPT definition for reporting

emergency department visit E/M codes, except that these hospitals are not available 24 hours a day. For CY 2007, we are establishing a set of codes for visits provided in dedicated emergency departments that have an EMTALA obligation. These codes will be billed by Type B emergency departments, specifically those that do not meet the Type A requirements. We are instructing hospitals to use current emergency department CPT codes to report visits provided in a specific subset of dedicated emergency departments, called Type A emergency departments, that are open 24 hours per day, 7 days per week and that do not have an EMTALA obligation solely based on providing at least one-third of their outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. An alternative to this policy is to continue to uphold past policy and allow only the Type A subset of dedicated emergency departments to bill emergency department visit codes and require Type B emergency departments to bill clinic visit codes. However, this would not allow us to determine whether visits to dedicated emergency departments or facilities that incur EMTALA obligations but do not meet more prescriptive expectations that are consistent with the CPT definition of an emergency department have different resource costs than visits to either clinics or the Type A subset of dedicated emergency departments that meet more prescriptive expectations, including 24 hours per day, 7 days per week availability.

We are creating one new G-code for critical care associated with trauma response, in response to commenters' requests that we distinguish between critical care provided with and without trauma response. An alternative to this policy is to continue to uphold past policy and instruct hospitals to bill one CPT code for critical care services, regardless of whether the critical services were associated with trauma response. However, if hospitals only billed one code for critical care services with and without trauma activation, it would be difficult to pay differentially for the two services, as our claims data indicate is appropriate.

We must also establish payment rates for clinic and emergency department visits and critical care services. For CY 2007, we are making payments at five payment levels for both clinic and emergency department visits and at two payment levels for critical care services. We see meaningful differences among the median costs of five levels of clinic and emergency department codes that suggest that five payment levels are more appropriate than three levels. In addition, providers have indicated that it is administratively burdensome to code for five levels, but receive payment at only three levels, as has been the historical policy in the OPPS. If future data indicate that three payment levels are more appropriate, we may revert back to three payment levels. For critical care, our claims data indicate that critical care services associated with trauma response are costlier than critical care services that are not associated with trauma response. Paying for critical care services that are associated with trauma response at a higher rate will lead to a more accurate distribution of payments. An alternative to this policy is to continue paying at three payment levels for both clinic and emergency department visits and one payment level for critical care services. However, for the reasons described above, we are making payment at five levels for clinic and emergency department visits and two levels for critical care services for CY 2007 to ensure that payments more accurately reflect the median costs of the services provided.

For CY 2007, we are making payment for emergency visits to Type B dedicated emergency departments that are not part of the specific subset identified as Type A emergency departments at the same rate as clinic visits, consistent with current policy. This payment policy is similar to our current policy that requires services furnished in emergency departments that have an EMTALA obligation but do 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. While maintaining the same payment policy for CY 2007, the reporting of specific G-codes for emergency department visits provided in Type B dedicated emergency departments will permit us to specifically collect and analyze the hospital resource costs of visits to these facilities in order to determine whether a future proposal of an alternative payment policy may be warranted. An alternative would be to provide payment for services billed by Type B emergency departments at payment rates other than the clinic visit rates. However, we do not know what the hospital facility costs of these visits would be because we are unable to identify these services in our historical claims data. In some respects, their costs may resemble the costs of visits to clinics because they may not be available 24 hours per day or may not require the same high state of readiness as Type A emergency departments. In other respects, their costs may resemble the costs of visits to Type A emergency departments because they both provide predominantly unscheduled visits. Therefore, we currently have no accurate methodology for establishing payment rates that are appropriate for visits to Type B emergency departments. Therefore, consistent with past payment policies for certain services, such as drug administration, in which we maintained consistent payment policies while gathering more detailed cost data, we are continuing payment to Type B emergency departments at clinic visit rates while we gather hospital claims data specific to these visits to review their costs.

b. Alternatives Considered for Brachytherapy Source Payments

Pursuant to sections 1833(t)(2)(H) and 1833(t)(16)(C) of the Act, we have paid for brachytherapy sources furnished on or after January 1, 2004, and before January 1, 2007, 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. For CY 2007, we are making payment for brachytherapy sources at a prospectively determined rate for each source for which we have claims data, and each source is assigned to its own APC. We are converting the median cost to a relative weight by dividing it by the median for APC 0606, scaling the unscaled weight for budget neutrality, and multiplying the scaled weight by the conversion factor to calculate the payment rate per source. This is our standard OPPS methodology for using median costs to calculate the payment for each APC.

The first alternative we considered was to establish a per day payment for brachytherapy sources based on our CY 2005 claims data. While this alternative would be consistent with the philosophy of a prospective payment system and would mitigate the effects on payment of inaccurate coding of the number of sources used, we believe that a per day payment may not provide source payment specifically addressed to the hospital resources used under the unique clinical circumstances of each individual treatment because of the variation in the number of sources required to treat patients under different clinical conditions. There is considerable clinical variation in the number of sources used for brachytherapy services, and we believe a per day payment based on an average

number of sources used may not as accurately reflect the resources used for an individual Medicare beneficiary's treatment as the per source payment methodology. Therefore, we are not setting payments on a per day basis.

The second alternative we considered was to continue to make separate payment for sources of brachytherapy under the current methodology of hospital charges reduced to costs. Although hospitals are familiar with this methodology and this alternative is consistent with the requirement that 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 a hospital to provide services efficiently and at the lowest cost.

The third alternative we considered and are accepting for CY 2007 is to make payment for each brachytherapy source on a per source rate that is calculated using our standard OPPS methodology. This is consistent with our methodology for setting payment rates for other services and is consistent with the expiration of the Public Law 108–173 requirement that payment for sources of brachytherapy be made at charges reduced to cost for dates of service on and after January 1, 2004, through December 31, 2006. Moreover, for the reasons we discuss in detail in section VII. of this final rule with comment period, we believe that this option will provide the most appropriate payment for brachytherapy sources.

c. Alternatives Considered for Payment of Radiopharmaceuticals

In developing the payment policy for separately payable radiopharmaceuticals for this CY 2007 final rule with comment period, we considered three policy options.

The first alternative we considered was to package additional radiopharmaceuticals, either through packaging payments for all radiopharmaceuticals with payments for the services with which they are billed or setting a packaging threshold established specifically for radiopharmaceuticals that was much higher than the $55 threshold proposed for other drugs and biologicals. In contrast to other separately payable drugs where the administration of many drugs is reported with only a few drug administration HCPCS codes, only a small number of specific radiopharmaceuticals may be appropriately provided in the performance of each particular nuclear medicine procedure. Because the provision of nuclear medicine procedures always requires one or more radiopharmaceuticals, packaging more radiopharmaceuticals effectively would result in some increases in the associated nuclear medicine procedure APC payment rates. A policy to package additional radiopharmaceuticals would be consistent with the OPPS packaging principles and payment policies which generally provide appropriate payment for the ''average'' service and would provide greater administrative simplicity for hospitals. However, packaging the costs of all radiopharmaceuticals into the procedures in which they are used could result in inadequate payment for the highest cost products.

The second alternative that we considered for CY 2007 would have established prospective payment rates for separately payable radiopharmaceuticals using mean costs derived from the CY 2005 claims data, where the costs are determined using our standard methodology of applying hospital-specific departmental CCRs to radiopharmaceutical charges and defaulting to hospital-specific overall CCRs only if appropriate departmental CCRs are unavailable. This policy would have established our packaging threshold for radiopharmaceuticals at $55, the same as the packaging threshold for drugs and biologicals under the CY 2007 OPPS. We did not select this option because commenters indicated that changes to many radiopharmaceutical HCPCS codes in CY 2006 were made because hospitals were having difficulty with the CY 2005 codes, and, therefore, the CY 2005 hospital claims data were not accurate and not applicable to the CY 2006 codes.

The third alternative that we considered and have selected for CY 2007 is to continue the temporary CY 2006 methodology of paying for separately payable radiopharmaceuticals at charges reduced to cost, where payment would be determined using each hospital's overall CCR, and establishing our radiopharmaceutical packaging threshold at $55, as we are doing for other drugs for the CY 2007 OPPS. This policy provides stability to the payment methodology for radiopharmaceuticals from CY 2006 to CY 2007. As we indicated for CY 2006, this payment methodology provides an acceptable proxy for the average acquisition of the radiopharmaceutical along with its handling cost. We intend this methodology to be a temporary measure until we have confidence in the coding and charging practices of hospitals under the HCPCS codes that were new for CY 2006.

2. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the policy changes, as well as the statutory changes that will be effective for CY 2007, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service-mix, or number of encounters. As we have done in previous rules, we solicited comments and information about the anticipated effect of the proposed changes on hospitals and our methodology for estimating them. Comments on the impact of the proposed changes for CY 2007 are included in the discussion of the applicable topics in the preamble of this final rule with comment period. There were no comments on the methodology we proposed to use to evaluate the impact of the proposed changes other than those discussed under applicable issues.

3. Estimated Impacts of This Final Rule With Comment Period on Hospitals

The estimated increase in the total payments made under the OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service-mix. The enactment of Public Law 108–173 on December 8, 2003, provided for the additional payment outside of the budget neutrality requirement for wage indices for specific hospitals reclassified under section 508 through CY 2007. Table 54 shows the estimated redistribution of hospital payments among providers as a result of a new APC structure, wage indices, and adjustment for rural SCHs (which includes EACHs), which are budget neutral; the estimated distribution of increased payments in CY 2007 resulting from the combined impact of the APC recalibration, wage effects, the rural SCH adjustment, and the market basket update to the conversion factor; and, finally, estimated payments considering all payments for CY 2007 relative to all payments for CY 2006, including the impact of expiring wage provisions and changes in the outlier threshold. 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 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 will depend on changes in volume, practice patterns, and the mix of services billed between CY 2006 and CY 2007, which CMS cannot forecast. Overall, the final OPPS rates for CY 2007 will have a positive effect for all hospitals paid under the OPPS. Changes will result in a 3.0 percent increase in Medicare payments to all hospitals, exclusive of transitional pass-through payments. Removing cancer and children's hospitals because their payments are held harmless to the pre-BBA ratio between payment and cost suggests that changes will result in a 3.0 percent increase in Medicare payments to all other hospitals.

To illustrate the impact of the final CY 2007 changes, our analysis begins with a baseline simulation model that uses the final CY 2006 weights, the FY 2006 final post-reclassification IPPS wage indices without additional increases resulting from section 508 reclassifications, and the final CY 2006 conversion factor. Column 2 in Table 54 reflects the independent effects of the APC reclassification and recalibration changes. Column 3 reflects the effects of updated wage indices, including the new occupational mix data described in the FY 2007 IPPS final rule, and the adjustment for rural SCHs and EACHs. The clarification that the rural adjustment applies to EACHs is not shown separately because there are so few EACHs that the overall impact cannot be observed when payments are aggregated by type of hospital. These effects are budget neutral, which is apparent in the overall zero impact in payment for all hospitals in the top row. Column 2 shows the independent effect of changes resulting from the reclassification of services codes among APC groups and the recalibration of APC weights based on a complete year of CY 2005 hospital OPPS claims data and more recent cost report data. We modeled the independent effect of APC recalibration by varying only the weights, the final CY 2006 weights versus the final CY 2007 weights in our baseline model, and calculating the percent difference in payments.

Column 3 shows the impact of updating the wage index used to calculate payment by applying the FY 2007 IPPS wage index, combined with the impact of the 7.1 percent rural adjustment for SCHs and EACHs for services other than drugs, biologicals, brachytherapy sources, and those receiving pass-through payments. The OPPS wage index used in Column 3 does not include changes to the wage index for hospitals reclassified under section 508 of Public Law 108–173. We modeled the independent effect of updating the wage index and the rural adjustment by varying only the wage index and the inclusion of EACHs, using the CY 2007 scaled weights, and a CY 2006 conversion factor that included a budget neutrality adjustment for changes in wage effects and the rural adjustment between CY 2006 and CY 2007.

Column 4 demonstrates the combined ''budget neutral'' impact of proposed APC recalibration, the wage index update, and the rural adjustment for rural SCHs and EACHs on various classes of hospitals, as well as the impact of updating the conversion factor with the market basket update. We modeled the independent effect of budget neutrality adjustments and the market basket update by using the weights and wage indices for each year, and using a CY 2006 conversion factor that included the proposed market basket update and budget neutrality adjustments for differences in wages and the adjustment for rural SCHs and EACHs.

Finally, Column 5 depicts the full impact of the final CY 2007 policy on each hospital group by including the effect of all the changes for CY 2007 and comparing them to all estimated payments in CY 2006, including those required by Public Law 108–173. Column 5 shows the combined budget neutral effects of Columns 2 through 4, plus the impact of increasing the outlier threshold after realigning the overall CCR calculation used to model the outlier threshold with the one used by the fiscal intermediaries for payment, the impact of changing the percentage of total payments dedicated to transitional pass-through payments to 0.21 percent, and the expiration of payment for wage index increases for hospitals reclassified under section 508 of Public Law 108–173 in April 2007. As noted in section II.D. of this preamble, because section 508 expires in April 2007 and OPPS operates on a calendar year basis, we used a blended wage index consisting of 25 percent of the IPPS wage index with section 508 and 75 percent of the IPPS wage index after section 508 expires.

We modeled the independent effect of all changes in Column 5 using the final weights for CY 2006 and the final weights for CY 2007. The wage indices in each year include wage index increases for hospitals eligible for reclassification under section 508 of Public Law 108–173, and in 2007, these provisions expire in April 2007. We used the final conversion factor for CY 2006 of $59.511 and the final CY 2007 conversion factor of $61.468. Column 5 also contains simulated outlier payments for each year. We used the charge inflation factor used in the FY 2007 IPPS rule of 7.57 percent (1.0757) to increase individual costs on the CY 2005 claims to reflect CY 2006 dollars, and we used the most recent overall CCR for each hospital as calculated for the APC median setting process. Using the CY 2005 claims and a 7.57 percent charge inflation factor, we currently estimate that actual outlier payments for CY 2006, using a multiple threshold of 1.75 and a fixed-dollar threshold of $1,250 would be 1.25 percent of total payments, which is 0.25 percent higher than the 1.0 percent that we projected in setting outlier policies for CY 2006, due to the differences in the calculation of the overall CCR, as discussed in section II.A.1.c. of this preamble. Outlier payments of 1.25 percent appear in the CY 2006 comparison in Column 5. We used the same set of claims and a charge inflation factor of 15.15 percent (1.1515) to model the CY 2007 outliers at 1.0 percent of total payments using a multiple threshold of 1.75 and a fixed-dollar threshold of $1,825.

Column 1: Total Number of Hospitals

Column 1 in Table 54 shows the total number of hospital providers (3,992) for which we were able to use CY 2005 hospital outpatient claims to model CY 2006 and CY 2007 payments by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2006 or CY 2007 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 Marianas, American Samoa, and the State of Maryland. This process is discussed in greater detail in section II.A. of this preamble. 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. Finally, section 1833(t)(7)(D) of the Act permanently holds harmless cancer hospitals and children's hospitals to the proportion of their pre-BBA payment relative to their costs. Because this final rule with comment period will not impact these hospitals negatively, we removed them from our impact analyses. We show the total number (3,928) of OPPS hospitals, excluding the hold-harmless cancer hospitals and children's hospitals, on the second line of the table.

Column 2: APC Recalibration

The combined effects of the APC reclassification and recalibration, in Column 2 are typical for APC recalibration. Overall, these changes increase payments to urban hospitals by 0.1 percent, although some classes of urban hospitals experience decreases in payments. However, changes to the APC structure for CY 2007 tend to favor, slightly, urban hospitals. We estimate that large urban hospitals would see a 0.1 percent decrease, while ''other'' urban hospitals experience an increase of 0.2 percent.

Overall, rural hospitals show a modest 0.3 percent decrease as a result of changes to the APC structure. Notwithstanding a modest overall increase in payments, there is substantial variation among classes of rural hospitals. The lowest volume hospitals experience the largest decrease of 3.0 percent. Rural hospitals with greater than 5,000 lines of volume demonstrate no change or decreases of no more than 0.4 percent as a result of APC recalibration.

Among other classes of hospitals, the largest observed impacts resulting from APC recalibration include an increase of 0.2 percent for minor teaching hospitals and a decrease of 0.3 percent for major teaching hospitals. Urban hospitals that are treating DSH patients and are also teaching hospitals experience an increase of 0.1 percent. We project that hospitals for which a DSH percentage is not available, including psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals, will experience decreases in payments of 7.2 percent, and for the urban subset, 7.4 percent.

Classifying hospitals by type of ownership suggests that proprietary hospitals would gain 0.2 percent, governmental hospitals would experience losses of 0.1 percent, and voluntary hospitals would experience no change.

Column 3: New Wage Indices and the Effect of the Rural Adjustment

Changes introduced by the FY 2007 IPPS wage indices together with the effect of including EACHs in the rural adjustment would have a modest impact in CY 2007, with no changes to payments to rural hospitals other than SCHs, a decrease of 0.1 percent for large urban hospitals, and an increase to other urban hospitals of 0.1 percent. We estimate that rural SCHs will experience an increase in payments of 0.1 percent, while all other rural hospitals experience no change. With respect to volume, rural hospitals with fewer than 11,000 lines and 21,000–42,999 lines experience increases of 0.1 to 0.9 percent. For both facility size and volume, no category of rural hospitals experiences an increase greater than 0.9 percent.

Overall, urban hospitals experience no change in payments as a result of the new wage indices and the rural adjustment. However, large urban hospitals experience a decrease of 0.1 percent and other urban hospitals experience an increase of 0.1 percent. When categorized by volume, urban hospitals with the largest volume experience no change in payment as a result of changes to the wage index and the presence of the rural adjustment, and urban hospitals with volumes less than 42,999 lines experience decreases in payment from 0.1 percent to 0.7 percent.

Looking across other categories of hospitals, we estimate that updating the wage index and continuing the rural adjustment will lead major teaching hospitals to gain 0.1 percent, and hospitals with minor graduate medical education programs are estimated to experience no change. Hospitals serving more than 35 percent low-income patients are estimated to experience a decrease of 0.1 percent. Hospitals serving no low-income patients are expected to see an increase of 0.2 percent, while hospitals for which the percent of low-income patients cannot be determined are expected to lose 0.4 percent. Voluntary hospitals as classes would experience an increase of 0.1 percent change in payment due to wage changes and the effect of the rural adjustment. Governmental and proprietary hospitals will lose 0.1 and 0.3 percent, respectively.

Column 4: All Budget Neutrality Changes and Market Basket Update

The addition of the market basket update alleviates any negative impacts on payments for CY 2007 created by the budget neutrality adjustments made in Columns 2, and 3, with the exception of urban hospitals with the lowest volume of services and hospitals not paid under the IPPS, including psychiatric hospitals, rehabilitation hospitals, and LTCHs (DSH not available). In many instances, the redistribution of payments created by APC recalibration offsets those introduced by updating the wage indices. However, in a few instances, negative APC recalibration changes compound a reduction in payment from updating the wage index.

We estimate that the cumulative impact of the budget neutrality adjustments and the addition of the market basket update would result in an increase in payments for urban hospitals of 3.5 percent, which is 0.1 percent higher than the market basket update of 3.4 percent. Large urban hospitals will experience an increase of 3.2 percent and other urban hospitals will experience an increase of 3.8 percent. Urban hospitals with the lowest volume experience a negative market basket update of 1.4 percent. Urban hospitals with volumes greater than 5,000 lines have increases from 1.8 percent to 3.5 percent.

We estimate that the cumulative impact of budget neutrality adjustments and the market basket update will result in an overall increase for rural hospitals of 3.2 percent, with rural SCHs experiencing an update of 3.3 percent and other rural hospitals also experiencing an update of 3.1 percent. In general, rural hospitals with more than 5,000 lines of volume experience increases equal to or greater than 3.1 percent. We estimate that low-volume rural hospitals would experience an increase of 0.9 percent.

The changes across columns for other classes of hospitals are fairly moderate and most show updates relatively close to the market basket update with the exception of hospitals not paid under the IPPS, which show negative payment updates. Voluntary and proprietary hospitals also show an increase equal to or greater than the market basket. Governmental hospitals show an increase of 3.2 percent.

Column 5: All Changes for CY 2007

Column 5 compares all changes for CY 2007 to final payment for CY 2006 and includes any additional dollars resulting from provisions in Public Law 108–173 in both years, changes in outlier payment percentages and thresholds, and the difference in pass-through estimates. Overall, we estimate that hospitals will gain 3.0 percent under this final rule with comment period in CY 2007 relative to total spending in CY 2006. When we

excluded cancer and children's hospitals, which are held harmless, the gain remains 3.0 percent. Hospitals will receive the 3.4 percent increase due to the market basket update appearing in Column 4. However, they lose 0.04 percent due to the increase in the pass-through estimate between CY 2006 and CY 2007. Moreover, we estimate that hospitals also experience a 0.25 percent loss due to outlier payments as a result of the increased threshold and the change to the overall CCR that is used to estimate outlier payments. In addition, there is a loss of 0.17 percent as a result of the expiration of the section 508 wage adjustment.

In general, urban hospitals appear to experience the largest gains from the combined effects of these factors. We estimate that, overall, urban hospitals will gain 3.1 percent. We estimate that hospitals in large urban areas will gain 2.9 percent in CY 2007, and hospitals in other urban areas will gain 3.2 percent. We estimate that low-volume urban hospitals will experience a decrease in total payments of 1.2 percent between CY 2006 and CY 2007.

Overall, rural hospitals experience increases that are lower than those observed for urban hospitals. Overall, we estimate that rural hospitals will experience an increase in payments of 2.7 percent. We also estimate that rural SCHs and other rural hospitals will experience an increase of 2.6 percent and 2.8 percent, respectively. Rural hospitals with volumes greater than 4,999 lines experience increases of at least 2.7 percent. We project that low-volume rural hospitals will experience the greatest decrease in overall payment of 0.9 percent.

Among other classes of hospitals, we estimate that hospitals not paid under the IPPS (DSH Not Available) will experience decreases in payments between CY 2006 and CY 2007 of 4.0 percent. We estimate that major teaching hospitals will experience an increase of 2.8 percent and that nonteaching hospitals will experience an increase of 3.0 percent.

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Table 54.--Impact of Changes for CY 2007 Hospital Outpatient Prospective Payment System

	(1)	(2)	(3)	(4)	(5)
	Number of Hospitals	APC Changes	New Wage Index and Rural Adjustment	Comb (cols 2,3) with Market Basket Update	All Changes
ALL HOSPITALS *	3992	0.0	0.0	3.4	3.0
ALL HOSPITALS	3928	0.0	0.0	3.4	3.0
(excludes hospitals held harmless)					
URBAN HOSPITALS	2918	0.1	0.0	3.5	3.1
LARGE URBAN	1591	-0.1	-0.1	3.2	2.9
(GT 1 MILL.)					
OTHER URBAN	1327	0.2	0.1	3.8	3.2
(LE 1 MILL.)					
RURAL HOSPITALS	1010	-0.3	0.0	3.2	2.7
SOLE COMMUNITY	415	-0.3	0.1	3.3	2.6
OTHER RURAL	595	-0.2	0.0	3.1	2.8
BEDS (URBAN)					
0 - 99 BEDS	959	-0.1	-0.2	3.2	2.8
100-199 BEDS	911	-0.1	0.0	3.4	2.9
200-299 BEDS	474	0.2	0.0	3.6	3.3
300-499 BEDS	409	0.1	0.0	3.6	3.0
500 + BEDS	165	0.1	0.0	3.4	3.1
BEDS (RURAL)					
0 - 49 BEDS	355	-0.5	0.2	3.0	2.7
50- 100 BEDS	383	-0.4	0.1	3.1	2.6
101- 149 BEDS	162	-0.1	0.0	3.3	3.0
150- 199 BEDS	64	0.0	0.0	3.3	2.8
200 + BEDS	46	-0.2	0.0	3.2	2.3
VOLUME (URBAN)					
LT 5,000 Lines	579	-4.6	-0.2	-1.4	-1.2
5,000 - 10,999 Lines	157	-0.9	-0.7	1.8	1.6
11,000 - 20,999 Lines	251	0.3	-0.3	3.3	3.2
21,000 - 42,999 Lines	526	-0.1	-0.1	3.2	2.8
GT 42,999 Lines	1405	0.1	0.0	3.5	3.1
VOLUME (RURAL)					

	(1)	(2)	(3)	(4)	(5)
	Number of Hospitals	APC Changes	New Wage Index and Rural Adjustment	Comb (cols 2,3) with Market Basket Update	All Changes
LT 5,000 Lines	84	-3.0	0.5	0.9	-0.9
5,000 - 10,999 Lines	93	-0.4	0.9	3.9	3.2
11,000 - 20,999 Lines	205	-0.3	0.0	3.1	2.7
21,000 - 42,999 Lines	313	-0.4	0.1	3.1	2.9
GT 42,999 Lines	315	-0.2	0.0	3.2	2.8
REGION (URBAN)					
NEW ENGLAND	156	-0.2	0.7	3.9	3.2
MIDDLE ATLANTIC	376	-0.2	0.5	3.8	3.2
SOUTH ATLANTIC	454	0.2	-0.3	3.3	3.0
EAST NORTH CENT.	458	0.1	0.2	3.7	3.3
EAST SOUTH CENT.	193	0.1	-0.6	3.0	2.8
WEST NORTH CENT.	182	-0.1	-0.5	2.8	2.4
WEST SOUTH CENT.	469	0.5	0.0	3.9	3.6
MOUNTAIN	178	0.3	0.1	3.9	3.6
PACIFIC	401	-0.2	-0.3	2.9	2.5
PUERTO RICO	51	0.9	-1.7	2.6	2.4
REGION (RURAL)					
NEW ENGLAND	21	-0.8	-0.3	2.3	2.2
MIDDLE ATLANTIC	73	-0.7	0.5	3.2	3.0
SOUTH ATLANTIC	174	-0.3	0.0	3.0	2.3
EAST NORTH CENT.	125	0.0	0.1	3.5	3.0
EAST SOUTH CENT.	178	-0.2	-0.3	2.9	2.7
WEST NORTH CENT.	117	-0.2	0.4	3.6	2.6
WEST SOUTH CENT.	199	-0.1	0.4	3.7	3.5
MOUNTAIN	80	0.0	-1.0	2.4	2.0
PACIFIC	43	-0.3	-0.2	3.0	2.4
TEACHING STATUS					
NON-TEACHING	2901	0.0	-0.1	3.3	3.0
MINOR	742	0.2	0.0	3.6	3.2
MAJOR	285	-0.3	0.1	3.3	2.8
DSH PATIENT PERCENT					
0	11	2.2	0.2	5.8	6.4
GT 0 - 0.10	391	0.3	0.0	3.7	3.4
0.10 - 0.16	481	0.1	0.1	3.6	3.0
0.16 - 0.23	767	0.1	0.0	3.6	3.2
0.23 - 0.35	963	0.0	0.0	3.4	2.9
GE 0.35	742	-0.1	-0.1	3.2	3.0
DSH NOT AVAILABLE **	573	-7.2	-0.4	-4.1	-4.0
URBAN TEACHING/DSH					

	(1)	(2)	(3)	(4)	(5)
	Number of Hospitals	APC Changes	New Wage Index and Rural Adjustment	Comb (cols 2,3) with Market Basket Update	All Changes
TEACHING & DSH	930	0.1	0.1	3.5	3.1
TEACHING/NO DSH	0	0.0	0.0	0.0	0.0
NO TEACHING/DSH	1432	0.2	-0.1	3.5	3.1
NO TEACHING/NO DSH	11	2.2	0.2	5.8	6.4
DSH NOT AVAILABLE**	545	-7.4	-0.5	-4.4	-4.3
TYPE OF OWNERSHIP					
VOLUNTARY	2167	0.0	0.1	3.5	3.0
PROPRIETARY	1178	0.2	-0.3	3.4	3.1
GOVERNMENT	583	-0.1	-0.1	3.2	2.7

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 2005 hospital claims data.
Column (3) shows the budget neutral impact of updating the wage index and rural adjustment by applying the FY 2007 hospital inpatient wage index and making EACHs eligible for the rural adjustment.
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 an increase in the fixed dollar threshold to accommodate a change in the overall CCR calculation. This column also shows the impact of the expiring 508 wage reclassification, which ends in April 2007

*These 3,992 hospitals include children and cancer hospitals, which are held harmless to pre-BBA payments.
**Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

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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 would increase for services for which OPPS payments will rise and would decrease for services for which OPPS payments would fall. For example, for an electrocardiogram (APC 0099), the minimum unadjusted copayment in CY 2006 was $4.49. In this final rule with comment period, the minimum unadjusted copayment for APC 0099 is $4.66 because the OPPS payment for the service will increase under this final rule with comment period. In another example, for a Level IV Needle Biopsy (APC 0037), in the CY 2006 OPPS, the national unadjusted copayment was $228.76, and the minimum unadjusted copayment was $114.38. In this final rule with comment period, the national unadjusted copayment for APC 0037 is $228.76. The minimum unadjusted copayment for APC 0037 is $126.20, or 20 percent of the payment for APC 0037. In all cases, the statute limits beneficiary liability for copayment for a service to the inpatient hospital deductible for the applicable year. For CY 2007, the inpatient deductible is $992.

In order to better understand the impact of changes in copayment on beneficiaries, we modeled the percent change in total copayment liability using CY 2005 claims. We estimate, using the claims of the 3,992 hospitals on which our modeling is based, that total beneficiary liability for copayments will decline as an overall percentage of total payments from 27.5 percent in CY 2006 (revised from the 29 percent that we estimated for CY 2006 in the CY 2006 OPPS final rule with comment period 70 FR 68727) to 26.6 percent in CY 2007. This estimated decline in beneficiary liability is a consequence of the APC recalibration and reconfiguration we are making for CY 2007.

5. Conclusion

The changes in this final rule with comment period will affect all classes of hospitals. Some hospitals experience significant gains and others less significant gains, but almost all hospitals will experience positive updates in OPPS payments in CY 2007. Table 54 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements and an additional 3.0 percent increase in payments for CY 2007, after considering the market basket increase, the cost of outliers, changes to the pass-through estimate and the elimination of the section 508 adjustment of Public Law 108–173. 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 55 below, we have prepared an accounting statement showing the classification of the expenditures associated with the CY 2007 OPPS provisions of this final rule with comment period. This table provides our best estimate of the increase in Medicare payments under the OPPS as a result of the provisions presented in this final rule with

comment period for CY 2007. All expenditures are classified as transfers.

TABLE 55.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED CY 2007 OPPS EXPENDITURES ASSOCIATED WITH CY 2007 FINAL RULE PROVISIONS

Category	Transfers
Annualized Monetized Transfers	$620 Million.
From Whom to Whom	Federal Government to OPPS Medicare Providers.
Annualized Monetized Transfer	$150 Million.
From Whom to Whom	Premium Payments from Beneficiaries to Federal Government.
Total	$470 Million.

C. Effects of Changes to the ASC Payment System for CY 2007

We are adding 19 surgical procedures to the ASC list of Medicare payable procedures for CY 2007. We are also implementing section 5103 of Public Law 109–171 and sections 1834(d)(2) and (d)(3) of the Act. Section 5103 of Public Law 109–171 requires the Secretary to substitute the OPPS payment amount for the ASC standard overhead amount if the standard overhead amount for facility services for surgical procedures performed in an ASC, without application of any geographic adjustment, exceeds the Medicare OPPS payment amount for the service for that year, without application of any geographic adjustment. The OPPS cap on ASC payment rates applies to surgical procedures furnished in ASCs on or after January 1, 2007, and before the effective date of the revised ASC payment system. Except for the payment changes required under section 5103 of Public Law 109–171, we are not making any changes in CY 2007 to the ASC payment rates that are currently in effect.

Sections 1834(d)(2) and (d)(3) of the Act require that the computed beneficiary coinsurance amount for screening flexible sigmoidoscopy and screening colonoscopy services provided in hospital outpatient departments and ASCs be equal to 25 percent of the payment amount. They also require Medicare to pay the lesser of the ASC or OPPS rate for those screening services in each geographic area. For CY 2007, the OPPS rate will be limited to the lesser ASC rate for screening colonoscopies. Medicare payment for screening sigmoidoscopies will not be affected in CY 2007 because those services are not currently provided in ASCs. There will be no effect on the fee paid to ASCs for screening colonoscopies. However, beginning in CY 2007, beneficiaries will be responsible for a 25 percent coinsurance for screening colonoscopies when provided in ASCs, as they have been for the services provided in hospital outpatient departments.

Except for the payment changes required under section 5103 of Public Law 109–171 and sections 1834(d)(2) and (d)(3) of the Act, we are not making any changes in CY 2007 to the ASC payment rates that are currently in effect.

CMS estimates that adding the 19 procedures discussed in section XVII. of this preamble and implementing the Public Law 109–171 mandate will result in a savings to the Medicare program of approximately $15 million in CY 2007.

1. Alternatives Considered

We are issuing this final rule with comment period to meet a statutory requirement that we update the list of approved ASC procedures at least every 2 years. We implement the biennial update of the list through notice and comment in the **Federal Register** to give interested parties an opportunity to review and comment on proposed additions to and deletions from the ASC list. The last update of the ASC list through notice and comment was effective July 5, 2005. However, the statute requires us to update the list at least every 2 years, which means we must update the list by July 2007.

2. Limitations of Our Analysis

Without datasets related to classes of ASCs which parallel the data maintained in the Medicare provider-specific files for hospitals, we cannot model distributional impacts of the CY 2007 changes in the ASC list and ASC payments similar to those we prepare for our OPPS impact analysis (see Table 54). The actuarial estimate of Medicare program costs or savings resulting from the update of the ASC list and implementation of section 5103 of Public Law 109–171 and sections 1834(d)(2) and (d)(3) of the Act in CY 2007 is based on estimated CY 2007 utilization. As we have done in previous rules, we solicited comments and information about the anticipated effect of these changes that we proposed for CY 2007 to gauge their impact on individual ASCs, but we received no comments on the subject.

3. Estimated Effects of This Final Rule With Comment Period on ASCs

CMS estimates that approximately 25 percent of the cases currently reported by hospitals for each of the 19 codes we are adding to the ASC list will shift to the ASC setting in CY 2007. We estimate that the shift of these procedures to the less costly ASC setting will result in modest savings for the Medicare program.

Savings will also be realized because section 5103 of the Public Law 109–171 will impose a payment limit for 275 procedures on the CY 2007 ASC list. The Office of the Actuary estimates that adding 19 surgical procedures to the ASC list and capping payment for 275 procedures on the current ASC list will result in a combined savings to the Medicare program of approximately $15 million in CY 2007. We have not estimated the impact of our changes for CY 2007 on Medicare expenditures in subsequent years because we have proposed to implement an entirely revised payment system in CY 2008.

Currently, Medicare pays a facility fee to ASCs only for those procedures that have been approved for the ASC list. The addition of 19 surgical procedures to the ASC list will be beneficial to ASCs by making it possible for them to offer more surgical procedures to Medicare beneficiaries. We believe that approximately 25 percent of the annual hospital outpatient volume of the 19 procedures added to the ASC list will move to the ASC setting in CY 2007. To the extent that hospital outpatient utilization decreases and ASC utilization increases in CY 2007, the Medicare program will realize a savings because the ASC standard overhead amount for all procedures, including the proposed additions to the ASC list, will be equal to or lower than the payment rate for the same procedures under the OPPS. Because hospitals perform a much higher volume of ambulatory

surgeries overall than are performed in ASCs, we do not expect significant hospital revenue losses to result from migration of procedures that we are adding to the ASC list to the ASC setting.

4. Estimated Effects of This Final Rule With Comment Period on Beneficiaries

The changes for CY 2007 will be positive for beneficiaries in at least two respects. First, with the exception of screening colonoscopies, beneficiary coinsurance for ASC facility services is set at 20 percent, which is generally lower than the OPPS coinsurance rate, which can range from 20 percent to 40 percent. In addition, in accordance with section 5103 of Public Law 109–171, no ASC payment rate in CY 2007 may be greater than the OPPS rate for a given procedure. Thus, due to the limitations on the ASC facility rate required by Public Law 109–171, beneficiaries will be assured a lower ASC coinsurance amount for more procedures in CY 2007 than in previous years.

Second, beneficiary access to services will be expanded by the addition of 19 surgical procedures to the ASC list. Beneficiaries will have an additional setting from which to choose were it necessary for them to undergo one of the surgical procedures that we are adding to the ASC list in CY 2007.

Beneficiary coinsurance for screening colonoscopies performed in an ASC will increase from 20 percent to 25 percent beginning in CY 2007, which is the same coinsurance rate applicable to screening colonoscopies under the OPPS. This coinsurance rate is legislated. However, we do not believe that this coinsurance increase will materially affect access to screening colonoscopies performed in ASCs.

5. Conclusion

The impact on ASCs of changes to the ASC payment system for CY 2007 will depend on an individual ASC's mix of patients and its payers, specifically, the proportion of its patients who are Medicare beneficiaries, whether or not the ASC chooses to perform the procedures added to the ASC list, and whether or not the ASC provides services that will be affected by the payment limits imposed by section 5103 of Public Law 109–171. Overall, the Office of the Actuary estimates that the Medicare program will realize a $15 million savings as a result of implementing the changes for CY 2007.

6. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf)*, in Table 56 below, we have prepared an accounting statement showing the classification of the expenditures associated with the CY 2007 ASC provisions of this final rule with comment period. This table provides our best estimate of the reduction in Medicare payments under the ASC payment system as a result of the provisions presented in this final rule with comment period for CY 2007. All expenditures are classified as transfers.

TABLE 56.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED CY 2007 ASC EXPENDITURES ASSOCIATED WITH CY 2007 FINAL RULE PROVISIONS

Category	Transfers
Annualized Monetized Transfers	−$15 Million.
From Whom to Whom	Federal Government to ASC Medicare Providers.
Annualized Monetized Transfer	−$4 Million.
From Whom to Whom	Premium Payments from Beneficiaries to Federal Government.
Total	−$11 Million.

D. Effects of the Medicare Contracting Reform Mandate

In section XVIII. of this preamble, we discuss our revision of the regulations under 42 CFR Part 421, Subpart B for Medicare intermediaries and carriers to conform the regulations to the statutory changes mandated by section 1874A of the Act as added by section 911 of Public Law 108–173, which took effect on October 1, 2005. As discussed in section XVIII. of this preamble, section 1874A of the Act is intended to improve Medicare's administrative services to beneficiaries and health care providers and to bring standard contracting principles to Medicare, such as competition and performance incentives, which the government has long applied to other Federal programs under the FAR. This provision requires that CMS replace its current claims payment contractors by October 1, 2011, with new contract entities referred to as MACs. We believe that this provision has no immediate economic effect on Medicare payments in CY 2007 because it is administrative in nature and does not change Medicare's coverage and reimbursement policies for hospital outpatient services or any other covered Medicare services.

E. Effects of Additional Quality Measures and Procedures for Hospital Reporting of Quality Data for IPPS FY 2008

We have tried to minimize the costs of HCAHPS, including minimizing the impact on small/rural hospitals. While there are no capital or operational/maintenance costs associated with the implementation of HCAHPS, there are costs for collecting the data. The nationwide costs of conducting the HCAHPS survey are estimated to be between $3.6 million and $16.9 million per year, assuming approximately 3,700 hospitals (see Abt Associates, Inc. report, *http://www.cms.hhs.gov/HospitalQualityInits/downloads/HCAHPSCostsBenefits200512.pdf)*.

Hospitals that are self-administering the survey (or their survey vendor, if the hospital chooses to employ one) beginning in 2007 will participate in free HCAHPS training offered via Webinar in January 2007. All hospitals that join in 2007 will be required to participate in a month-long dry run in March 2007. Hospitals that chose not to participate in HCAHPS will not meet the HCAHPS requirements necessary to receive the full market basket update for FY 2008.

The costs of collecting HCAHPS patient survey data will vary across hospitals depending on the method used to collect patient survey data, the number of patients surveyed, and whether HCAHPS is incorporated into their existing patient satisfaction surveys. While hospitals may choose to administer HCAHPS as a stand-alone survey, there are significant cost savings associated with combining HCAHPS with existing surveys.

We have cited a cost/benefit report showing that the costs of conducting HCAHPS would be as follows. HCAHPS collected as a separate survey is

between $11.00 and $15.25 per complete survey ($3,300 to $4,575 per hospital), assuming that 80–85 percent of hospitals collect HCAHPS by mail and the remainder by phone or active IVR. It would be considerably less expensive to combine HCAHPS with existing surveys. In a combined survey, it is estimated that it will cost only $3.26 per complete survey (or $978 per hospital) to incorporate the 27-item HCAHPS instrument into existing surveys. Depending on the proportion of hospitals that incorporate HCAHPS into existing surveys, it is therefore estimated that the costs of HCAHPS is between $3.6 million and $16.9 million per year (Abt Associates, Inc. report, *http://www.cms.hhs.gov/HospitalQualityInits/downloads/HCAHPSCostsBenefits200512.pdf).*

We have made provisions to reduce the burden of the HCAHPS initiative for small/rural hospitals. As a cost savings provisions for all hospitals (but one that is particularly useful for small hospitals), a free on-line tool for data entry is available to hospitals choosing to conduct data entry themselves in lieu of contracting with a survey vendor for this service. The sample size requirements are reduced for small hospitals unable to achieve 300 completed surveys. For all hospitals, we are allowing four modes of survey administration (mail, telephone, combination of mail and telephone, and active interactive voice recognition), and we are allowing for hospitals to either use a vendor or conduct the survey on their own. Additionally, we are allowing hospitals to integrate the HCAHPS survey with their own patient satisfaction surveys. This option provides significant cost savings to conduct HCAHPS annually: for the mail mode, it is estimated to cost $603 per hospital; and for the telephone mode, it is estimated to be $2,478 per hospital. For hospitals collecting 100 completed surveys, it costs about $326 annually per hospital. CMS is providing free HCAHPS training and materials and the cost of reporting HCAHPS results to CMS is minimal.

The benefits of public reporting for hospitals are great. There are multiple reports of hospitals being motivated by these data and using them for improvement. Not only is there more consistent evidence regarding hospital impact, but there are also several well-designed studies that have found at least some impact on hospital clinical performance (Abt report).

HCAHPS provides many benefits to hospitals and also to society at-large. The HCAHPS initiative has taken substantial steps to assure that the survey will be credible, useful, and practical. First, the survey is designed to produce comparable data on the patient's perspective of care that allow objective and meaningful comparisons between hospitals on domains that are important to consumers. Second, public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care. Third, public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of hospital care provided in return for the public investment. For the public at-large, there is the potential benefit of improved health through improvements in hospital care.

The intent of HCAHPS is to provide one standardized instrument and accompanying data collection methodology that is in the public domain for measuring patients' perspectives of hospital care. While many hospitals currently collect information on patients' satisfaction with care, there is no one national standard for collecting or publicly reporting this information that would enable valid comparisons to be made across all hospitals. In order to make ''apples to apples'' comparisons to support consumer choice, it is necessary to introduce a standard measurement approach. HCAHPS can be viewed as a core set of questions that can be combined with a broader, customized set of hospital-specific items. HCAHPS is meant to complement the data hospitals currently collect to support improvements in internal customer services and quality related activities.

- SCIP

While there are no capital or operational/maintenance costs associated with the implementation of SCIP, our pilot study concluded that there will be costs associated with the collection of the data. The data collection costs have been calculated as follows: SCIP collection as additional measures has been calculated to be $75.00 and $100.00 per additional hour of data abstraction (approximately $16,000 per hospital). Depending on the proportion of hospitals that already collect these measures, it is estimated that the costs of collecting the additional measures is approximately $58.7 million per year. For a detailed discussion of the data collection burden (burden hours) associated with these costs, please refer to the information collection section of the preamble.

- Mortality

The 30-day mortality measures for AMI and HF are each individually calculated solely on administrative data already submitted to CMS for other purposes, such as claims submitted for payment by the hospitals. As no new or additional data will be required from hospitals to calculate the rates for these measures, we believe that there will be no measurable impact on the hospitals as a result of the inclusion of these measures in the RHQDAPU set.

1. Alternatives Considered

The HCAHPS survey and the SCIP and mortality measures are a subset of CMS's larger Quality Initiative for both the Medicare and Medicaid programs. The Hospital Quality Initiative was established nationally in November 2002 for nursing homes, and was expanded in 2003 to the nation's home health care agencies and hospitals. The Hospital Quality Initiative supports significant improvement in the quality of hospital care that is integral to both the Medicare and Medicaid programs. This initiative aims to improve hospitals' quality of care by distributing objective and easy to understand data on hospital performance. The public availability of this information will encourage consumers and their physicians to discuss and make better informed decisions on how to get the best hospital care, create incentives for hospitals to improve care, and support public accountability. In all, improved care equates to the improvement of health for Medicare and Medicaid beneficiaries.

HCAHPS, SCIP and Mortality measures parallel the trend in both the federal and many state governments to make hospital performance information (generally clinical processes or outcomes of care) publicly available. The goals of HCAHPS are to: (1) Produce comparable data on the patient's perspective of care to allow objective and meaningful comparisons between hospitals on domains that are important to consumer decision-making; (2) to have these data publicly reported to create incentives for hospitals to improve their quality of care; and (3) to enhance public accountability by providers by increasing the transparency of the quality of hospital care provided in return for the public investment. HCAHPS, SCIP and Mortality measures fit into a larger context of performance reporting developed by the Strategic Framework Board of the National Quality Forum. This is based on the assumption that consumers take value (both cost and quality) into account in any major purchasing decision. Public reporting of both the clinical measures and HCAHPS is vital to the value-based healthcare purchasing approach. Patient

perspectives of care encompasses an important CMS priority, as indicated by the Agency's support for programs related to the Institute of Medicine's (IOM) call for public reporting, the Hospital Quality Initiative (HQI) and the Hospital Quality Alliance (HQA), a public-private measurement and reporting collaborative.

The HCAHPS survey has been endorsed by the National Quality Forum. Implementing this survey fulfills the requirements of sections 1886 (b)(3)(B)(viii)(III) and (IV) of the Act that require CMS to expand the starter set of 10 quality measures used since FY 2005. In expanding these measures, we must begin to adopt the baseline set of performance measures as set forth in a 2005 report issued by the Institute of Medicine (IOM) of the National Academy of Sciences under section 238(b) of Public Law 108–173, effective for payments beginning with FY 2007. The IOM measures include the Hospital Quality Alliance (HQA) measures, the HCAHPS patient perspective survey, and three structural measures.

No alternatives were discussed for the SCIP and mortality measures.

2. Estimated Effects of This Final Rule With Comment Period

a. Effects on Hospitals

Hospitals will benefit from the information that the HCAHPS survey and the SCIP and Mortality measures data collection will provide. Hospitals are an essential part of the National Quality Forum's Strategic Framework Board. We have made provisions that reduce the burden of the HCAHPS initiative, especially for small/rural hospitals. The public reporting of HCAHPS results and additional quality measures may stimulate improvements in hospital quality of care in several ways. Hospitals can use the publicly reported data to benchmark their performance with other institutions. Consumers/patients would potentially seek care in hospitals that are publicly reported to perform well.

CMS does not plan to make major revisions to the HCAHPS survey itself or to its implementation procedures soon after HCAHPS national implementation. With the core set of HCAHPS measures, hospitals will have the beginnings of a benchmark for trending of their hospital results over time.

To promote its wide and rapid adoption, HCAHPS has been carefully designed to fit within the framework of patient satisfaction surveying that hospitals currently employ. Still, CMS fully understands that participation in the HCAHPS initiative will require some effort and expense on the part of hospitals that volunteer to take part.

b. Effects on Other Providers

Physicians will benefit by learning what surveyed consumers/patients answered about their quality of care during their hospital stays, as well as become informed about surgical care improvement and mortality rates. Studies indicate that providers are potentially affected by public reporting. They may be motivated to improve the quality of care they deliver with the availability of performance information. Primary care physicians are also users of this information during the referral process of patients to hospitals. Studies indicate that the public reporting of hospital quality indicators may spur internal hospital quality improvement and lead to changes in physician behavior within the hospital environment.

c. Effects on the Medicare and Medicaid Programs

Some potential benefits of publicly reporting quality information has been described in the literature as pertaining to consumers, providers and purchasers. Consumers (beneficiaries) could incorporate the quality information into their decision-making about hospital choices, and benefit from better care resulting from the additional measures as well as the questions asked by HCAHPS, such as questions about communication with providers (fewer medical errors due to patient feedback about medication effect) and discharge planning (fewer readmissions due to better patient awareness about what to expect when discharged) and the reporting of clinical measures.

Providers could potentially be motivated to improve the quality of care they provide for results of more effective and efficient hospital operation. Providers could also use the information internally to improve communication and improve performance, use the information to justify the need to increase staff ratios, use the measures in choices about practitioner practice locales, use the information to improve their ratings on patient perspectives and potentially compete with one another in the area of improving accreditation results, and use the information to choose hospitals on the basis of quality of care for their patients.

Purchasers could potentially benefit from this information for supporting shorter lengths of stay, availability of benchmarks, and availability of information to support purchasing decisions.

F. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this final rule with comment period was reviewed by the OMB.

List of Subjects

42 CFR Part 410

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

42 CFR Part 416

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 421

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

42 CFR Part 485

Grant program-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 488

Administrative practice and procedure, Health facilities, 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 410.152 is amended by revising paragraph (i) and removing footnote 1 to read as follows:

§ 410.152 Amounts of payment.

* * * * *

(i) *Amount of payment: ASC facility services.* (1) For ASC facility services furnished on or after July 1, 1987 and before January 1, 2008, in connection with the surgical procedures specified in part 416 of this chapter, Medicare Part B pays 80 percent of a standard overhead amount as specified in § 416.120(c) of this chapter, except that,

for screening flexible sigmoidoscopies and screening colonoscopies, Part B coinsurance is 25 percent of the standard overhead amount and Medicare Part B pays 75 percent of the standard overhead amount.

(2) [Reserved]

* * * * *

PART 416—AMBULATORY SURGICAL SERVICES

■ 3. The authority citation for Part 416 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 4. Section 416.1 is amended by—

■ a. Revising paragraph (a)(2).

■ b. Revising paragraph (a)(3).

■ c. Adding new paragraphs (a)(4) and (a)(5).

The revisions and additions read as follows:

§ 416.1 Basis and scope.

(a) * * *

(2) Section 1833(i)(1)(A) of the Act requires the Secretary to specify the surgical procedures that can be performed safely on an ambulatory basis in an ambulatory surgical center.

(3) Sections 1833(i)(2)(A) and (D) and 1833(a)(1)(G) of the Act specify the amounts to be paid for facility services furnished in connection with the specified surgical procedures when they are performed in an ASC.

(4) Section 1833(i)(2)(C) of the Act provides that if the Secretary has not updated amounts for ASC facility services furnished during a fiscal year through 2005 or a calendar year beginning with 2006, the amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved, except that, in fiscal year 2005, the last quarter of calendar year 2005, and each of the calendar years 2006 through 2009, the increase shall be zero percent.

(5) Section 1833(i)(2)(E) of the Act provides that, with respect to surgical procedures furnished on or after January 1, 2007, and before the effective date of the implementation of a revised payment system, the payment amount shall be the lesser of the ASC payment rate established under section 1833(i)(2)(A) of the Act or the prospective payment rate for hospital outpatient department services established under section 1833(t)(3)(D) of the Act. The lesser payment amount shall be determined prior to application of any geographic adjustment.

* * * * *

■ 5. Section 416.2 is amended by revising the definitions of ''Covered surgical procedures'' and ''Facility services'' to read as follows:

§ 416.2 Definitions.

* * * * *

Covered surgical procedures means those surgical procedures that meet the criteria specified in § 416.65 and are published in the **Federal Register**.

Facility services means services that are furnished in connection with covered surgical procedures performed in an ASC.

■ 6. The heading for Subpart D is revised to read as follows:

Subpart D—Scope of Benefits for Services Furnished Before January 1, 2008

■ 7. Section 416.65 is amended by—

■ a. Revising the introductory text.

■ b. Revising paragraph (a)(4).

The revisions read as follows:

§ 416.65 Covered surgical procedures.

Effective for services furnished before January 1, 2008, covered surgical procedures are those procedures that meet the standards described in paragraphs (a) and (b) of this section and are included in the list published in accordance with paragraph (c) of this section.

(a) * * *

(4) Are not otherwise excluded under § 411.15 of this chapter.

* * * * *

■ 8. A new § 416.76 is added to Subpart D to read as follows:

§ 416.76 Applicability.

The provisions of this subpart apply to facility services furnished before January 1, 2008.

■ 9. The heading for Subpart E is revised to read as follows:

Subpart E—Prospective Payment System for Facility Services Furnished Before January 1, 2008

§ 416.120 [Amended]

■ 10. In paragraph (a) of § 416.120, the cross-reference ''Part 413'' is removed and the cross-reference ''Part 419'' added in its place.

■ 11. A new § 416.121 is added to read as follows:

§ 416.121 Applicability.

The provisions of this subpart apply to facility services furnished before January 1, 2008.

■ 12. Section 416.125 is amended by adding a new paragraph (c) to read as follows:

§ 416.125 ASC facility services payment rate.

* * * * *

(c) For services furnished on or after January 1, 2007, and before the effective date of implementation of a revised payment system, the ASC payment rate for a surgical procedure is the lesser of the ASC payment rate established under paragraph (a) of this section or the prospective payment rate for the procedure established under § 419.32 of this chapter. The lesser payment amount is determined prior to application of any geographic adjustment.

§ 416.150 [Removed]

■ 13. Section 416.150 is removed.

Subpart F [Redesignated]

■ 14. Subpart F is redesignated as Subpart G.

New Subpart F [Added and Reserved]

■ 15. A new Subpart F is added and reserved.

■ 16. Newly designated Subpart G is revised to read as follows:

Subpart G—Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Service Centers

Sec.

416.180 Basis and scope.
416.185 Process for establishing a new class of new technology IOLs.
416.190 Request for review of payment amount.
416.195 Determination of membership in new classes of new technology IOLs.
416.200 Payment adjustment.

§ 416.180 Basis and scope.

(a) *Basis.* This subpart implements section 141 of Public Law 103–432, which provides for adjustments to payment amounts for new technology intraocular lenses (IOLs) furnished at ambulatory surgical centers (ASCs).

(b) *Scope.* This subpart sets forth—

(1) The process for interested parties to request that CMS review the appropriateness of the ASC facility fee for insertion of an IOL. This process includes a review of whether that payment is reasonable and related to the cost of acquiring a lens determined by CMS as belonging to a class of new technology IOLs;

(2) Factors that CMS considers for determination of a new class of new technology IOLs; and

(3) Application of the payment adjustment.

§ 416.185 Process for establishing a new class of new technology IOLs.

(a) *Announcement of deadline for requests for review.* CMS announces the deadline for each year's requests for review of a new class of new technology IOLs in the final rule updating the ASC payment rates for that calendar year.

(b) *Announcement of new classes of new technology IOLs for which review requests have been made and solicitation of public comments.* CMS announces the requests for review received in a calendar year and the deadline for public comments regarding the requests in the proposed rule updating the ASC payment rates for the following calendar year. The deadline for submission of public comments is 30 days following the date of the publication of the proposed rule.

(c) *Announcement of determinations regarding requests for review.* CMS announces its determinations for a calendar year in the final rule updating the ASC payment rates for the following calendar year. CMS publishes the codes and effective dates allowed for those lenses recognized by CMS as belonging to a class of new technology IOLs. New classes of new technology IOLs are effective 30 days following the date of publication of the final rule.

§ 416.190 Request for review of payment amount.

(a) *When requests can be submitted.* A request for review of the appropriateness of ASC payment for insertion of an IOL that might qualify for a payment adjustment as belonging to a new class of new technology IOLs must be submitted to CMS in accordance with the annual published deadline.

(b) *Who may submit a request.* Any individual, partnership, corporation, association, society, scientific or academic establishment, or professional or trade organization able to furnish the information required in paragraph (c) of this section may request that CMS review the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act with respect to an IOL that meets the criteria of a new technology IOL under § 416.195.

(c) *Content of a request.* In order to be accepted by CMS for review, a request for review of the ASC payment amount for insertion of an IOL must include all the information as specified by CMS.

(d) *Confidential information.* In order for CMS to invoke the protection allowed under Exemption 4 of the Freedom of Information Act (5 U.S.C. 552(b)(4)) and, with respect to trade secrets, the Trade Secrets Act (18 U.S.C. 1905), the requestor must clearly identify all information that is to be characterized as confidential.

§ 416.195 Determination of membership in new classes of new technology IOLs.

(a) *Factors to be considered.* CMS uses the following criteria to determine whether an IOL qualifies for a payment adjustment as a member of a new class of new technology IOLs when inserted at an ASC:

(1) The IOL is approved by the FDA.

(2) Claims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison to currently available IOLs are approved by the FDA for use in labeling and advertising.

(3) The IOL is not described by an active or expired class of new technology IOLs; that is, it does not share a predominant, class-defining characteristic associated with improved clinical outcomes with members of an active or expired class.

(4) Evidence demonstrates that use of the IOL results in measurable, clinically meaningful, improved outcomes in comparison with use of currently available IOLs. Superior outcomes include:

(i) Reduced risk of intraoperative or postoperative complication or trauma;

(ii) Accelerated postoperative recovery;

(iii) Reduced induced astigmatism;

(iv) Improved postoperative visual acuity;

(v) More stable postoperative vision;

(vi) Other comparable clinical advantages.

(b) *CMS determination of eligibility for payment adjustment.* CMS reviews the information submitted with a completed request for review, public comments submitted timely, and other pertinent information and makes a determination as follows:

(1) The IOL is eligible for a payment adjustment as a member of a new class of new technology IOLs.

(2) The IOL is a member of an active class of new technology IOLs and is eligible for a payment adjustment for the remainder of the period established for that class.

(3) The IOL does not meet the criteria for designation as a new technology IOL and a payment adjustment is not appropriate.

§ 416.200 Payment adjustment.

(a) CMS establishes the amount of the payment adjustment for classes of new technology IOLs through proposed and final rulemaking in connection with ASC facility services.

(b) CMS adjusts the payment for insertion of an IOL approved as belonging to a class of new technology IOLs for the 5-year period of time established for that class.

(c) Upon expiration of the 5-year period of the payment adjustment, payment reverts to the standard rate for IOL insertion procedures performed in ASCs.

(d) ASCs that furnish an IOL designated by CMS as belonging to a class of new technology IOLs must submit claims using billing codes specified by CMS to receive the new technology IOL payment adjustment.

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

■ 17. 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).

■ 18. Section 419.21 is amended by revising the introductory text of paragraph (d) to read as follows:

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

* * * * *

(d) The following medical and other health services furnished by a home health agency (HHA) to patients who are not under an HHA plan or treatment or by a hospice program furnishing services to patients outside the hospice benefit:

* * * * *

■ 19. Section 419.43 is amended by—

■ a. Revising paragraph (f).

■ b. Revising paragraph (g)(1)(i).

■ c. Adding a new paragraph (h).

The revision and addition read as follows:

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

* * * * *

(f) *Excluded services and groups.* Drugs and biologicals that are paid under a separate APC are excluded from qualification for outlier payments.

(g) * * *

(1) * * *

(i) Is a sole community hospital under § 412.92 of this chapter or is an essential access community hospital under § 412.109 of this chapter; and

* * * * *

(h) *Applicable adjustments to conversion factor for CY 2009 and for subsequent calendar years*—(1) *General*

rule. For CY 2009 and for subsequent calendar years, the applicable adjustment to the conversion factor specified in § 419.32(b)(1)(iv) is reduced by 2.0 percentage points for any hospital that fails to meet the standards for reporting of hospital outpatient quality measures as established by the Secretary for the corresponding calendar year.

(2) *Limitation*. Any reduction to a hospital's adjustment to its conversion factor specified in § 419.32(b)(1)(iv) which occurs as a result of paragraph (h)(1) of this section will apply only to the calendar year involved and will not be taken into account in computing that hospital's applicable adjustment for a subsequent calendar year.

(3) *Budget neutrality*. For CY 2009 and for each subsequent calendar year, CMS makes an adjustment to the conversion factor, so that estimated aggregate payments under the OPPS for such calendar year are not affected by any reductions to hospital adjustments which occur as a result of paragraph (h)(1) of this section,

■ 20. A new § 419.45 is added to Subpart D to read as follows:

§ 419.45 Payment and copayment reduction for devices replaced without cost or full credit is received.

(a) *General rule*. CMS reduces the amount of payment for an implanted device made under the hospital outpatient prospective payment system in accordance with § 419.66 for which CMS determines that a significant portion of the payment is attributable to the cost of an implanted device, when one of the following situations occur:

(1) The device is replaced without cost to the provider or the beneficiary; or

(2) The provider receives full credit for the cost of a replaced device.

(b) *Amount of reduction to the APC payment.* The amount of the reduction to the APC payment made under paragraph (a) of this section is calculated in the same manner as the offset amount that would be applied if the device implanted in a procedure assigned to the APC had transitional pass-through status under § 419.66.

(c) *Amount of beneficiary copayment.* The beneficiary copayment is calculated based on the APC payment after application of the reduction under paragraph (b) of this section.

■ 21. Section 419.70 is amended by—

■ a. Revising paragraph (d)(1).

■ b. Redesignating paragraphs (d)(2) and (d)(3) as paragraphs (d)(3) and (d)(4), respectively.

■ c. Adding a new paragraph (d)(2).

The revisions and addition read as follows:

§ 419.70 Transitional adjustment to limit decline in payments.

* * * * *

(d) *Hold harmless provisions*—(1) *Temporary treatment for small rural hospitals before January 1, 2006.* For covered hospital outpatient services furnished in a calendar year before January 1, 2006, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by the amount of that difference if the hospital—

(i) Is located in a rural area as defined in § 412.63(b) of this chapter or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act; and

(ii) Has 100 or fewer beds as defined in § 412.105(b) of this chapter.

(2) *Temporary treatment for small rural hospitals on or after January 1, 2006.* For covered hospital outpatient services furnished in a calendar year from January 1, 2006, through December 31, 2008, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this paragraph is increased by 95 percent of that difference for services furnished during 2006, 90 percent of that difference for services furnished during 2007, and 85 percent of that difference for services furnished during 2008 if the hospital—

(i) Is located in a rural area as defined in § 412.63(b) of this chapter or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act;

(ii) Has 100 or fewer beds as defined in § 412.105(b) of this chapter;

(iii) Is not a sole community hospital as defined in § 412.92 of this chapter; and

(iv) Is not an essential access community hospital under § 412.109 of this chapter.

* * * * *

PART 421—MEDICARE CONTRACTING

■ 22. The heading of Part 421 is revised to read as set out above.

■ 23. The authority citation for Part 421 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 24. Section 421.3 is revised to read as follows:

§ 421.3 Definitions.

As used in this part—

Intermediary means an entity that has a contract with CMS (under statutory provisions in effect prior to October 1, 2005) to determine and make Medicare payments for Part A or Part B benefits payable on a cost basis (or under the prospective payment system for hospitals) and to perform other related functions. For purposes of applying the performance criteria in § 421.120 and the performance standards in § 421.122 and any adverse action resulting from that application, the term ''intermediary'' also means a Blue Cross plan that has entered into a subcontract approved by CMS with the Blue Cross and Blue Shield Association to perform intermediary functions.

■ 25. Section 421.100 is amended by revising paragraph (i) to read as follows:

§ 421.100 Intermediary functions.

* * * * *

(i) *Dual intermediary responsibilities.* Regarding the responsibility for service to provider-based HHAs and provider-based hospices, where the HHA or the hospice and its parent provider will be served by different intermediaries, the designated regional intermediary will process bills, make coverage determinations, and make payments to the HHAs and the hospices. The intermediary serving the parent provider will perform all fiscal functions, including audits and settlement of the Medicare cost reports and the HHA and hospice supplement worksheets.

■ 26. Section 421.103 is revised to read as follows:

§ 421.103 Payment to providers.

Providers are assigned to intermediaries in accordance with § 421.104. As the Medicare Administrative Contractors (MACs) are implemented, providers are reassigned from intermediaries to MACs in accordance with § 412.404 of this chapter.

■ 27. Section 421.104 is revised to read as follows:

§ 421.104 Assignment of providers of services to intermediaries during transition to Medicare Administrative Contractors (MACs).

(a) Beginning October 1, 2005, CMS assigns providers of services and other entities that may bill Part A benefits to intermediaries in a manner that will best support the transition to Medicare Administrative Contractors (MACs) under section 1874A of the Act in accordance with Subpart E of this part.

(b) These providers of services and other entities must continue to bill the intermediary that they were billing prior to October 1, 2005, until one of the following events occurs:

(1) The intermediary's agreement with CMS ends, and the provider or entity is

directed by CMS to bill another CMS contractor.

(2) The provider or entity is assigned to a MAC that has begun to administer claims within the geographic locale of the provider or entity.

(3) CMS directs the provider or entity to begin billing another CMS contractor in order to support the implementation of MACs under section 1874A of the Act and Subpart E of this part.

(c) New providers of services and new entities will be assigned to the intermediary serving their geographic locale if no MAC has begun to administer Medicare claims in the locale. These providers or entities must continue to bill the intermediary until one of the events in paragraph (b) of this section occurs.

(d) Providers or entities will only be granted exceptions to the provisions of paragraphs (b) or (c) of this section if CMS deems the exception to be in the compelling interest of the Medicare program.

(e) CMS will notify the provider or entity, the outgoing intermediary, and the newly assigned intermediary of assignment or reassignment decisions.

§ 421.105 [Removed]

■ 28. Section 421.105 is removed.

§ 421.106 [Removed]

■ 29. Section 421.106 is removed.
■ 30. Section 421.112 is amended by—
■ a. Revising paragraph (a).
■ b. Revising paragraph (b).

The revisions read as follows:

§ 421.112 Considerations relating to the effective and efficient administration of the program.

(a) In order to accomplish the most effective and efficient administration of the Medicare program, the Secretary may make determinations with respect to the termination of an intermediary agreement, and CMS may make determinations with respect to renewal of an intermediary agreement under § 421.110.

(b) When taking the actions specified in paragraph (a) of this section, the Secretary or CMS will consider the performance of the individual intermediary in its Medicare operations using the factors contained in the performance criteria specified in § 421.120 and the performance standards specified in § 421.122.

* * * * *

■ 31. Section 421.114 is revised to read as follows:

§ 421.114 Assignment and reassignment of providers by CMS.

CMS may assign or reassign any provider to any intermediary if it determines that the assignment or reassignment will be in the best interests of the Medicare program.

§ 421.116 [Removed]

■ 32. Section 421.116 is removed.

§ 421.117 [Removed]

■ 33. Section 421.117 is removed.

§ 421.118 [Removed]

■ 34. Section 421.118 is removed.

Subpart D [Added and Reserved]

■ 35. Subpart D is added to Part 421 and reserved.
■ 36. A new Subpart E is added to Part 421 to read as follows:

Subpart E—Medicare Administrative Contractors (MACs)

Sec.
421.400 Statutory basis and scope.
421.401 Definitions.
421.404 Assignment of providers and suppliers to MACs.

§ 421.400 Statutory basis and scope.

(a) *Statutory basis.* This subpart implements section 1874A of the Act, which provides for the transition of the claims processing functions and operations for both Medicare Part A and Part B intermediaries and carriers to Medicare Administrative Contractors (MACs). The transition will occur between October 1, 2005, and October 1, 2011. MACs will be fully operational in distinct, nonoverlapping geographic jurisdictions by October 1, 2011.

(b) *Scope.* This subpart specifies the requirements under which providers and suppliers will be assigned to MACs.

§ 421.401 Definitions.

For purposes of this subpart—

Appropriate MAC means a MAC that has a contract under section 1874A of the Act to perform a particular Medicare administrative function in relation to:

(1) A particular individual entitled to benefits under Part A or enrolled under Part B, or both;

(2) A specific provider of services or supplier; or

(3) A class of providers of services or suppliers.

Medicare Administrative Contractor (MAC) means an agency, organization, or other person with a contract under section 1874A of the Act.

§ 421.404 Assignment of providers and suppliers to MACs.

(a) *Definitions.* As used in this section—

Chain provider means a group of two or more providers under common ownership or control.

Common control exists when an individual, a group of individuals, or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of the group of suppliers or eligible providers.

Common ownership exists when an individual, a group of individuals, or an organization possesses significant equity in the group of suppliers or eligible providers.

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) means the types of services specified in § 421.210(b).

Eligible provider means a hospital, skilled nursing facility, or critical access hospital that meets the definition of a provider under § 400.202 of this chapter.

Home office means the entity that provides centralized management and administrative services to the individual providers or suppliers under common ownership and common control, such as centralized accounting, purchasing, personnel services, management direction and control, and other similar services.

Ineligible provider means a provider under § 400.202 of this chapter that is not an eligible provider.

Medicare benefit category means a category of covered benefits under Part A or Part B of the Medicare program (for example, inpatient hospital services, post-hospital extended care services, and physicians' services).

Provider has the same meaning as specified under § 400.202 of this chapter.

Qualified chain provider means a chain provider comprised of—

(1) 10 or more eligible providers collectively totaling 500 or more certified beds; or

(2) 5 or more eligible providers collectively totaling 300 or more certified beds, with eligible providers in 3 or more contiguous States.

Supplier has the same meaning as specified in § 400.202 of this chapter.

(b) *Assignment of providers to MACs.* (1) Providers enroll with and receive Medicare payment and other Medicare services from the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the provider's covered services for the geographic locale in which the provider is physically located.

(2) Qualified chain providers may request and receive an exception from the requirement of paragraph (b)(1) of this section from CMS. Upon CMS' approval, a qualified chain provider may enroll with and bill on behalf of the eligible providers under its common ownership or common control to the

MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the eligible providers' covered services for the geographic locale in which the qualified chain provider's home office is physically located.

(3) As MAC contractors become available, qualified chain providers, granted approval by CMS to enroll with and bill a single intermediary on behalf of their eligible member providers prior to October 1, 2005, will be assigned at an appropriate time to the MAC contracted by CMS to administer claims for the applicable Medicare benefit category for the geographic locale in which the chain provider's home office is physically located. The qualified chain provider will not need to request an exception to the requirement of paragraph (b)(1) of this section in order for this assignment to take effect.

(4) CMS may grant an exception to the requirement of paragraph (b)(1) of this section to eligible providers that are not under the common ownership or common control of a qualified chain provider, as well as ineligible providers, only if CMS finds the exception will support the implementation of MACs or will serve some other compelling interest of the Medicare program.

(c) *Assignment of suppliers to MACs.* (1) Suppliers, including physicians and other practitioners, but excluding suppliers of DMEPOS, enroll with and receive Medicare payment and other Medicare services from the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the supplier's covered services for the geographic locale in which the supplier furnished such services.

(2) Suppliers of DMEPOS receive Medicare payment and other Medicare services from the MAC assigned to administer claims for DMEPOS for the regional area in which the beneficiary receiving the DMEPOS resides. The terms of §§ 421.210 and 421.212 continue to apply to suppliers of DMEPOS.

(3) CMS may allow a group of ESRD suppliers under common ownership and common control to enroll with the MAC contracted by CMS to administer ESRD claims for the geographic locale in which the group's home office is located only if—

(i) The group of ESRD suppliers requests such privileges; and

(ii) CMS finds the exception will support the implementation of MACs or will serve some other compelling interest of the Medicare program.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

■ 37. 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).

■ 38. Section 485.618 is amended by—

■ a. Revising paragraph (d)(1) introductory text.

■ b. Redesignating paragraphs (d)(2) and (d)(3) as paragraphs (d)(3) and (d)(4), respectively.

■ c. Adding a new paragraph (d)(2).

■ d. In redesignated paragraph (d)(3)(iv), removing the cross-reference ''paragraph (d)(2)(iii)'' and adding the cross-reference ''paragraph (d)(3)(iii)'' in its place.

■ e. In redesignated paragraph (d)(4), removing the cross-reference ''paragraph (d)(2)(iii)'' and adding the cross-reference ''paragraph (d)(3)(iii)'' in its place.

The revisions and additions read as follows:

§ 485.618 Condition of participation: Emergency services.

* * * * *

(d) *Standard: Personnel.* (1) Except as specified in paragraph (d)(3) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care, on call and immediately available by telephone or radio contact, and available on site within the following timeframes:

* * * * *

(2) A registered nurse with training and experience in emergency care can be utilized to conduct specific medical screening examinations only if—

(i) The registered nurse is on site and immediately available at the CAH when a patient requests medical care; and

(ii) The nature of the patient's request for medical care is within the scope of practice of a registered nurse and consistent with applicable State laws and the CAH's bylaws or rules and regulations.

* * * * *

PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

■ 39. The authority citation for Part 488 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 41. In § 488.1, the definition of ''supplier'' is revised to read as follows:

§ 488.1 Definitions.

* * * * *

Supplier means any of the following: Independent laboratory; portable X-ray services; physical therapist in independent practice; ESRD facility; rural health clinic; Federally qualified health center; chiropractor; or ambulatory surgical center.

* * * * *

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

Dated: October 27, 2006.

Leslie Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: October 31, 2006.

Michael O. Leavitt,

Secretary.

ADDENDUM A.—OPPS LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007

APC	Group title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001	Level I Photochemotherapy	S	0.4914	30.21	7.00	6.04
0002	Level I Fine Needle Biopsy/Aspiration	T	1.0995	67.58		13.52
0003	Bone Marrow Biopsy/Aspiration	T	2.4011	147.59		29.52
0004	Level I Needle Biopsy/Aspiration Except Bone Marrow	T	2.0687	127.16		25.43
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	3.9045	240.00	71.59	48.00
0006	Level I Incision & Drainage	T	1.4392	88.46		17.69
0007	Level II Incision & Drainage	T	11.1535	685.58		137.12
0008	Level III Incision and Drainage	T	17.5086	1,076.22		215.24
0009	Nail Procedures	T	0.7744	47.60		9.52
0010	Level I Destruction of Lesion	T	0.4760	29.26	8.02	5.85
0011	Level II Destruction of Lesion	T	2.5665	157.76		31.55
0012	Level I Debridement & Destruction	T	0.8432	51.83	11.18	10.37
0013	Level II Debridement & Destruction	T	1.0918	67.11		13.42
0015	Level III Debridement & Destruction	T	1.6241	99.83	20.13	19.97
0016	Level IV Debridement & Destruction	T	2.6749	164.42		32.88
0017	Level VI Debridement & Destruction	T	17.4423	1,072.14	227.84	214.43
0018	Biopsy of Skin/Puncture of Lesion	T	1.0259	63.06	15.44	12.61
0019	Level I Excision/ Biopsy	T	4.0919	251.52	71.87	50.30
0020	Level II Excision/ Biopsy	T	6.8083	418.49	107.67	83.70
0021	Level III Excision/ Biopsy	T	15.1024	928.31	219.48	185.66
0022	Level IV Excision/ Biopsy	T	20.0656	1,233.39	354.45	246.68
0023	Exploration Penetrating Wound	T	4.2212	259.47		51.89
0024	Level I Skin Repair	T	1.4843	91.24	29.88	18.25
0025	Level II Skin Repair	T	5.2594	323.28	101.85	64.66
0027	Level IV Skin Repair	T	21.4302	1,317.27	329.72	263.45
0028	Level I Breast Surgery	T	19.2788	1,185.03	303.74	237.01
0029	Level II Breast Surgery	T	28.0166	1,722.12	581.52	344.42
0030	Level III Breast Surgery	T	37.8692	2,327.74	747.07	465.55
0031	Smoking Cessation Services	X	0.1766	10.86		2.17
0033	Partial Hospitalization	P	3.8188	234.73		46.95
0035	Arterial/Venous Puncture	T	0.1999	12.29		2.46
0036	Level II Fine Needle Biopsy/Aspiration	T	2.0738	127.47		25.49
0037	Level IV Needle Biopsy/Aspiration Except Bone Marrow	T	10.2655	631.00	228.76	126.20
0038	Spontaneous MEG	S	53.5161	3,289.53		657.91
0039	Level I Implantation of Neurostimulator	S	187.3821	11,518.00		2,303.60
0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	S	56.5705	3,477.28		695.46
0041	Level I Arthroscopy	T	28.6245	1,759.49		351.90
0042	Level II Arthroscopy	T	45.5027	2,796.96	804.74	559.39
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.6857	103.62		20.72
0045	Bone/Joint Manipulation Under Anesthesia	T	14.5947	897.11	268.47	179.42
0047	Arthroplasty without Prosthesis	T	33.4505	2,056.14	537.03	411.23
0048	Level I Arthroplasty with Prosthesis	T	47.4378	2,915.91		583.18
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	20.8706	1,282.87		256.57
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	25.1296	1,544.67		308.93
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	41.0893	2,525.68		505.14
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	66.5800	4,092.54		818.51
0053	Level I Hand Musculoskeletal Procedures	T	16.1540	992.95	253.49	198.59
0054	Level II Hand Musculoskeletal Procedures	T	25.8758	1,590.53		318.11
0055	Level I Foot Musculoskeletal Procedures	T	20.4263	1,255.56	355.34	251.11
0056	Level II Foot Musculoskeletal Procedures	T	40.8559	2,511.33		502.27
0057	Bunion Procedures	T	28.2349	1,735.54	475.91	347.11
0058	Level I Strapping and Cast Application	S	1.0607	65.20		13.04
0060	Manipulation Therapy	S	0.4657	28.63		5.73
0061	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	S	84.1967	5,175.40		1,035.08
0062	Level I Treatment Fracture/Dislocation	T	25.5264	1,569.06	372.87	313.81
0063	Level II Treatment Fracture/Dislocation	T	37.5382	2,307.40	548.33	461.48
0064	Level III Treatment Fracture/Dislocation	T	57.2172	3,517.03	835.79	703.41
0065	Level I Stereotactic Radiosurgery	S	20.3224	1,249.18		249.84
0066	Level II Stereotactic Radiosurgery	S	43.0297	2,644.95		528.99
0067	Level III Stereotactic Radiosurgery	S	63.3759	3,895.59		779.12
0068	CPAP Initiation	S	1.5353	94.37	29.48	18.87
0069	Thoracoscopy	T	31.9442	1,963.55	591.64	392.71
0070	Thoracentesis/Lavage Procedures	T	3.6244	222.78		44.56
0071	Level I Endoscopy Upper Airway	T	0.7698	47.32	11.20	9.46
0072	Level II Endoscopy Upper Airway	T	1.4054	86.39	21.27	17.28
0073	Level III Endoscopy Upper Airway	T	3.8463	236.42	69.15	47.28
0074	Level IV Endoscopy Upper Airway	T	14.7928	909.28	292.25	181.86

ADDENDUM A.—OPPS LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0075	Level V Endoscopy Upper Airway	T	21.9512	1,349.30	445.92	269.86
0076	Level I Endoscopy Lower Airway	T	9.5228	585.35	189.82	117.07
0077	Level I Pulmonary Treatment	S	0.3527	21.68	7.74	4.34
0078	Level II Pulmonary Treatment	S	1.1206	68.88	14.55	13.78
0079	Ventilation Initiation and Management	S	2.6116	160.53		32.11
0080	Diagnostic Cardiac Catheterization	T	37.0615	2,278.10	838.92	455.62
0081	Non-Coronary Angioplasty or Atherectomy	T	42.9360	2,639.19		527.84
0082	Coronary Atherectomy	T	72.1982	4,437.88	954.62	887.58
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	58.7904	3,613.73		722.75
0084	Level I Electrophysiologic Evaluation	S	9.8924	608.07		121.61
0085	Level II Electrophysiologic Evaluation	T	34.2808	2,107.17	426.25	421.43
0086	Ablate Heart Dysrhythm Focus	T	47.4931	2,919.31	812.36	583.86
0087	Cardiac Electrophysiologic Recording/Mapping	T	32.8988	2,022.22		404.44
0088	Thrombectomy	T	37.7391	2,319.75	655.22	463.95
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	T	123.6693	7,601.70	1,682.28	1,520.34
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	98.3023	6,042.45	1,612.80	1,208.49
0091	Level II Vascular Ligation	T	34.7288	2,134.71		426.94
0092	Level I Vascular Ligation	T	24.8809	1,529.38	309.87	305.88
0093	Vascular Reconstruction/Fistula Repair without Device	T	22.8653	1,405.48		281.10
0094	Level I Resuscitation and Cardioversion	S	2.4233	148.96	46.29	29.79
0095	Cardiac Rehabilitation	S	0.5748	35.33	13.86	7.07
0096	Non-Invasive Vascular Studies	S	1.5303	94.06	37.62	18.81
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0225	62.85	23.79	12.57
0098	Injection of Sclerosing Solution	T	1.0798	66.37		13.27
0099	Electrocardiograms	S	0.3789	23.29		4.66
0100	Cardiac Stress Tests	X	2.5336	155.74	41.44	31.15
0101	Tilt Table Evaluation	S	4.2769	262.89	100.24	52.58
0103	Miscellaneous Vascular Procedures	T	16.2375	998.09	223.63	199.62
0104	Transcatheter Placement of Intracoronary Stents	T	87.7183	5,391.87		1,078.37
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices.	T	25.6142	1,574.45	370.40	314.89
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	T	58.8594	3,617.97		723.59
0107	Insertion of Cardioverter-Defibrillator	T	304.4894	18,716.35		3,743.27
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	379.7339	23,341.48		4,668.30
0109	Removal of Implanted Devices	T	10.9918	675.64		135.13
0110	Transfusion	S	3.4584	212.58		42.52
0111	Blood Product Exchange	S	11.7134	720.00	198.40	144.00
0112	Apheresis, Photopheresis, and Plasmapheresis	S	30.2231	1,857.75	433.29	371.55
0113	Excision Lymphatic System	T	21.2621	1,306.94		261.39
0114	Thyroid/Lymphadenectomy Procedures	T	37.7224	2,318.72	467.95	463.74
0115	Cannula/Access Device Procedures	T	29.2133	1,795.68	374.81	359.14
0121	Level I Tube changes and Repositioning	T	2.3587	144.98	43.80	29.00
0122	Level II Tube changes and Repositioning	T	7.4800	459.78		91.96
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant.	S	20.3582	1,251.38		250.28
0125	Refilling of Infusion Pump	T	2.2041	135.48		27.10
0126	Level I Urinary and Anal Procedures	T	1.0887	66.92	16.45	13.38
0127	Level IV Stereotactic Radiosurgery	S	138.4486	8,510.16		1,702.03
0130	Level I Laparoscopy	T	32.1241	1,974.60	659.53	394.92
0131	Level II Laparoscopy	T	43.5488	2,676.86	1,001.89	535.37
0132	Level III Laparoscopy	T	70.5066	4,333.90	1,239.22	866.78
0140	Esophageal Dilation without Endoscopy	T	5.4566	335.41	91.40	67.08
0141	Level I Upper GI Procedures	T	8.3175	511.26	143.38	102.25
0142	Small Intestine Endoscopy	T	9.4946	583.61	152.78	116.72
0143	Lower GI Endoscopy	T	8.7686	538.99	186.06	107.80
0146	Level I Sigmoidoscopy and Anoscopy	T	4.8683	299.24	64.40	59.85
0147	Level II Sigmoidoscopy and Anoscopy	T	8.5477	525.41		105.08
0148	Level I Anal/Rectal Procedures	T	5.0770	312.07		62.41
0149	Level III Anal/Rectal Procedures	T	22.2682	1,368.78	293.06	273.76
0150	Level IV Anal/Rectal Procedures	T	29.6189	1,820.61	437.12	364.12
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	19.8381	1,219.41	245.46	243.88
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	20.2682	1,245.85		249.17
0153	Peritoneal and Abdominal Procedures	T	22.0832	1,357.41	397.95	271.48
0154	Hernia/Hydrocele Procedures	T	29.2182	1,795.98	464.85	359.20
0155	Level II Anal/Rectal Procedures	T	12.7389	783.03		156.61
0156	Level III Urinary and Anal Procedures	T	3.4079	209.48		41.90
0157	Colorectal Cancer Screening: Barium Enema	S	2.1149	130.00		26.00
0158	Colorectal Cancer Screening: Colonoscopy	T	7.8492	446.00		111.50

ADDENDUM A.—OPPS LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	3.6592	224.92		56.23
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	6.4951	399.24	101.58	79.85
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	19.2251	1,181.73	249.36	236.35
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	23.8700	1,467.24		293.45
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	34.9261	2,146.84		429.37
0164	Level II Urinary and Anal Procedures	T	2.1393	131.50		26.30
0165	Level IV Urinary and Anal Procedures	T	18.1679	1,116.74		223.35
0166	Level I Urethral Procedures	T	18.3960	1,130.77		226.15
0168	Level II Urethral Procedures	T	29.0253	1,784.13	388.16	356.83
0169	Lithotripsy	T	43.5398	2,676.30	1,009.47	535.26
0170	Dialysis	S	6.6089	406.24		81.25
0171	Level V Anal/Rectal Procedures	T	37.8991	2,329.58	716.76	465.92
0180	Circumcision	T	20.5513	1,263.25	304.87	252.65
0181	Penile Procedures	T	32.9873	2,027.66	621.82	405.53
0183	Testes/Epididymis Procedures	T	23.5310	1,446.40		289.28
0184	Prostate Biopsy	T	5.6262	345.83	96.27	69.17
0188	Level II Female Reproductive Proc	T	1.2900	79.29		15.86
0189	Level III Female Reproductive Proc	T	2.8966	178.05		35.61
0190	Level I Hysteroscopy	T	21.3586	1,312.87	424.28	262.57
0191	Level I Female Reproductive Proc	T	0.1468	9.02	2.55	1.80
0192	Level IV Female Reproductive Proc	T	6.6592	409.33		81.87
0193	Level V Female Reproductive Proc	T	14.8489	912.73		182.55
0194	Level VIII Female Reproductive Proc	T	20.5081	1,260.59	397.84	252.12
0195	Level IX Female Reproductive Proc	T	28.5095	1,752.42	483.80	350.48
0196	Dilation and Curettage	T	17.7499	1,091.05	338.23	218.21
0197	Infertility Procedures	T	4.0007	245.92		49.18
0198	Pregnancy and Neonatal Care Procedures	T	1.4222	87.42	32.19	17.48
0200	Level VII Female Reproductive Proc	T	16.9328	1,040.83	243.36	208.17
0201	Level VI Female Reproductive Proc	T	18.5201	1,138.39	329.65	227.68
0202	Level X Female Reproductive Proc	T	42.9896	2,642.48	981.50	528.50
0203	Level IV Nerve Injections	T	12.1702	748.08	240.33	149.62
0204	Level I Nerve Injections	T	2.2614	139.00	40.13	27.80
0206	Level II Nerve Injections	T	5.7253	351.92	75.55	70.38
0207	Level III Nerve Injections	T	6.3603	390.95	86.92	78.19
0208	Laminotomies and Laminectomies	T	44.1489	2,713.74		542.75
0209	Level II MEG, Extended EEG Studies and Sleep Studies	S	11.2463	691.29	268.73	138.26
0212	Nervous System Injections	T	2.9907	183.83	65.96	36.77
0213	Level I MEG, Extended EEG Studies and Sleep Studies	S	2.2755	139.87	53.58	27.97
0214	Electroencephalogram	S	1.1968	73.56	28.24	14.71
0215	Level I Nerve and Muscle Tests	S	0.5741	35.29		7.06
0216	Level III Nerve and Muscle Tests	S	2.7199	167.19		33.44
0218	Level II Nerve and Muscle Tests	S	1.1872	72.97		14.59
0220	Level I Nerve Procedures	T	17.8499	1,097.20		219.44
0221	Level II Nerve Procedures	T	33.1520	2,037.79	463.62	407.56
0222	Implantation of Neurological Device	T	181.6249	11,164.12		2,232.82
0223	Implantation or Revision of Pain Management Catheter	T	30.8394	1,895.64		379.13
0224	Implantation of Reservoir/Pump/Shunt	T	47.0342	2,891.10		578.22
0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	S	221.1512	13,593.72		2,718.74
0226	Implantation of Drug Infusion Reservoir	T	112.6322	6,923.28		1,384.66
0227	Implantation of Drug Infusion Device	T	174.4056	10,720.36		2,144.07
0228	Creation of Lumbar Subarachnoid Shunt	T	39.2633	2,413.44		482.69
0229	Transcatherter Placement of Intravascular Shunts	T	68.4697	4,208.70		841.74
0230	Level I Eye Tests & Treatments	S	0.7898	48.55	14.97	9.71
0231	Level III Eye Tests & Treatments	S	2.1451	131.86		26.37
0232	Level I Anterior Segment Eye Procedures	T	6.0673	372.94	93.43	74.59
0233	Level II Anterior Segment Eye Procedures	T	15.2259	935.91	266.33	187.18
0234	Level III Anterior Segment Eye Procedures	T	22.9970	1,413.58	511.31	282.72
0235	Level I Posterior Segment Eye Procedures	T	3.9333	241.77	58.93	48.35
0236	Level II Posterior Segment Eye Procedures	T	16.5239	1,015.69		203.14
0237	Level III Posterior Segment Eye Procedures	T	27.6020	1,696.64		339.33
0238	Level I Repair and Plastic Eye Procedures	T	2.8954	177.97		35.59
0239	Level II Repair and Plastic Eye Procedures	T	7.2819	447.60		89.52
0240	Level III Repair and Plastic Eye Procedures	T	17.1243	1,052.60	309.52	210.52
0241	Level IV Repair and Plastic Eye Procedures	T	25.2550	1,552.37	384.47	310.47
0242	Level V Repair and Plastic Eye Procedures	T	35.2292	2,165.47	597.36	433.09
0243	Strabismus/Muscle Procedures	T	21.2801	1,308.05	430.35	261.61
0244	Corneal Transplant	T	38.2707	2,352.42	803.26	470.48
0245	Level I Cataract Procedures without IOL Insert	T	14.8702	914.04	217.05	182.81
0246	Cataract Procedures with IOL Insert	T	23.6313	1,452.57	495.96	290.51

ADDENDUM A.—OPPS LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0247	Laser Eye Procedures Except Retinal	T	5.0839	312.50	104.31	62.50
0248	Laser Retinal Procedures	T	5.0841	312.51	95.08	62.50
0249	Level II Cataract Procedures without IOL Insert	T	29.2281	1,796.59	524.67	359.32
0250	Nasal Cauterization/Packing	T	1.1791	72.48	25.39	14.50
0251	Level I ENT Procedures	T	2.4520	150.72		30.14
0252	Level II ENT Procedures	T	7.5511	464.15	109.16	92.83
0253	Level III ENT Procedures	T	16.4266	1,009.71	282.29	201.94
0254	Level IV ENT Procedures	T	23.3299	1,434.04	321.35	286.81
0256	Level V ENT Procedures	T	38.1991	2,348.02		469.60
0257	Level I Therapeutic Radiologic Procedures	S	1.0974	67.45		13.49
0258	Tonsil and Adenoid Procedures	T	22.1165	1,359.46	437.25	271.89
0259	Level VI ENT Procedures	T	414.8455	25,499.72	8,698.43	5,099.94
0260	Level I Plain Film Except Teeth	X	0.7093	43.60		8.72
0261	Level II Plain Film Except Teeth Including Bone Density Measurement.	X	1.2224	75.14		15.03
0262	Plain Film of Teeth	X	0.6550	40.26		8.05
0263	Level I Miscellaneous Radiology Procedures	X	1.6956	104.23	23.77	20.85
0264	Level II Miscellaneous Radiology Procedures	X	2.9586	181.86	70.27	36.37
0265	Level I Diagnostic and Screening Ultrasound	S	0.9923	60.99	23.63	12.20
0266	Level II Diagnostic and Screening Ultrasound	S	1.5607	95.93	37.80	19.19
0267	Level III Diagnostic and Screening Ultrasound	S	2.4606	151.25	60.50	30.25
0268	Level I Ultrasound Guidance Procedures	S	1.1882	73.04		14.61
0269	Level II Echocardiogram Except Transesophageal	S	3.2154	197.64	75.60	39.53
0270	Transesophageal Echocardiogram	S	6.2505	384.21	141.32	76.84
0272	Fluoroscopy	X	1.2908	79.34	31.64	15.87
0274	Myelography	S	2.5544	157.01	62.80	31.40
0275	Arthrography	S	3.6915	226.91	69.09	45.38
0276	Level I Digestive Radiology	S	1.4294	87.86	34.97	17.57
0277	Level II Digestive Radiology	S	2.2176	136.31	54.52	27.26
0278	Diagnostic Urography	S	2.4159	148.50	59.40	29.70
0279	Level II Angiography and Venography	S	9.5061	584.32	150.03	116.86
0280	Level III Angiography and Venography	S	20.8225	1,279.92	353.85	255.98
0282	Miscellaneous Computerized Axial Tomography	S	1.5379	94.53	37.81	18.91
0283	Computed Tomography with Contrast	S	4.0825	250.94	100.37	50.19
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast.	S	6.1231	376.37	148.40	75.27
0288	Bone Density:Axial Skeleton	S	1.1755	72.26	28.90	14.45
0293	Level V Anterior Segment Eye Procedures	T	51.9894	3,195.68	1,128.29	639.14
0296	Level II Therapeutic Radiologic Procedures	S	2.6802	164.75	53.99	32.95
0297	Level III Therapeutic Radiologic Procedures	S	3.6392	223.69	89.47	44.74
0298	Level IV Therapeutic Radiologic Procedures	S	8.3906	515.75	206.30	103.15
0299	Miscellaneous Radiation Treatment	S	5.8839	361.67		72.33
0300	Level I Radiation Therapy	S	1.4826	91.13		18.23
0301	Level II Radiation Therapy	S	2.2295	137.04		27.41
0302	Computer Assisted Navigational Procedures	S	4.9138	302.04	105.94	60.41
0303	Treatment Device Construction	X	2.9430	180.90	66.95	36.18
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.5735	96.72	38.68	19.34
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.9723	244.17	91.38	48.83
0307	Myocardial Positron Emission Tomography (PET) imaging	S	11.8963	731.24	292.49	146.25
0308	Non-Myocardial Positron Emission Tomography (PET) imaging	S	13.9166	855.43		171.09
0309	Level II Ultrasound Guidance Procedures	S	2.1012	129.16		25.83
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.8081	848.76	325.27	169.75
0312	Radioelement Applications	S	4.8569	298.54		59.71
0313	Brachytherapy	S	12.8473	789.70		157.94
0314	Hyperthermic Therapies	S	3.3461	205.68	60.88	41.14
0315	Level II Implantation of Neurostimulator	T	242.9363	14,932.81		2,986.56
0320	Electroconvulsive Therapy	S	5.5676	342.23	80.06	68.45
0321	Biofeedback and Other Training	S	1.3384	82.27	21.72	16.45
0322	Brief Individual Psychotherapy	S	1.1798	72.52		14.50
0323	Extended Individual Psychotherapy	S	1.7066	104.90		20.98
0324	Family Psychotherapy	S	2.1633	132.97		26.59
0325	Group Psychotherapy	S	1.0765	66.17	14.47	13.23
0330	Dental Procedures	S	7.0550	433.66		86.73
0332	Computed Tomography without Contrast	S	3.0908	189.99	75.24	38.00
0333	Computed Tomography without Contrast followed by Contrast)	S	4.8405	297.54	119.01	59.51
0335	Magnetic Resonance Imaging, Miscellaneous	S	4.5523	279.82	111.92	55.96
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast.	S	5.6745	348.80	139.51	69.76

ADDENDUM A.—OPPS LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast.	S	8.1155	498.84	199.53	99.77
0339	Observation	S	7.2039	442.81		88.56
0340	Minor Ancillary Procedures	X	0.6102	37.51		7.50
0341	Skin Tests	X	0.0914	5.62	2.24	1.12
0342	Level I Pathology	X	0.0824	5.06	2.02	1.01
0343	Level III Pathology	X	0.5211	32.03	10.84	6.41
0344	Level IV Pathology	X	0.7927	48.73	15.66	9.75
0345	Level I Transfusion Laboratory Procedures	X	0.2178	13.39	2.87	2.68
0346	Level II Transfusion Laboratory Procedures	X	0.3484	21.42	4.39	4.28
0347	Level III Transfusion Laboratory Procedures	X	0.7423	45.63	11.28	9.13
0348	Fertility Laboratory Procedures	X	0.8321	51.15		10.23
0350	Administration of flu and PPV vaccine	S	0.3945	24.25		0.00
0360	Level I Alimentary Tests	X	1.4154	87.00	33.88	17.40
0361	Level II Alimentary Tests	X	3.8887	239.03	83.23	47.81
0362	Contact Lens and Spectacle Services	X	0.5865	36.05		7.21
0363	Level I Otorhinolaryngologic Function Tests	X	0.8525	52.40	17.44	10.48
0364	Level I Audiometry	X	0.4627	28.44	7.06	5.69
0365	Level II Audiometry	X	1.2419	76.34	18.52	15.27
0366	Level III Audiometry	X	1.8511	113.78	26.14	22.76
0367	Level I Pulmonary Test	X	0.6277	38.58	14.68	7.72
0368	Level II Pulmonary Tests	X	0.9454	58.11	22.77	11.62
0369	Level III Pulmonary Tests	X	2.7669	170.08	44.18	34.02
0370	Allergy Tests	X	1.0270	63.13		12.63
0372	Therapeutic Phlebotomy	X	0.5723	35.18	10.09	7.04
0373	Level I Neuropsychological Testing	X	1.7682	108.69		21.74
0374	Monitoring Psychiatric Drugs	X	1.1418	70.18		14.04
0375	Ancillary Outpatient Services When Patient Expires	S	58.0781	3,569.94		713.99
0376	Level II Cardiac Imaging	S	4.9832	306.31	119.77	61.26
0377	Level III Cardiac Imaging	S	6.5012	399.62	158.84	79.92
0378	Level II Pulmonary Imaging	S	5.0975	313.33	125.33	62.67
0379	Injection adenosine 6 MG	K		30.49		6.10
0381	Single Allergy Tests	X	0.2688	16.52		3.30
0382	Level II Neuropsychological Testing	X	2.8460	174.94	69.97	34.99
0384	GI Procedures with Stents	T	22.9475	1,410.54	295.41	282.11
0385	Level I Prosthetic Urological Procedures	S	79.2092	4,868.83		973.77
0386	Level II Prosthetic Urological Procedures	S	137.3897	8,445.07		1,689.01
0387	Level II Hysteroscopy	T	34.0155	2,090.86	655.55	418.17
0388	Discography	S	15.9758	982.00	289.72	196.40
0389	Level I Non-imaging Nuclear Medicine	S	1.3754	84.54	33.81	16.91
0390	Level I Endocrine Imaging	S	2.3432	144.03	57.61	28.81
0391	Level II Endocrine Imaging	S	2.7146	166.86	66.18	33.37
0392	Level II Non-imaging Nuclear Medicine	S	2.0057	123.29	49.31	24.66
0393	Red Cell/Plasma Studies	S	3.7562	230.89	82.04	46.18
0394	Hepatobiliary Imaging	S	4.3774	269.07	102.61	53.81
0395	GI Tract Imaging	S	3.6526	224.52	89.73	44.90
0396	Bone Imaging	S	3.9174	240.79	95.02	48.16
0397	Vascular Imaging	S	2.4204	148.78	49.58	29.76
0398	Level I Cardiac Imaging	S	4.1265	253.65	100.06	50.73
0399	Nuclear Medicine Add-on Imaging	S	1.5054	92.53	35.80	18.51
0400	Hematopoietic Imaging	S	3.9073	240.17	93.22	48.03
0401	Level I Pulmonary Imaging	S	3.1802	195.48	78.19	39.10
0402	Brain Imaging	S	4.6418	285.32	114.12	57.06
0403	CSF Imaging	S	3.4923	214.66	83.35	42.93
0404	Renal and Genitourinary Studies Level I	S	3.4209	210.28	84.11	42.06
0405	Renal and Genitourinary Studies Level II	S	4.0378	248.20	98.77	49.64
0406	Level I Tumor/Infection Imaging	S	3.9934	245.47	98.18	49.09
0407	Level I Radionuclide Therapy	S	3.1779	195.34	78.13	39.07
0408	Level II Tumor/Infection Imaging	S	5.9245	364.17		72.83
0409	Red Blood Cell Tests	X	0.1227	7.54	2.20	1.51
0411	Respiratory Procedures	S	0.3848	23.65		4.73
0412	IMRT Treatment Delivery	S	5.4731	336.42		67.28
0413	Level II Radionuclide Therapy	S	5.2957	325.52		65.10
0415	Level II Endoscopy Lower Airway	T	22.0099	1,352.90	459.92	270.58
0416	Level I Intravascular and Intracardiac Ultrasound and Flow Reserve.	S	32.5472	2,000.61		400.12
0417	Computerized Reconstruction	S	3.2393	199.11		39.82
0418	Insertion of Left Ventricular Pacing Elect.	T	307.2828	18,888.06		3,777.61
0421	Prolonged Physiologic Monitoring	X	1.6270	100.01		20.00

ADDENDUM A.—OPPS LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0422	Level II Upper GI Procedures	T	25.7552	1,583.12	448.81	316.62
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	37.3604	2,296.47		459.29
0425	Level II Arthroplasty with Prosthesis	T	107.1942	6,589.01	1,378.01	1,317.80
0426	Level II Strapping and Cast Application	S	2.2777	140.01		28.00
0427	Level III Tube Changes and Repositioning	T	11.6575	716.56		143.31
0428	Level III Sigmoidoscopy and Anoscopy	T	20.6375	1,268.55		253.71
0429	Level V Cystourethroscopy and other Genitourinary Procedures	T	43.1004	2,649.30		529.86
0432	Health and Behavior Services	S	0.6072	37.32		7.46
0433	Level II Pathology	X	0.2557	15.72	5.93	3.14
0434	Cardiac Defect Repair	T	88.0728	5,413.66		1,082.73
0436	Level I Drug Administration	S	0.1809	11.12		2.22
0437	Level II Drug Administration	S	0.3945	24.25		4.85
0438	Level III Drug Administration	S	0.7942	48.82		9.76
0439	Level IV Drug Administration	S	1.5848	97.41		19.48
0440	Level V Drug Administration	S	1.8090	111.20		22.24
0441	Level VI Drug Administration	S	2.4851	152.75		30.55
0442	Dosimetric Drug Administration	S	22.3666	1,374.83		274.97
0443	Overnight Pulse Oximetry	X	1.0409	63.98	25.59	12.80
0604	Level 1 Hospital Clinic Visits	V	0.8242	50.66		10.13
0605	Level 2 Hospital Clinic Visits	V	0.9840	60.48		12.10
0606	Level 3 Hospital Clinic Visits	V	1.3646	83.88		16.78
0607	Level 4 Hospital Clinic Visits	V	1.7096	105.09		21.02
0608	Level 5 Hospital Clinic Visits	V	2.1794	133.96		26.79
0609	Level 1 Emergency Visits	V	0.8136	50.01	12.70	10.00
0613	Level 2 Emergency Visits	V	1.3497	82.96	21.06	16.59
0614	Level 3 Emergency Visits	V	2.1150	130.00	34.50	26.00
0615	Level 4 Emergency Visits	V	3.4163	209.99	48.49	42.00
0616	Level 5 Emergency Visits	V	5.2915	325.26	75.11	65.05
0617	Critical Care	S	6.5894	405.04	111.59	81.01
0618	Trauma Response with Critical Care	S	8.0455	494.54	197.81	98.91
0621	Level I Vascular Access Procedures	T	8.7846	539.97		107.99
0622	Level II Vascular Access Procedures	T	22.6665	1,393.26		278.65
0623	Level III Vascular Access Procedures	T	28.5032	1,752.03		350.41
0624	Minor Vascular Access Device Procedures	X	0.5145	31.63	12.65	6.33
0625	Level IV Vascular Access Procedures	T	83.4609	5,130.17		1,026.03
0648	Level IV Breast Surgery	T	51.2269	3,148.82		629.76
0651	Complex Interstitial Radiation Source Application	S	16.8462	1,035.50		207.10
0652	Insertion of Intraperitoneal and Pleural Catheters	T	29.5416	1,815.86		363.17
0653	Vascular Reconstruction/Fistula Repair with Device	T	32.3818	1,990.44		398.09
0654	Insertion/Replacement of a permanent dual chamber pacemaker.	T	112.7719	6,931.86		1,386.37
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	T	152.6392	9,382.43		1,876.49
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	108.3003	6,657.00		1,331.40
0657	Placement of Tissue Clips	S	1.7369	106.76		21.35
0658	Percutaneous Breast Biopsies	T	6.4387	395.77		79.15
0659	Hyperbaric Oxygen	S	1.5906	97.77		19.55
0660	Level II Otorhinolaryngologic Function Tests	X	1.4461	88.89	28.06	17.78
0661	Level V Pathology	X	2.5255	155.24	62.09	31.05
0662	CT Angiography	S	4.8552	298.44	118.88	59.69
0663	Level I Electronic Analysis of Neurostimulator Pulse Generators	S	1.1067	68.03	17.45	13.61
0664	Level I Proton Beam Radiation Therapy	S	18.8926	1,161.29		232.26
0665	Bone Density:AppendicularSkeleton	S	0.5497	33.79	13.51	6.76
0667	Level II Proton Beam Radiation Therapy	S	22.6031	1,389.37		277.87
0668	Level I Angiography and Venography	S	6.2463	383.95	88.26	76.79
0670	Level II Intravascular and Intracardiac Ultrasound and Flow Reserve.	S	32.2854	1,984.52	536.10	396.90
0672	Level IV Posterior Segment Eye Procedures	T	37.4290	2,300.69		460.14
0673	Level IV Anterior Segment Eye Procedures	T	37.8967	2,329.43	649.56	465.89
0674	Prostate Cryoablation	T	108.7566	6,685.05		1,337.01
0675	Prostatic Thermotherapy	T	41.1375	2,528.64		505.73
0676	Thrombolysis and Thrombectomy	T	2.0726	127.40		25.48
0678	External Counterpulsation	T	1.7418	107.06		21.41
0679	Level II Resuscitation and Cardioversion	S	5.5233	339.51	95.30	67.90
0680	Insertion of Patient Activated Event Recorders	S	72.6022	4,462.71		892.54
0681	Knee Arthroplasty	T	205.6815	12,642.83		2,528.57
0682	Level V Debridement & Destruction	T	6.8832	423.10	158.65	84.62
0683	Level II Photochemotherapy	S	2.6734	164.33		32.87
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	6.1384	377.32	115.47	75.46

ADDENDUM A.—OPPS LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0686	Level III Skin Repair	T	14.0346	862.68		172.54
0687	Revision/Removal of Neurostimulator Electrodes	T	17.8334	1,096.18	438.47	219.24
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	35.5702	2,186.43	874.57	437.29
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.6003	36.90		7.38
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.3613	22.21	8.67	4.44
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.8942	177.90	60.61	35.58
0692	Level II Electronic Analysis of Neurostimulator Pulse Generators	S	1.9323	118.77	30.16	23.75
0693	Breast Reconstruction	T	36.9988	2,274.24	721.30	454.85
0694	Mohs Surgery	T	3.7292	229.23	91.69	45.85
0695	Level VII Debridement & Destruction	T	20.4276	1,255.64	266.59	251.13
0697	Level I Echocardiogram Except Transesophageal	S	1.5973	98.18	35.99	19.64
0698	Level II Eye Tests & Treatments	S	1.1607	71.35		14.27
0699	Level IV Eye Tests & Treatments	T	14.3845	884.19		176.84
0700	Antepartum Manipulation	T	2.3864	146.69		29.34
0701	Sr89 strontium	H				
0702	Sm 153 lexidronm	H				
0704	In111 satumomab	H				
0705	Tc99m tetrofosmin	H				
0722	Tc99m pentetate	H				
0723	Co57/58	H				
0724	Co57 cyano	H				
0726	Dexrazoxane HCl injection	K		180.13		36.03
0728	Filgrastim 300 mcg injection	K		188.07		37.61
0730	Pamidronate disodium /30 MG	K		34.80		6.96
0731	Sargramostim injection	K		25.55		5.11
0732	Mesna injection	K		10.10		2.02
0735	Ampho b cholesteryl sulfate	K		12.00		2.40
0736	Amphotericin b liposome inj	K		21.25		4.25
0737	Nitrogen N-13 ammonia	H				
0738	Rasburicase	K		121.26		24.25
0739	Tc99m depreotide	H				
0740	Tc99m gluceptate	H				
0741	Cr51 chromate	H				
0742	Tc99m labeled rbc	H				
0743	Tc99m mertiatide	H				
0744	Plague vaccine, im	K		150.00		30.00
0746	Dacarbazine 100 mg inj	K		4.90		0.98
0747	Chlorothiazide sodium inj	K		123.84		24.77
0748	Bleomycin sulfate injection	K		37.62		7.52
0750	Dolasetron mesylate	K		6.89		1.38
0751	Mechlorethamine hcl inj	K		141.61		28.32
0752	Dactinomycin actinomycin d	K		493.43		98.69
0753	Spectinomycn di-hcl inj	K		30.08		6.02
0759	Naltrexone, depot form	K		1.94		0.39
0760	Anadulafungin injection	G		1.91		0.38
0763	Dolasetron mesylate oral	K		48.91		9.78
0764	Granisetron HCl injection	K		7.21		1.44
0765	Granisetron HCl 1 mg oral	K		41.18		8.24
0766	Apomorphine hydrochloride	K		2.92		0.58
0767	Enfuvirtide injection	K		21.82		4.36
0768	Ondansetron hcl injection	K		3.72		0.74
0769	Ondansetron HCl 8mg oral	K		36.06		7.21
0800	Leuprolide acetate /3.75 MG	K		437.58		87.52
0802	Etoposide oral 50 MG	K		32.01		6.40
0804	Immune globulin subcutaneous	K		7.08		1.42
0805	Mecasermin injection	K		11.93		2.39
0806	Hyaluronidase recombinant	G		0.40		0.08
0807	Aldesleukin/single use vial	K		726.69		145.34
0808	Nabilone oral	K		16.96		3.39
0809	Bcg live intravesical vac	K		113.44		22.69
0810	Goserelin acetate implant	K		199.12		39.82
0811	Carboplatin injection	K		10.12		2.02
0812	Carmus bischl nitro inj	K		139.84		27.97
0814	Asparaginase injection	K		54.46		10.89
0820	Daunorubicin	K		24.56		4.91
0821	Daunorubicin citrate liposom	K	56.21		11.24	
0823	Docetaxel	K		302.68		60.54
0825	Nelarabine injection	K		83.10		16.62
0827	Floxuridine injection	K		64.17		12.83

ADDENDUM A.—OPPS LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0828	Gemcitabine HCl	K		121.30		24.26
0829	Technetium TC-99m aerosol	H				
0830	Irinotecan injection	K		126.88		25.38
0831	Ifosfomide injection	K		52.39		10.48
0832	Idarubicin hcl injection	K		308.97		61.79
0834	Interferon alfa-2a inj	K		37.56		7.51
0835	Inj cosyntropin per 0.25 MG	K		62.91		12.58
0836	Interferon alfa-2b inj	K		13.75		2.75
0838	Interferon gamma 1-b inj	K		289.87		57.97
0840	Inj melphalan hydrochl 50 MG	K		1,194.15		238.83
0842	Fludarabine phosphate inj	K		243.82		48.76
0843	Pegaspargase/singl dose vial	K		1,687.04		337.41
0844	Pentostatin injection	K		2,034.63		406.93
0849	Rituximab cancer treatment	K		481.69		96.34
0850	Streptozocin injection	K		152.92		30.58
0851	Thiotepa injection	K		44.58		8.92
0852	Topotecan	K		813.08		162.62
0855	Vinorelbine tartrate/10 mg	K		22.82		4.56
0856	Porfimer sodium	K		2,505.40		501.08
0858	Inj cladribine per 1 MG	K		37.87		7.57
0860	Plicamycin (mithramycin) inj	K		61.36		12.27
0861	Leuprolide acetate injeciton	K		11.10		2.22
0862	Mitomycin 5 MG inj	K		18.31		3.66
0863	Paclitaxel injection	K		14.35		2.87
0864	Mitoxantrone hydrochl / 5 MG	K		223.27		44.65
0865	Interferon alfa-n3 inj	K		39.48		7.90
0868	Oral aprepitant	G		4.85		0.97
0876	Caffeine citrate injection	K		3.54		0.71
0884	Rho d immune globulin inj	K		80.52		16.10
0887	Azathioprine parenteral	K		49.17		9.83
0888	Cyclosporine oral 100 mg	K		3.66		0.73
0890	Lymphocyte immune globulin	K		315.76		63.15
0891	Tacrolimus oral per 1 MG	K		3.55		0.71
0892	Edetate calcium disodium inj	K		40.19		8.04
0895	Deferoxamine mesylate inj	K		14.84		2.97
0896	Sodium Hyaluronate Injection	K		124.68		24.94
0900	Alglucerase injection	K		39.22		7.84
0901	Alpha 1 proteinase inhibitor	K		3.31		0.66
0902	Botulinum toxin a per unit	K		5.04		1.01
0903	Cytomegalovirus imm IV /vial	K		853.18		170.64
0906	RSV-ivig	K		16.18		3.24
0910	Interferon beta-1b / .25 MG	K		90.00		18.00
0911	Inj streptokinase /250000 IU	K		79.50		15.90
0912	Interferon alfacon-1	K		4.65		0.93
0913	Ganciclovir long act implant	K		4,766.14		953.23
0916	Injection imiglucerase /unit	K		3.91		0.78
0917	Adenosine injection	K		30.49		6.10
0925	Factor viii	K		0.69		0.14
0926	Factor VIII (porcine)	K		1.33		0.27
0927	Factor viii recombinant	K		1.06		0.21
0928	Factor ix complex	K		0.72		0.14
0929	Anti-inhibitor	K		1.36		0.27
0930	Antithrombin iii injection	K		1.62		0.32
0931	Factor IX non-recombinant	K		0.90		0.18
0932	Factor IX recombinant	K		0.99		0.20
0935	Clonidine hydrochloride	K		66.04		13.21
0949	Frozen plasma, pooled, sd	K	0.9346	57.45		11.49
0950	Whole blood for transfusion	K	2.1472	131.98		26.40
0952	Cryoprecipitate each unit	K	0.7905	48.59		9.72
0954	RBC leukocytes reduced	K	2.8590	175.74		35.15
0955	Plasma, frz between 8-24hour	K	1.2489	76.77		15.35
0956	Plasma protein fract,5%,50ml	K	0.8339	51.26		10.25
0957	Platelets, each unit	K	0.9590	58.95		11.79
0958	Plaelet rich plasma unit	K	3.4048	209.29		41.86
0959	Red blood cells unit	K	2.1073	129.53		25.91
0960	Washed red blood cells unit	K	3.4331	211.03		42.21
0961	Albumin (human), 5%, 50ml	K		29.68		5.94
0963	Albumin (human), 5%, 250 ml	K		76.81		15.36
0964	Albumin (human), 25%, 20 ml	K		28.80		5.76

ADDENDUM A.—OPPS LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0965	Albumin (human), 25%, 50ml	K		65.26		13.05
0966	Plasmaprotein fract, 5%,250ml	K	3.8746	238.16		47.63
0967	Blood split unit	K	2.2323	137.22		27.44
0968	Platelets leukoreduced irrad	K	2.0390	125.33		25.07
0969	RBC leukoreduced irradiated	K	3.5394	217.56		43.51
1009	Cryoprecipitatereducedplasma	K	1.3404	82.39		16.48
1010	Blood, l/r, cmv-neg	K	2.5493	156.70		31.34
1011	Platelets, hla-m, l/r, unit	K	10.9263	671.62		134.32
1013	Platelets leukocytes reduced	K	1.5469	95.08		19.02
1016	Blood, l/r, froz/degly/wash	K	3.4335	211.05		42.21
1017	Plt, aph/pher, l/r, cmv-neg	K	6.4556	396.81		79.36
1018	Blood, l/r, irradiated	K	2.3472	144.28		28.86
1019	Plate pheres leukoredu irrad	K	10.0443	617.40		123.48
1020	Plt, pher, l/r cmv-neg, irr	K	11.4755	705.38		141.08
1021	RBC, frz/deg/wsh, l/r, irrad	K	8.0727	496.21		99.24
1022	RBC, l/r, cmv-neg, irrad	K	4.2653	262.18		52.44
1032	Aud osseo dev, int/ext comp	H				
1045	I131 iodobenguate, dx	H				
1052	Injection, voriconazole	K		4.66		0.93
1064	I131 iodide cap, rx	H				
1083	Adalimumab injection	K		308.33		61.67
1084	Denileukin diftitox, 300 mcg	K		1,403.23		280.65
1086	Temozolomide	K		7.30		1.46
1088	Iodine I-131 iodide cap, dx	H				
1096	Tc99m exametazime	H				
1150	I131 iodide sol, rx	H				
1166	Cytarabine liposome	K		396.66		79.33
1167	Inj, epirubicin hcl, 2 mg	K		24.67		4.93
1178	Busulfan injection	K		8.89		1.78
1203	Verteporfin injection	K		8.91		1.78
1207	Octreotide injection, depot	K		93.35		18.67
1280	Corticotropin injection	K		116.60		23.32
1330	Ergonovine maleate injection	K		33.11		6.62
1436	Etidronate disodium inj	K		71.41		14.28
1491	New Technology—Level IA ($0–$10)	S		5.00		1.00
1492	New Technology—Level IB ($10–$20)	S		15.00		3.00
1493	New Technology—Level IC ($20–$30)	S		25.00		5.00
1494	New Technology—Level ID ($30–$40)	S		35.00		7.00
1495	New Technology—Level IE ($40–$50)	S		45.00		9.00
1496	New Technology—Level IA ($0–$10)	T		5.00		1.00
1497	New Technology—Level IB($10–$20)	T		15.00		3.00
1498	New Technology—Level IC ($20–$30)	T		25.00		5.00
1499	New Technology—Level ID($30–$40)	T		35.00		7.00
1500	New Technology—Level IE ($40–$50)	T		45.00		9.00
1502	New Technology—Level II ($50–$100)	S		75.00		15.00
1503	New Technology—Level III ($100–$200)	S		150.00		30.00
1504	New Technology—Level IV ($200–$300)	S		250.00		50.00
1505	New Technology—Level V ($300–$400)	S		350.00		70.00
1506	New Technology—Level VI ($400–$500)	S		450.00		90.00
1507	New Technology—Level VII ($500–$600)	S		550.00		110.00
1508	New Technology—Level VIII ($600–$700)	S		650.00		130.00
1509	New Technology—Level IX ($700–$800)	S		750.00		150.00
1510	New Technology—Level X ($800–$900)	S		850.00		170.00
1511	New Technology—Level XI ($900–$1000)	S		950.00		190.00
1512	New Technology—Level XII ($1000–$1100)	S		1,050.00		210.00
1513	New Technology—Level XIII ($1100–$1200)	S		1,150.00		230.00
1514	New Technology—Level XIV ($1200–$1300)	S		1,250.00		250.00
1515	New Technology—Level XV ($1300–$1400)	S		1,350.00		270.00
1516	New Technology—Level XVI ($1400–$1500)	S		1,450.00		290.00
1517	New Technology—Level XVII ($1500–$1600)	S		1,550.00		310.00
1518	New Technology—Level XVIII ($1600–$1700)	S		1,650.00		330.00
1519	New Technology—Level IXX ($1700–$1800)	S		1,750.00		350.00
1520	New Technology—Level XX ($1800–$1900)	S		1,850.00		370.00
1521	New Technology—Level XXI ($1900–$2000)	S		1,950.00		390.00
1522	New Technology—Level XXII ($2000–$2500)	S		2,250.00		450.00
1523	New Technology—Level XXIII ($2500–$3000)	S		2,750.00		550.00
1524	New Technology—Level XXIV ($3000–$3500)	S		3,250.00		650.00
1525	New Technology—Level XXV ($3500–$4000)	S		3,750.00		750.00
1526	New Technology—Level XXVI ($4000–$4500)	S		4,250.00		850.00

ADDENDUM A.—OPPS LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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
1600	Tc99m sestamibi	H				
1603	TL201 thallium	H				
1604	In111 capromab	H				
1605	Abciximab injection	K		416.27		83.25
1606	Injection anistreplase 30 u	K		2,268.46		453.69
1607	Eptifibatide injection	K		15.37		3.07
1608	Etanercept injection	K		160.39		32.08
1609	Rho(D) immune globulin h, sd	K		14.30		2.86
1612	Daclizumab, parenteral	K		328.83		65.77
1613	Trastuzumab	K		56.17		11.23
1629	Nonmetabolic act d/e tissue	K		18.49		3.70
1630	Hep b ig, im	K		119.06		23.81
1631	Baclofen intrathecal trial	K		69.63		13.93
1632	Metabolic active D/E tissue	K		27.89		5.58
1633	Alefacept	K		26.31		5.26
1642	In111 ibritumomab, dx	H				
1643	Y90 ibritumomab, rx	H				
1644	I131 tositumomab, dx	H				
1645	1131 tositumomab, rx	H				
1646	In111 oxyquinoline	H				
1647	In111 pentetate	H				
1648	Technetium tc99m arcitumomab	H				

ADDENDUM A.—OPPS LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1650	Tc99m succimer	H				
1651	F18 fdg	H				
1654	Rb82 rubidium	H				
1655	Tinzaparin sodium injection	K		2.48		0.50
1670	Tetanus immune globulin inj	K		87.77		17.55
1671	Ga67 gallium	H				
1672	Tc99m bicisate	H				
1675	P32 Na phosphate	H				
1676	P32 chromic phosphate	H				
1677	In111 pentetreotide	H				
1678	Tc99m fanolesomab	H				
1680	Acetylcysteine injection	K		1.94		0.39
1682	Aprotonin, 10,000 kiu	K		2.52		0.50
1683	Basiliximab	K		1,385.86		277.17
1684	Corticorelin ovine triflutal	K		4.17		0.83
1685	Darbepoetin alfa, non-esrd	K		2.99		0.60
1686	Epoetin alfa, non-esrd	K		9.36		1.87
1687	Digoxin immune fab (ovine)	K		533.72		106.74
1688	Ethanolamine oleate 100 mg	K		69.60		13.92
1689	Fomepizole, 15 mg	K		12.33		2.47
1690	Hemin, 1 mg	K		6.80		1.36
1691	Iron dextran 165 injection	K		11.78		2.36
1692	Iron dextran 267 injection	K		10.38		2.08
1693	Lepirudin	K		153.54		30.71
1694	Ziconotide injection	G		6.34		1.27
1695	Nesiritide injection	K		30.13		6.03
1696	Palifermin injection	K		11.43		2.29
1697	Pegaptanib sodium injection	G		1,107.54		221.51
1700	Inj secretin synthetic human	K		20.31		4.06
1701	Treprostinil injection	K		54.02		10.80
1703	Ovine, 1000 USP units	K		137.43		27.49
1704	Inj Vonwillebrand factor IU	K		0.88		0.18
1705	Factor viia	K		1.10		0.22
1707	Non-human, metabolic tissue	K		1.78		0.36
1709	Azacitidine injection	K		4.22		0.84
1710	Clofarabine injection	G		116.62		23.32
1711	Histrelin implant	K		1,741.71		348.34
1712	Paclitaxel protein bound	G		8.73		1.75
1713	Inj Fe-based MR contrast,1ml	K		30.41		6.08
1716	Brachytx source, Gold 198	K	0.5991	36.83		7.37
1717	Brachytx source, HDR Ir-192	K	2.3195	142.58		28.52
1718	Brachytx source, Iodine 125	K	0.5910	36.33		7.27
1719	Brachytx sour,Non-HDR Ir-192	K	0.3765	23.14		4.63
1720	Brachytx sour, Palladium 103	K	0.7942	48.82		9.76
1738	Oxaliplatin	K		8.77		1.75
1739	Pegademase bovine, 25 iu	K		177.83		35.57
1740	Diazoxide injection	K		111.89		22.38
1741	Urofollitropin, 75 iu	K		49.35		9.87
1820	Generator neuro rechg bat sys	H				
1821	Interspinous implant	H				
2210	Methyldopate hcl injection	K		10.01		2.00
2616	Brachytx source, Yttrium-90	K	172.2337	10,586.86		2,117.37
2632	Iodine I-125 sodium iodide	K	0.3321	20.41		4.08
2633	Brachytx source, Cesium-131	K	1.4779	90.84		18.17
2634	Brachytx source, HA, I-125	K	0.5316	32.68		6.54
2635	Brachytx source, HA, P-103	K	0.8878	54.57		10.91
2636	Brachytx linear source,P-103	K	0.6427	39.51		7.90
2731	Immune globulin, powder	K		25.27		5.05
2732	Immune globulin, liquid	K		30.33		6.07
2770	Quinupristin/dalfopristin	K		114.49		22.90
2940	Somatrem injection	K		35.60		7.12
3030	Sumatriptan succinate / 6 MG	K		57.40		11.48
3032	Dtp/hib vaccine, im	K		45.01		9.00
3038	Inj biperiden lactate/5 mg	K		88.15		17.63
3039	Inj metaraminol bitartrate	K		2.62		0.52
3041	Bivalirudin	K		1.75		0.35
3042	Foscarnet sodium injection	K		10.49		2.10
3043	Gamma globulin 1 CC inj	K		10.34		2.07
3045	Meropenem	K		3.68		0.74

ADDENDUM A.—OPPS LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3048	Doxorubic hcl 10 MG vl chemo	K		6.00		1.20
3049	Cyclophosphamide lyophilized	K		5.72		1.14
3050	Sermorelin acetate injection	K		1.75		0.35
7000	Amifostine	K		463.27		92.65
7005	Gonadorelin hydroch/ 100 mcg	K		189.84		37.97
7011	Oprelvekin injection	K		245.98		49.20
7015	Oral busulfan	K		2.14		0.43
7028	Fosphenytoin, 50 mg	K		5.59		1.12
7034	Somatropin injection	K		46.80		9.36
7035	Teniposide, 50 mg	K		264.88		52.98
7036	Urokinase 250,000 IU inj	K		457.73		91.55
7038	Monoclonal antibodies	K		856.05		171.21
7041	Tirofiban HCl	K		8.74		1.75
7042	Capecitabine, oral, 150 mg	K		3.83		0.77
7043	Infliximab injection	K		53.74		10.75
7045	Inj trimetrexate glucoronate	K		145.17		29.03
7046	Doxorubicin hcl liposome inj	K		379.21		75.84
7048	Alteplase recombinant	K		32.07		6.41
7049	Filgrastim 480 mcg injection	K		298.70		59.74
7051	Leuprolide acetate implant	K		2,208.90		441.78
7308	Aminolevulinic acid hcl top	K		107.72		21.54
9001	Linezolid injection	K		24.16		4.83
9002	Tenecteplase injection	K		2,036.66		407.33
9003	Palivizumab, per 50 mg	K		609.62		121.92
9004	Gemtuzumab ozogamicin	K		2,317.16		463.43
9005	Reteplase injection	K		902.72		180.54
9006	Tacrolimus injection	K		140.72		28.14
9012	Arsenic trioxide	K		33.36		6.67
9015	Mycophenolate mofetil oral	K		2.50		0.50
9018	Botulinum toxin type B	K		8.16		1.63
9019	Caspofungin acetate	K		32.25		6.45
9020	Sirolimus, oral	K		7.25		1.45
9022	IM inj interferon beta 1-a	K		108.04		21.61
9023	Rho d immune globulin 50 mcg	K		27.70		5.54
9024	Amphotericin b lipid complex	K		11.11		2.22
9031	Arbutamine HCl injection	K		160.00		32.00
9032	Baclofen 10 MG injection	K		198.54		39.71
9033	Cidofovir injection	K		763.15		152.63
9038	Inj estrogen conjugate 25 MG	K		58.05		11.61
9040	Intraocular Fomivirsen na	K		212.00		42.40
9042	Glucagon hydrochloride/1 MG	K		70.23		14.05
9044	Ibutilide fumarate injection	K		265.75		53.15
9046	Iron sucrose injection	K		0.36		0.07
9047	Itraconazole injection	K		36.45		7.29
9051	Urea injection	K		37.81		7.56
9054	Metabolically active tissue	K		13.87		2.77
9100	I131 serum albumin, dx	H				
9104	Antithymocyte globuln rabbit	K		329.62		65.92
9108	Thyrotropin injection	K		765.76		153.15
9110	Alemtuzumab injection	K		531.24		106.25
9112	Inj perflutren lip micros,ml	K		61.64		12.33
9115	Zoledronic acid	K		204.03		40.81
9119	Injection, pegfilgrastim 6mg	K		2,163.61		432.72
9120	Injection, Fulvestrant	K		80.66		16.13
9121	Injection, argatroban	K		17.48		3.50
9122	Triptorelin pamoate	K		218.53		43.71
9124	Daptomycin injection	K		0.33		0.07
9125	Risperidone, long acting	K		4.80		0.96
9126	Natalizumab injection	G		7.72		1.54
9133	Rabies ig, im/sc	K		64.53		12.91
9134	Rabies ig, heat treated	K		68.24		13.65
9135	Varicella-zoster ig, im	K		140.92		28.18
9137	Bcg vaccine, percut	K		117.39		23.48
9139	Rabies vaccine, im	K		157.74		31.55
9140	Rabies vaccine, id	K		166.16		33.23
9141	Measles-rubella vaccine, sc	K		60.82		12.16
9143	Meningococcal vaccine, sc	K		84.46		16.89
9144	Encephalitis vaccine, sc	K		96.22		19.24
9145	Meningococcal vaccine, im	K		53.71		10.74

ADDENDUM A.—OPPS LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9148	I123 iodide cap, dx	H				
9156	Nonmetabolic active tissue	K		45.02		9.00
9157	LOCM <=149 mg/ml iodine, 1ml	K		0.29		0.06
9158	LOCM 150–199mg/ml iodine,1ml	K		1.96		0.39
9159	LOCM 200–249mg/ml iodine,1ml	K		1.42		0.28
9160	LOCM 250–299mg/ml iodine,1ml	K		0.27		0.05
9161	LOCM 300–349mg/ml iodine,1ml	K		0.35		0.07
9162	LOCM 350–399mg/ml iodine,1ml	K		0.21		0.04
9163	LOCM >= 400 mg/ml iodine,1ml	K		0.30		0.06
9164	Inj Gad-base MR contrast,1ml	K		2.87		0.57
9165	Oral MR contrast, 100 ml	K		8.90		1.78
9167	Valrubicin, 200 mg	K		369.60		73.92
9202	Inj octafluoropropane mic,ml	K		49.61		9.92
9203	Inj perflexane lip micros,ml	K		7.05		1.41
9207	Bortezomib injection	K		31.87		6.37
9208	Agalsidase beta injection	K		127.20		25.44
9209	Laronidase injection	K		23.87		4.77
9210	Palonosetron HCl	K		18.08		3.62
9213	Pemetrexed injection	K		42.49		8.50
9214	Bevacizumab injection	K		56.88		11.38
9215	Cetuximab injection	K		49.86		9.97
9216	Abarelix injection	K		71.18		14.24
9217	Leuprolide acetate suspnsion	K		227.63		45.53
9219	Mycophenolic acid	K		2.15		0.43
9222	Injectable human tissue	K		743.96		148.79
9224	Galsulfase injection	K		1,516.12		303.22
9225	Fluocinolone acetonide implt	G		18,250.00		3,650.00
9227	Micafungin sodium injection	G		1.87		0.37
9228	Tigecycline injection	G		0.91		0.18
9229	Ibandronate sodium injection	G		139.12		27.82
9230	Abatacept injection	G		18.70		3.74
9231	Decitabine injection	G		26.50		5.30
9232	Injection, idursulfase	G		464.32		92.86
9233	Injection, ranibizumab	G		2,067.00		413.40
9234	Inj, alglucosidase alfa	K		127.20		25.44
9235	Injection, panitumumab	K		84.80		16.96
9300	Omalizumab injection	K		16.61		3.32
9350	Porous collagen tube per cm	G		494.53		98.91
9351	Acellular derm tissue percm2	G		44.01		8.80
9500	Platelets, irradiated	K	2.1079	129.57		25.91
9501	Platelet pheres leukoreduced	K	7.9511	488.74		97.75
9502	Platelet pheresis irradiated	K	6.8088	418.52		83.70
9503	Fr frz plasma donor retested	K	1.2119	74.49		14.90
9504	RBC deglycerolized	K	5.8292	358.31		71.66
9505	RBC irradiated	K	3.2049	197.00		39.40
9506	Granulocytes, pheresis unit	K	12.2073	750.36		150.07
9507	Platelets, pheresis	K	7.3686	452.93		90.59
9508	Plasma 1 donor frz w/in 8 hr	K	1.1422	70.21		14.04

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
10121	Remove foreign body		928.31	2	446.00		89.20
10180	Complex drainage, wound		1,076.22	2	446.00		89.20
11010	Debride skin, fx		251.52	2	251.52	Y	50.30
11011	Debride skin/muscle, fx		251.52	2	251.52	Y	50.30
11012	Debride skin/muscle/bone, fx		251.52	2	251.52	Y	50.30
11042	Debride skin/tissue		164.42	2	164.42	Y	32.88
11043	Debride tissue/muscle		164.42	2	164.42	Y	32.88
11044	Debride tissue/muscle/bone		423.10	2	423.10	Y	84.62

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
11404	Exc tr-ext b9+marg 3.1–4 cm		928.31	1	333.00		66.60
11406	Exc tr-ext b9+marg > 4.0 cm		928.31	2	446.00		89.20
11424	Exc h-f-nk-sp b9+marg 3.1–4		928.31	2	446.00		89.20
11426	Exc h-f-nk-sp b9+marg > 4 cm		1,233.39	2	446.00		89.20
11444	Exc face-mm b9+marg 3.1–4 cm		418.49	1	333.00		66.60
11446	Exc face-mm b9+marg > 4 cm		1,233.39	2	446.00		89.20
11450	Removal, sweat gland lesion		1,233.39	2	446.00		89.20
11451	Removal, sweat gland lesion		1,233.39	2	446.00		89.20
11462	Removal, sweat gland lesion		1,233.39	2	446.00		89.20
11463	Removal, sweat gland lesion		1,233.39	2	446.00		89.20
11470	Removal, sweat gland lesion		1,233.39	2	446.00		89.20
11471	Removal, sweat gland lesion		1,233.39	2	446.00		89.20
11604	Exc tr-ext mlg+marg 3.1–4 cm		418.49	2	418.49	Y	83.70
11606	Exc tr-ext mlg+marg > 4 cm		928.31	2	446.00		89.20
11624	Exc h-f-nk-sp mlg+marg 3.1–4		928.31	2	446.00		89.20
11626	Exc h-f-nk-sp mlg+mar > 4 cm		1,233.39	2	446.00		89.20
11644	Exc face-mm malig+marg 3.1–4		928.31	2	446.00		89.20
11646	Exc face-mm mlg+marg > 4 cm		1,233.39	2	446.00		89.20
11770	Removal of pilonidal lesion		1,233.39	3	510.00		102.00
11771	Removal of pilonidal lesion		1,233.39	3	510.00		102.00
11772	Removal of pilonidal lesion		1,233.39	3	510.00		102.00
11960	Insert tissue expander(s)		1,317.27	2	446.00		89.20
11970	Replace tissue expander		2,525.68	3	510.00		102.00
11971	Remove tissue expander(s)		1,233.39	1	333.00		66.60
12005	Repair superficial wound(s)		91.24	2	91.24	Y	18.25
12006	Repair superficial wound(s)		91.24	2	91.24	Y	18.25
12007	Repair superficial wound(s)		91.24	2	91.24	Y	18.25
12016	Repair superficial wound(s)		91.24	2	91.24	Y	18.25
12017	Repair superficial wound(s)		91.24	2	91.24	Y	18.25
12018	Repair superficial wound(s)		91.24	2	91.24	Y	18.25
12020	Closure of split wound		91.24	1	91.24	Y	18.25
12021	Closure of split wound		91.24	1	91.24	Y	18.25
12034	Layer closure of wound(s)		91.24	2	91.24	Y	18.25
12035	Layer closure of wound(s)		91.24	2	91.24	Y	18.25
12036	Layer closure of wound(s)		91.24	2	91.24	Y	18.25
12037	Layer closure of wound(s)		323.28	2	323.28	Y	64.66
12044	Layer closure of wound(s)		91.24	2	91.24	Y	18.25
12045	Layer closure of wound(s)		91.24	2	91.24	Y	18.25
12046	Layer closure of wound(s)		91.24	2	91.24	Y	18.25
12047	Layer closure of wound(s)		323.28	2	323.28	Y	64.66
12054	Layer closure of wound(s)		91.24	2	91.24	Y	18.25
12055	Layer closure of wound(s)		91.24	2	91.24	Y	18.25
12056	Layer closure of wound(s)		91.24	2	91.24	Y	18.25
12057	Layer closure of wound(s)		323.28	2	323.28	Y	64.66
13100	Repair of wound or lesion		323.28	2	323.28	Y	64.66
13101	Repair of wound or lesion		323.28	3	323.28	Y	64.66
13102	Repair wound/lesion add-on	A*	91.24	1	91.24	Y	18.25
13120	Repair of wound or lesion		91.24	2	91.24	Y	18.25
13121	Repair of wound or lesion		91.24	3	91.24	Y	18.25
13122	Repair wound/lesion add-on	A*	91.24	1	91.24	Y	18.25
13131	Repair of wound or lesion		91.24	2	91.24	Y	18.25
13132	Repair of wound or lesion		91.24	3	91.24	Y	18.25
13133	Repair wound/lesion add-on	A*	91.24	1	91.24	Y	18.25
13150	Repair of wound or lesion		323.28	3	323.28	Y	64.66
13151	Repair of wound or lesion		323.28	3	323.28	Y	64.66
13152	Repair of wound or lesion		323.28	3	323.28	Y	64.66
13153	Repair wound/lesion add-on	A*	91.24	3	91.24	Y	18.25
13160	Late closure of wound		1,317.27	2	446.00		89.20
14000	Skin tissue rearrangement		862.68	2	446.00		89.20
14001	Skin tissue rearrangement		1,317.27	3	510.00		102.00
14020	Skin tissue rearrangement		862.68	3	510.00		102.00
14021	Skin tissue rearrangement		862.68	3	510.00		102.00
14040	Skin tissue rearrangement		862.68	2	446.00		89.20
14041	Skin tissue rearrangement		862.68	3	510.00		102.00
14060	Skin tissue rearrangement		862.68	3	510.00		102.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
14061	Skin tissue rearrangement		862.68	3	510.00		102.00
14300	Skin tissue rearrangement		1,317.27	4	630.00		126.00
14350	Skin tissue rearrangement		1,317.27	3	510.00		102.00
15000	Wound prep, 1st 100 sq cm	D		2	446.00		
15001	Wound prep, addl 100 sq cm	D		1	333.00		
15002	Wnd prep, ch/inf, trk/arm/lg	A	323.28	2	323.28	Y	64.66
15003	Wnd prep, ch/inf addl 100 cm	A	323.28	1	323.28	Y	64.66
15004	Wnd prep ch/inf, f/n/hf/g	A	323.28	2	323.28	Y	64.66
15005	Wnd prep, f/n/hf/g, addl cm	A	323.28	1	323.28	Y	64.66
15040	Harvest cultured skin graft		91.24	2	91.24	Y	18.25
15050	Skin pinch graft		323.28	2	323.28	Y	64.66
15100	Skin splt grft, trnk/arm/leg		1,317.27	2	446.00		89.20
15101	Skin splt grft t/a/l, add-on		1,317.27	3	510.00		102.00
15110	Epidrm autogrft trnk/arm/leg		1,317.27	2	446.00		89.20
15111	Epidrm autogrft t/a/l add-on		1,317.27	1	333.00		66.60
15115	Epidrm a-grft face/nck/hf/g		1,317.27	2	446.00		89.20
15116	Epidrm a-grft f/n/hf/g addl		1,317.27	1	333.00		66.60
15120	Skn splt a-grft fac/nck/hf/g		1,317.27	2	446.00		89.20
15121	Skn splt a-grft f/n/hf/g add		1,317.27	3	510.00		102.00
15130	Derm autograft, trnk/arm/leg		1,317.27	2	446.00		89.20
15131	Derm autograft t/a/l add-on		1,317.27	1	333.00		66.60
15135	Derm autograft face/nck/hf/g		1,317.27	2	446.00		89.20
15136	Derm autograft, f/n/hf/g add		1,317.27	1	333.00		66.60
15150	Cult epiderm grft t/arm/leg		1,317.27	2	446.00		89.20
15151	Cult epiderm grft t/a/l addl		1,317.27	1	333.00		66.60
15152	Cult epiderm graft t/a/l +%		1,317.27	1	333.00		66.60
15155	Cult epiderm graft, f/n/hf/g		1,317.27	2	446.00		89.20
15156	Cult epidrm grft f/n/hfg add		1,317.27	1	333.00		66.60
15157	Cult epiderm grft f/n/hfg +%		1,317.27	1	333.00		66.60
15200	Skin full graft, trunk		862.68	3	510.00		102.00
15201	Skin full graft trunk add-on		323.28	2	323.28	Y	64.66
15220	Skin full graft sclp/arm/leg		862.68	2	446.00		89.20
15221	Skin full graft add-on		323.28	2	323.28	Y	64.66
15240	Skin full grft face/genit/hf		862.68	3	510.00		102.00
15241	Skin full graft add-on		323.28	3	323.28	Y	64.66
15260	Skin full graft een & lips		862.68	2	446.00		89.20
15261	Skin full graft add-on		323.28	2	323.28	Y	64.66
15300	Apply skinallogrft, t/arm/lg		323.28	2	323.28	Y	64.66
15301	Apply sknallogrft t/a/l addl		323.28	1	323.28	Y	64.66
15320	Apply skin allogrft f/n/hf/g		323.28	2	323.28	Y	64.66
15321	Aply sknallogrft f/n/hfg add		323.28	1	323.28	Y	64.66
15330	Aply acell alogrft t/arm/leg		323.28	2	323.28	Y	64.66
15331	Aply acell grft t/a/l add-on		323.28	1	323.28	Y	64.66
15335	Apply acell graft, f/n/hf/g		323.28	2	323.28	Y	64.66
15336	Aply acell grft f/n/hf/g add		323.28	1	323.28	Y	64.66
15400	Apply skin xenograft, t/a/l		323.28	2	323.28	Y	64.66
15401	Apply skn xenogrft t/a/l add		323.28	2	323.28	Y	64.66
15420	Apply skin xgraft, f/n/hf/g		323.28	2	323.28	Y	64.66
15421	Apply skn xgrft f/n/hf/g add		323.28	1	323.28	Y	64.66
15430	Apply acellular xenograft		323.28	2	323.28	Y	64.66
15431	Apply acellular xgraft add		323.28	1	323.28	Y	64.66
15570	Form skin pedicle flap		1,317.27	3	510.00		102.00
15572	Form skin pedicle flap		1,317.27	3	510.00		102.00
15574	Form skin pedicle flap		1,317.27	3	510.00		102.00
15576	Form skin pedicle flap		862.68	3	510.00		102.00
15600	Skin graft		1,317.27	3	510.00		102.00
15610	Skin graft		1,317.27	3	510.00		102.00
15620	Skin graft		1,317.27	4	630.00		126.00
15630	Skin graft		1,317.27	3	510.00		102.00
15650	Transfer skin pedicle flap		1,317.27	5	717.00		143.40
15731	Forehead flap w/vasc pedicle	A	862.68	3	510.00		102.00
15732	Muscle-skin graft, head/neck		1,317.27	3	510.00		102.00
15734	Muscle-skin graft, trunk		1,317.27	3	510.00		102.00
15736	Muscle-skin graft, arm		1,317.27	3	510.00		102.00
15738	Muscle-skin graft, leg		1,317.27	3	510.00		102.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
15740	Island pedicle flap graft		862.68	2	446.00		89.20
15750	Neurovascular pedicle graft		1,317.27	2	446.00		89.20
15760	Composite skin graft		1,317.27	2	446.00		89.20
15770	Derma-fat-fascia graft		1,317.27	3	510.00		102.00
15775	Hair transplant punch grafts		323.28	3	323.28	Y	64.66
15776	Hair transplant punch grafts		323.28	3	323.28	Y	64.66
15820	Revision of lower eyelid		1,317.27	3	510.00		102.00
15821	Revision of lower eyelid		1,317.27	3	510.00		102.00
15822	Revision of upper eyelid		1,317.27	3	510.00		102.00
15823	Revision of upper eyelid		862.68	5	717.00		143.40
15824	Removal of forehead wrinkles		1,317.27	3	510.00		102.00
15825	Removal of neck wrinkles		1,317.27	3	510.00		102.00
15826	Removal of brow wrinkles		1,317.27	3	510.00		102.00
15828	Removal of face wrinkles		1,317.27	3	510.00		102.00
15829	Removal of skin wrinkles		1,317.27	5	717.00		143.40
15830	Exc skin abd	A	1,233.39	3	510.00		102.00
15831	Excise excessive skin tissue	D		3	510.00		
15832	Excise excessive skin tissue		1,233.39	3	510.00		102.00
15833	Excise excessive skin tissue		1,233.39	3	510.00		102.00
15834	Excise excessive skin tissue		1,233.39	3	510.00		102.00
15835	Excise excessive skin tissue		323.28	3	323.28	Y	64.66
15836	Excise excessive skin tissue		928.31	3	510.00		102.00
15839	Excise excessive skin tissue		928.31	3	510.00		102.00
15840	Graft for face nerve palsy		1,317.27	4	630.00		126.00
15841	Graft for face nerve palsy		1,317.27	4	630.00		126.00
15845	Skin and muscle repair, face		1,317.27	4	630.00		126.00
15847	Exc skin abd add-on	A	1,233.39	3	510.00		102.00
15876	Suction assisted lipectomy		1,317.27	3	510.00		102.00
15877	Suction assisted lipectomy		1,317.27	3	510.00		102.00
15878	Suction assisted lipectomy		862.68	3	510.00		102.00
15879	Suction assisted lipectomy		1,317.27	3	510.00		102.00
15920	Removal of tail bone ulcer		251.52	3	251.52	Y	50.30
15922	Removal of tail bone ulcer		1,317.27	4	630.00		126.00
15931	Remove sacrum pressure sore		1,233.39	3	510.00		102.00
15933	Remove sacrum pressure sore		1,233.39	3	510.00		102.00
15934	Remove sacrum pressure sore		1,317.27	3	510.00		102.00
15935	Remove sacrum pressure sore		1,317.27	4	630.00		126.00
15936	Remove sacrum pressure sore		1,317.27	4	630.00		126.00
15937	Remove sacrum pressure sore		1,317.27	4	630.00		126.00
15940	Remove hip pressure sore		1,233.39	3	510.00		102.00
15941	Remove hip pressure sore		1,233.39	3	510.00		102.00
15944	Remove hip pressure sore		1,317.27	3	510.00		102.00
15945	Remove hip pressure sore		1,317.27	4	630.00		126.00
15946	Remove hip pressure sore		1,317.27	4	630.00		126.00
15950	Remove thigh pressure sore		1,233.39	3	510.00		102.00
15951	Remove thigh pressure sore		1,233.39	4	630.00		126.00
15952	Remove thigh pressure sore		1,317.27	3	510.00		102.00
15953	Remove thigh pressure sore		1,317.27	4	630.00		126.00
15956	Remove thigh pressure sore		1,317.27	3	510.00		102.00
15958	Remove thigh pressure sore		1,317.27	4	630.00		126.00
16025	Dress/debrid p-thick burn, m		67.11	2	67.11	Y	13.42
16030	Dress/debrid p-thick burn, l		99.83	2	99.83	Y	19.97
19020	Incision of breast lesion		1,076.22	2	446.00		89.20
19100	Bx breast percut w/o image		240.00	1	240.00	Y	48.00
19101	Biopsy of breast, open		1,185.03	2	446.00		89.20
19102	Bx breast percut w/image		240.00	2	240.00	Y	48.00
19103	Bx breast percut w/device		395.77	2	395.77	Y	79.15
19110	Nipple exploration		1,185.03	2	446.00		89.20
19112	Excise breast duct fistula		1,185.03	3	510.00		102.00
19120	Removal of breast lesion		1,185.03	3	510.00		102.00
19125	Excision, breast lesion		1,185.03	3	510.00		102.00
19126	Excision, addl breast lesion		1,185.03	3	510.00		102.00
19140	Removal of breast tissue	D		4	630.00		
19160	Partial mastectomy	D		3	510.00		
19162	P-mastectomy w/ln removal	D		7	995.00		

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
19180	Removal of breast	D		4	630.00		
19182	Removal of breast	D		4	630.00		
19290	Place needle wire, breast			1	333.00		66.60
19291	Place needle wire, breast			1	333.00		66.60
19295	Place breast clip, percut	A*	106.76	1	106.76	Y	21.35
19296	Place po breast cath for rad		3,148.82	9	1,339.00		267.80
19297	Place breast cath for rad	A*	3,148.82	9	1,339.00		267.80
19298	Place breast rad tube/caths		3,250.00	9	1,339.00		267.80
19300	Removal of breast tissue	A	1,185.03	4	630.00		126.00
19301	Partical mastectomy	A	1,185.03	3	510.00		102.00
19302	P-mastectomy w/ln removal	A	2,274.24	7	995.00		199.00
19303	Mast, simple, complete	A	1,722.12	4	630.00		126.00
19304	Mast, subq	A	1,722.12	4	630.00		126.00
19316	Suspension of breast		1,722.12	4	630.00		126.00
19318	Reduction of large breast		2,274.24	4	630.00		126.00
19324	Enlarge breast		2,274.24	4	630.00		126.00
19325	Enlarge breast with implant		3,148.82	9	1,339.00		267.80
19328	Removal of breast implant		1,722.12	1	333.00		66.60
19330	Removal of implant material		1,722.12	1	333.00		66.60
19340	Immediate breast prosthesis		2,327.74	2	446.00		89.20
19342	Delayed breast prosthesis		3,148.82	3	510.00		102.00
19350	Breast reconstruction		1,185.03	4	630.00		126.00
19355	Correct inverted nipple(s)		1,722.12	4	630.00		126.00
19357	Breast reconstruction		3,148.82	5	717.00		143.40
19366	Breast reconstruction		1,722.12	5	717.00		143.40
19370	Surgery of breast capsule		1,722.12	4	630.00		126.00
19371	Removal of breast capsule		1,722.12	4	630.00		126.00
19380	Revise breast reconstruction		2,327.74	5	717.00		143.40
20005	Incision of deep abscess		1,282.87	2	446.00		89.20
20200	Muscle biopsy		928.31	2	446.00		89.20
20205	Deep muscle biopsy		928.31	3	510.00		102.00
20206	Needle biopsy, muscle		240.00	1	240.00	Y	48.00
20220	Bone biopsy, trocar/needle		251.52	1	251.52	Y	50.30
20225	Bone biopsy, trocar/needle		418.49	2	418.49	Y	83.70
20240	Bone biopsy, excisional		1,233.39	2	446.00		89.20
20245	Bone biopsy, excisional		1,233.39	3	510.00		102.00
20250	Open bone biopsy		1,282.87	3	510.00		102.00
20251	Open bone biopsy		1,282.87	3	510.00		102.00
20525	Removal of foreign body		1,233.39	3	510.00		102.00
20650	Insert and remove bone pin		1,282.87	3	510.00		102.00
20670	Removal of support implant		928.31	1	333.00		66.60
20680	Removal of support implant		1,233.39	3	510.00		102.00
20690	Apply bone fixation device		1,544.67	2	446.00		89.20
20692	Apply bone fixation device		1,544.67	3	510.00		102.00
20693	Adjust bone fixation device		1,282.87	3	510.00		102.00
20694	Remove bone fixation device		1,282.87	1	333.00		66.60
20900	Removal of bone for graft		1,544.67	3	510.00		102.00
20902	Removal of bone for graft		1,544.67	4	630.00		126.00
20910	Remove cartilage for graft		1,317.27	3	510.00		102.00
20912	Remove cartilage for graft		1,317.27	3	510.00		102.00
20920	Removal of fascia for graft		862.68	4	630.00		126.00
20922	Removal of fascia for graft		1,317.27	3	510.00		102.00
20924	Removal of tendon for graft		1,544.67	4	630.00		126.00
20926	Removal of tissue for graft		862.68	4	630.00		126.00
20975	Electrical bone stimulation		37.51	2	37.51	Y	7.50
21010	Incision of jaw joint		1,434.04	2	446.00		89.20
21015	Resection of facial tumor		1,009.71	3	510.00		102.00
21025	Excision of bone, lower jaw		2,348.02	2	446.00		89.20
21026	Excision of facial bone(s)		2,348.02	2	446.00		89.20
21029	Contour of face bone lesion		2,348.02	2	446.00		89.20
21034	Excise max/zygoma mlg tumor		2,348.02	3	510.00		102.00
21040	Excise mandible lesion		1,434.04	2	446.00		89.20
21044	Removal of jaw bone lesion		2,348.02	2	446.00		89.20
21046	Remove mandible cyst complex		2,348.02	2	446.00		89.20
21047	Excise lwr jaw cyst w/repair		2,348.02	2	446.00		89.20

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
21050	Removal of jaw joint		2,348.02	3	510.00		102.00
21060	Remove jaw joint cartilage		2,348.02	2	446.00		89.20
21070	Remove coronoid process		2,348.02	3	510.00		102.00
21100	Maxillofacial fixation		2,348.02	2	446.00		89.20
21120	Reconstruction of chin		1,434.04	7	995.00		199.00
21121	Reconstruction of chin		1,434.04	7	995.00		199.00
21122	Reconstruction of chin		1,434.04	7	995.00		199.00
21123	Reconstruction of chin		1,434.04	7	995.00		199.00
21125	Augmentation, lower jaw bone		1,434.04	7	995.00		199.00
21127	Augmentation, lower jaw bone		2,348.02	9	1,339.00		267.80
21181	Contour cranial bone lesion		1,434.04	7	995.00		199.00
21206	Reconstruct upper jaw bone		2,348.02	5	717.00		143.40
21208	Augmentation of facial bones		2,348.02	7	995.00		199.00
21209	Reduction of facial bones		2,348.02	5	717.00		143.40
21210	Face bone graft		2,348.02	7	995.00		199.00
21215	Lower jaw bone graft		2,348.02	7	995.00		199.00
21230	Rib cartilage graft		2,348.02	7	995.00		199.00
21235	Ear cartilage graft		1,434.04	7	995.00		199.00
21240	Reconstruction of jaw joint		2,348.02	4	630.00		126.00
21242	Reconstruction of jaw joint		2,348.02	5	717.00		143.40
21243	Reconstruction of jaw joint		2,348.02	5	717.00		143.40
21244	Reconstruction of lower jaw		2,348.02	7	995.00		199.00
21245	Reconstruction of jaw		2,348.02	7	995.00		199.00
21246	Reconstruction of jaw		2,348.02	7	995.00		199.00
21248	Reconstruction of jaw		2,348.02	7	995.00		199.00
21249	Reconstruction of jaw		2,348.02	7	995.00		199.00
21267	Revise eye sockets		2,348.02	7	995.00		199.00
21270	Augmentation, cheek bone		2,348.02	5	717.00		143.40
21275	Revision, orbitofacial bones		2,348.02	7	995.00		199.00
21280	Revision of eyelid		2,348.02	5	717.00		143.40
21282	Revision of eyelid		1,009.71	5	717.00		143.40
21295	Revision of jaw muscle/bone		464.15	1	333.00		66.60
21296	Revision of jaw muscle/bone		1,434.04	1	333.00		66.60
21300	Treatment of skull fracture	D		2	446.00		
21310	Treatment of nose fracture		150.72	2	150.72	Y	30.14
21315	Treatment of nose fracture		150.72	2	150.72	Y	30.14
21320	Treatment of nose fracture		464.15	2	446.00		89.20
21325	Treatment of nose fracture		1,434.04	4	630.00		126.00
21330	Treatment of nose fracture		1,434.04	5	717.00		143.40
21335	Treatment of nose fracture		1,434.04	7	995.00		199.00
21336	Treat nasal septal fracture		2,307.40	4	630.00		126.00
21337	Treat nasal septal fracture		1,009.71	2	446.00		89.20
21338	Treat nasoethmoid fracture		1,434.04	4	630.00		126.00
21339	Treat nasoethmoid fracture		1,434.04	5	717.00		143.40
21340	Treatment of nose fracture		2,348.02	4	630.00		126.00
21345	Treat nose/jaw fracture		1,434.04	7	995.00		199.00
21355	Treat cheek bone fracture		2,348.02	3	510.00		102.00
21356	Treat cheek bone fracture	A*	1,434.04	3	510.00		102.00
21400	Treat eye socket fracture		464.15	2	446.00		89.20
21401	Treat eye socket fracture		1,009.71	3	510.00		102.00
21421	Treat mouth roof fracture		1,434.04	4	630.00		126.00
21445	Treat dental ridge fracture		1,434.04	4	630.00		126.00
21450	Treat lower jaw fracture		150.72	3	150.72	Y	30.14
21451	Treat lower jaw fracture		464.15	4	464.15	Y	92.83
21452	Treat lower jaw fracture		1,009.71	2	446.00		89.20
21453	Treat lower jaw fracture		2,348.02	3	510.00		102.00
21454	Treat lower jaw fracture		1,434.04	5	717.00		143.40
21461	Treat lower jaw fracture		2,348.02	4	630.00		126.00
21462	Treat lower jaw fracture		2,348.02	5	717.00		143.40
21465	Treat lower jaw fracture		2,348.02	4	630.00		126.00
21480	Reset dislocated jaw		150.72	1	150.72	Y	30.14
21485	Reset dislocated jaw		1,009.71	2	446.00		89.20
21490	Repair dislocated jaw		2,348.02	3	510.00		102.00
21497	Interdental wiring		1,009.71	2	446.00		89.20
21501	Drain neck/chest lesion		1,076.22	2	446.00		89.20

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
21502	Drain chest lesion		1,282.87	2	446.00		89.20
21555	Remove lesion, neck/chest		1,233.39	2	446.00		89.20
21556	Remove lesion, neck/chest		1,233.39	2	446.00		89.20
21600	Partial removal of rib		1,544.67	2	446.00		89.20
21610	Partial removal of rib		1,544.67	2	446.00		89.20
21700	Revision of neck muscle		1,282.87	2	446.00		89.20
21720	Revision of neck muscle		1,282.87	3	510.00		102.00
21725	Revision of neck muscle		88.46	3	88.46	Y	17.69
21800	Treatment of rib fracture		103.62	1	103.62	Y	20.72
21805	Treatment of rib fracture		1,569.06	2	446.00		89.20
21820	Treat sternum fracture		103.62	1	103.62	Y	20.72
21925	Biopsy soft tissue of back		1,233.39	2	446.00		89.20
21930	Remove lesion, back or flank		1,233.39	2	446.00		89.20
21935	Remove tumor, back		1,233.39	3	510.00		102.00
22305	Treat spine process fracture		103.62	1	103.62	Y	20.72
22310	Treat spine fracture		103.62	1	103.62	Y	20.72
22315	Treat spine fracture		103.62	2	103.62	Y	20.72
22505	Manipulation of spine		897.11	2	446.00		89.20
22520	Percut vertebroplasty thor	A*	1,544.67	9	1,339.00		267.80
22521	Percut vertebroplasty lumb	A*	1,544.67	9	1,339.00		267.80
22522	Percut vertebroplasty addÆ	A*	1,544.67	9	1,339.00		267.80
22900	Remove abdominal wall lesion		1,233.39	4	630.00		126.00
23000	Removal of calcium deposits		928.31	2	446.00		89.20
23020	Release shoulder joint		2,525.68	2	446.00		89.20
23030	Drain shoulder lesion		1,076.22	1	333.00		66.60
23031	Drain shoulder bursa		1,076.22	3	510.00		102.00
23035	Drain shoulder bone lesion		1,282.87	3	510.00		102.00
23040	Exploratory shoulder surgery		1,544.67	3	510.00		102.00
23044	Exploratory shoulder surgery		1,544.67	4	630.00		126.00
23066	Biopsy shoulder tissues		1,233.39	2	446.00		89.20
23075	Removal of shoulder lesion		928.31	2	446.00		89.20
23076	Removal of shoulder lesion		1,233.39	2	446.00		89.20
23077	Remove tumor of shoulder		1,233.39	3	510.00		102.00
23100	Biopsy of shoulder joint		1,282.87	2	446.00		89.20
23101	Shoulder joint surgery		1,544.67	7	995.00		199.00
23105	Remove shoulder joint lining		1,544.67	4	630.00		126.00
23106	Incision of collarbone joint		1,544.67	4	630.00		126.00
23107	Explore treat shoulder joint		1,544.67	4	630.00		126.00
23120	Partial removal, collar bone		2,525.68	5	717.00		143.40
23125	Removal of collar bone		2,525.68	5	717.00		143.40
23130	Remove shoulder bone, part		2,525.68	5	717.00		143.40
23140	Removal of bone lesion		1,282.87	4	630.00		126.00
23145	Removal of bone lesion		1,544.67	5	717.00		143.40
23146	Removal of bone lesion		1,544.67	5	717.00		143.40
23150	Removal of humerus lesion		1,544.67	4	630.00		126.00
23155	Removal of humerus lesion		1,544.67	5	717.00		143.40
23156	Removal of humerus lesion		1,544.67	5	717.00		143.40
23170	Remove collar bone lesion		1,544.67	2	446.00		89.20
23172	Remove shoulder blade lesion		1,544.67	2	446.00		89.20
23174	Remove humerus lesion		1,544.67	2	446.00		89.20
23180	Remove collar bone lesion		1,544.67	4	630.00		126.00
23182	Remove shoulder blade lesion		1,544.67	4	630.00		126.00
23184	Remove humerus lesion		1,544.67	4	630.00		126.00
23190	Partial removal of scapula		1,544.67	4	630.00		126.00
23195	Removal of head of humerus		1,544.67	5	717.00		143.40
23330	Remove shoulder foreign body		418.49	1	333.00		66.60
23331	Remove shoulder foreign body		1,233.39	1	333.00		66.60
23395	Muscle transfer,shoulder/arm		2,525.68	5	717.00		143.40
23397	Muscle transfers		4,092.54	7	995.00		199.00
23400	Fixation of shoulder blade		1,544.67	7	995.00		199.00
23405	Incision of tendon & muscle		1,544.67	2	446.00		89.20
23406	Incise tendon(s) & muscle(s)		1,544.67	2	446.00		89.20
23410	Repair rotator cuff, acute		2,525.68	5	717.00		143.40
23412	Repair rotator cuff, chronic		2,525.68	7	995.00		199.00
23415	Release of shoulder ligament		2,525.68	5	717.00		143.40

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
23420	Repair of shoulder		2,525.68	7	995.00		199.00
23430	Repair biceps tendon		2,525.68	4	630.00		126.00
23440	Remove/transplant tendon		2,525.68	4	630.00		126.00
23450	Repair shoulder capsule		4,092.54	5	717.00		143.40
23455	Repair shoulder capsule		4,092.54	7	995.00		199.00
23460	Repair shoulder capsule		4,092.54	5	717.00		143.40
23462	Repair shoulder capsule		2,525.68	7	995.00		199.00
23465	Repair shoulder capsule		4,092.54	5	717.00		143.40
23466	Repair shoulder capsule		2,525.68	7	995.00		199.00
23480	Revision of collar bone		2,525.68	4	630.00		126.00
23485	Revision of collar bone		4,092.54	7	995.00		199.00
23490	Reinforce clavicle		2,525.68	3	510.00		102.00
23491	Reinforce shoulder bones		4,092.54	3	510.00		102.00
23500	Treat clavicle fracture		103.62	1	103.62	Y	20.72
23505	Treat clavicle fracture		103.62	1	103.62	Y	20.72
23515	Treat clavicle fracture		3,517.03	3	510.00		102.00
23520	Treat clavicle dislocation		103.62	1	103.62	Y	20.72
23525	Treat clavicle dislocation		103.62	1	103.62	Y	20.72
23530	Treat clavicle dislocation		2,307.40	3	510.00		102.00
23532	Treat clavicle dislocation		1,569.06	4	630.00		126.00
23540	Treat clavicle dislocation		103.62	1	103.62	Y	20.72
23545	Treat clavicle dislocation		103.62	1	103.62	Y	20.72
23550	Treat clavicle dislocation		2,307.40	3	510.00		102.00
23552	Treat clavicle dislocation		2,307.40	4	630.00		126.00
23570	Treat shoulder blade fx		103.62	1	103.62	Y	20.72
23575	Treat shoulder blade fx		103.62	1	103.62	Y	20.72
23585	Treat scapula fracture		3,517.03	3	510.00		102.00
23605	Treat humerus fracture		103.62	2	103.62	Y	20.72
23615	Treat humerus fracture		3,517.03	4	630.00		126.00
23616	Treat humerus fracture		3,517.03	4	630.00		126.00
23625	Treat humerus fracture		103.62	2	103.62	Y	20.72
23630	Treat humerus fracture		3,517.03	5	717.00		143.40
23650	Treat shoulder dislocation		103.62	1	103.62	Y	20.72
23655	Treat shoulder dislocation		897.11	1	333.00		66.60
23660	Treat shoulder dislocation		2,307.40	3	510.00		102.00
23665	Treat dislocation/fracture		103.62	2	103.62	Y	20.72
23670	Treat dislocation/fracture		3,517.03	3	510.00		102.00
23675	Treat dislocation/fracture		103.62	2	103.62	Y	20.72
23680	Treat dislocation/fracture		2,307.40	3	510.00		102.00
23700	Fixation of shoulder		897.11	1	333.00		66.60
23800	Fusion of shoulder joint		4,092.54	4	630.00		126.00
23802	Fusion of shoulder joint		2,525.68	7	995.00		199.00
23921	Amputation follow-up surgery		323.28	3	323.28	Y	64.66
23930	Drainage of arm lesion		1,076.22	1	333.00		66.60
23931	Drainage of arm bursa		1,076.22	2	446.00		89.20
23935	Drain arm/elbow bone lesion		1,282.87	2	446.00		89.20
24000	Exploratory elbow surgery		1,544.67	4	630.00		126.00
24006	Release elbow joint		1,544.67	4	630.00		126.00
24066	Biopsy arm/elbow soft tissue		928.31	2	446.00		89.20
24075	Remove arm/elbow lesion		928.31	2	446.00		89.20
24076	Remove arm/elbow lesion		1,233.39	2	446.00		89.20
24077	Remove tumor of arm/elbow		1,233.39	3	510.00		102.00
24100	Biopsy elbow joint lining		1,282.87	1	333.00		66.60
24101	Explore/treat elbow joint		1,544.67	4	630.00		126.00
24102	Remove elbow joint lining		1,544.67	4	630.00		126.00
24105	Removal of elbow bursa		1,282.87	3	510.00		102.00
24110	Remove humerus lesion		1,282.87	2	446.00		89.20
24115	Remove/graft bone lesion		1,544.67	3	510.00		102.00
24116	Remove/graft bone lesion		1,544.67	3	510.00		102.00
24120	Remove elbow lesion		1,282.87	3	510.00		102.00
24125	Remove/graft bone lesion		1,544.67	3	510.00		102.00
24126	Remove/graft bone lesion		1,544.67	3	510.00		102.00
24130	Removal of head of radius		1,544.67	3	510.00		102.00
24134	Removal of arm bone lesion		1,544.67	2	446.00		89.20
24136	Remove radius bone lesion		1,544.67	2	446.00		89.20

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
24138	Remove elbow bone lesion		1,544.67	2	446.00		89.20
24140	Partial removal of arm bone		1,544.67	3	510.00		102.00
24145	Partial removal of radius		1,544.67	3	510.00		102.00
24147	Partial removal of elbow		1,544.67	2	446.00		89.20
24155	Removal of elbow joint		2,525.68	3	510.00		102.00
24160	Remove elbow joint implant		1,544.67	2	446.00		89.20
24164	Remove radius head implant		1,544.67	3	510.00		102.00
24201	Removal of arm foreign body		928.31	2	446.00		89.20
24301	Muscle/tendon transfer		1,544.67	4	630.00		126.00
24305	Arm tendon lengthening		1,544.67	4	630.00		126.00
24310	Revision of arm tendon		1,282.87	3	510.00		102.00
24320	Repair of arm tendon		2,525.68	3	510.00		102.00
24330	Revision of arm muscles		4,092.54	3	510.00		102.00
24331	Revision of arm muscles		2,525.68	3	510.00		102.00
24340	Repair of biceps tendon		2,525.68	3	510.00		102.00
24341	Repair arm tendon/muscle		2,525.68	3	510.00		102.00
24342	Repair of ruptured tendon		2,525.68	3	510.00		102.00
24345	Repr elbw med ligmnt w/tissu		1,544.67	2	446.00		89.20
24350	Repair of tennis elbow		1,544.67	3	510.00		102.00
24351	Repair of tennis elbow		1,544.67	3	510.00		102.00
24352	Repair of tennis elbow		1,544.67	3	510.00		102.00
24354	Repair of tennis elbow		1,544.67	3	510.00		102.00
24356	Revision of tennis elbow		1,544.67	3	510.00		102.00
24360	Reconstruct elbow joint		2,056.14	5	717.00		143.40
24361	Reconstruct elbow joint		6,589.01	5	717.00		143.40
24362	Reconstruct elbow joint		2,915.91	5	717.00		143.40
24363	Replace elbow joint		6,589.01	7	995.00		199.00
24365	Reconstruct head of radius		2,056.14	5	717.00		143.40
24366	Reconstruct head of radius		6,589.01	5	717.00		143.40
24400	Revision of humerus		1,544.67	4	630.00		126.00
24410	Revision of humerus		1,544.67	4	630.00		126.00
24420	Revision of humerus		2,525.68	3	510.00		102.00
24430	Repair of humerus		4,092.54	3	510.00		102.00
24435	Repair humerus with graft		4,092.54	4	630.00		126.00
24470	Revision of elbow joint		2,525.68	3	510.00		102.00
24495	Decompression of forearm		1,544.67	2	446.00		89.20
24498	Reinforce humerus		4,092.54	3	510.00		102.00
24500	Treat humerus fracture		103.62	1	103.62	Y	20.72
24505	Treat humerus fracture		103.62	1	103.62	Y	20.72
24515	Treat humerus fracture		3,517.03	4	630.00		126.00
24516	Treat humerus fracture		3,517.03	4	630.00		126.00
24530	Treat humerus fracture		103.62	1	103.62	Y	20.72
24535	Treat humerus fracture		103.62	1	103.62	Y	20.72
24538	Treat humerus fracture		1,569.06	2	446.00		89.20
24545	Treat humerus fracture		3,517.03	4	630.00		126.00
24546	Treat humerus fracture		3,517.03	5	717.00		143.40
24560	Treat humerus fracture		103.62	1	103.62	Y	20.72
24565	Treat humerus fracture		103.62	2	103.62	Y	20.72
24566	Treat humerus fracture		1,569.06	2	446.00		89.20
24575	Treat humerus fracture		3,517.03	3	510.00		102.00
24576	Treat humerus fracture		103.62	1	103.62	Y	20.72
24577	Treat humerus fracture		103.62	1	103.62	Y	20.72
24579	Treat humerus fracture		3,517.03	3	510.00		102.00
24582	Treat humerus fracture		1,569.06	2	446.00		89.20
24586	Treat elbow fracture		3,517.03	4	630.00		126.00
24587	Treat elbow fracture		3,517.03	5	717.00		143.40
24600	Treat elbow dislocation		103.62	1	103.62	Y	20.72
24605	Treat elbow dislocation		897.11	2	446.00		89.20
24615	Treat elbow dislocation		3,517.03	3	510.00		102.00
24620	Treat elbow fracture		103.62	2	103.62	Y	20.72
24635	Treat elbow fracture		3,517.03	3	510.00		102.00
24655	Treat radius fracture		103.62	1	103.62	Y	20.72
24665	Treat radius fracture		2,307.40	4	630.00		126.00
24666	Treat radius fracture		3,517.03	4	630.00		126.00
24670	Treat ulnar fracture		103.62	1	103.62	Y	20.72

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
24675	Treat ulnar fracture		103.62	1	103.62	Y	20.72
24685	Treat ulnar fracture		2,307.40	3	510.00		102.00
24800	Fusion of elbow joint		2,525.68	4	630.00		126.00
24802	Fusion/graft of elbow joint		2,525.68	5	717.00		143.40
24925	Amputation follow-up surgery		1,282.87	3	510.00		102.00
25000	Incision of tendon sheath		1,282.87	3	510.00		102.00
25020	Decompress forearm 1 space		1,282.87	3	510.00		102.00
25023	Decompress forearm 1 space		1,544.67	3	510.00		102.00
25024	Decompress forearm 2 spaces		1,544.67	3	510.00		102.00
25025	Decompress forearm 2 spaces		1,544.67	3	510.00		102.00
25028	Drainage of forearm lesion		1,282.87	1	333.00		66.60
25031	Drainage of forearm bursa		1,282.87	2	446.00		89.20
25035	Treat forearm bone lesion		1,282.87	2	446.00		89.20
25040	Explore/treat wrist joint		1,544.67	5	717.00		143.40
25066	Biopsy forearm soft tissues		1,233.39	2	446.00		89.20
25075	Removal forearm lesion subcu		928.31	2	446.00		89.20
25076	Removal forearm lesion deep		1,233.39	3	510.00		102.00
25077	Remove tumor, forearm/wrist		1,233.39	3	510.00		102.00
25085	Incision of wrist capsule		1,282.87	3	510.00		102.00
25100	Biopsy of wrist joint		1,282.87	2	446.00		89.20
25101	Explore/treat wrist joint		1,544.67	3	510.00		102.00
25105	Remove wrist joint lining		1,544.67	4	630.00		126.00
25107	Remove wrist joint cartilage		1,544.67	3	510.00		102.00
25110	Remove wrist tendon lesion		1,282.87	3	510.00		102.00
25111	Remove wrist tendon lesion		992.95	3	510.00		102.00
25112	Remove wrist tendon lesion		992.95	4	630.00		126.00
25115	Remove wrist/forearm lesion		1,282.87	4	630.00		126.00
25116	Remove wrist/forearm lesion		1,282.87	4	630.00		126.00
25118	Excise wrist tendon sheath		1,544.67	2	446.00		89.20
25119	Partial removal of ulna		1,544.67	3	510.00		102.00
25120	Removal of forearm lesion		1,544.67	3	510.00		102.00
25125	Remove/graft forearm lesion		1,544.67	3	510.00		102.00
25126	Remove/graft forearm lesion		1,544.67	3	510.00		102.00
25130	Removal of wrist lesion		1,544.67	3	510.00		102.00
25135	Remove & graft wrist lesion		1,544.67	3	510.00		102.00
25136	Remove & graft wrist lesion		1,544.67	3	510.00		102.00
25145	Remove forearm bone lesion		1,544.67	2	446.00		89.20
25150	Partial removal of ulna		1,544.67	2	446.00		89.20
25151	Partial removal of radius		1,544.67	2	446.00		89.20
25210	Removal of wrist bone		1,590.53	3	510.00		102.00
25215	Removal of wrist bones		1,590.53	4	630.00		126.00
25230	Partial removal of radius		1,544.67	4	630.00		126.00
25240	Partial removal of ulna		1,544.67	4	630.00		126.00
25248	Remove forearm foreign body		1,282.87	2	446.00		89.20
25250	Removal of wrist prosthesis		1,544.67	1	333.00		66.60
25251	Removal of wrist prosthesis		1,544.67	1	333.00		66.60
25260	Repair forearm tendon/muscle		1,544.67	4	630.00		126.00
25263	Repair forearm tendon/muscle		1,544.67	2	446.00		89.20
25265	Repair forearm tendon/muscle		1,544.67	3	510.00		102.00
25270	Repair forearm tendon/muscle		1,544.67	4	630.00		126.00
25272	Repair forearm tendon/muscle		1,544.67	3	510.00		102.00
25274	Repair forearm tendon/muscle		1,544.67	4	630.00		126.00
25275	Repair forearm tendon sheath		1,544.67	4	630.00		126.00
25280	Revise wrist/forearm tendon		1,544.67	4	630.00		126.00
25290	Incise wrist/forearm tendon		1,544.67	3	510.00		102.00
25295	Release wrist/forearm tendon		1,282.87	3	510.00		102.00
25300	Fusion of tendons at wrist		1,544.67	3	510.00		102.00
25301	Fusion of tendons at wrist		1,544.67	3	510.00		102.00
25310	Transplant forearm tendon		2,525.68	3	510.00		102.00
25312	Transplant forearm tendon		2,525.68	4	630.00		126.00
25315	Revise palsy hand tendon(s)		2,525.68	3	510.00		102.00
25316	Revise palsy hand tendon(s)		4,092.54	3	510.00		102.00
25320	Repair/revise wrist joint		2,525.68	3	510.00		102.00
25332	Revise wrist joint		2,056.14	5	717.00		143.40
25335	Realignment of hand		2,525.68	3	510.00		102.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
25337	Reconstruct ulna/radioulnar		2,525.68	5	717.00		143.40
25350	Revision of radius		4,092.54	3	510.00		102.00
25355	Revision of radius		2,525.68	3	510.00		102.00
25360	Revision of ulna		1,544.67	3	510.00		102.00
25365	Revise radius & ulna		1,544.67	3	510.00		102.00
25370	Revise radius or ulna		2,525.68	3	510.00		102.00
25375	Revise radius & ulna		2,525.68	4	630.00		126.00
25390	Shorten radius or ulna		1,544.67	3	510.00		102.00
25391	Lengthen radius or ulna		2,525.68	4	630.00		126.00
25392	Shorten radius & ulna		1,544.67	3	510.00		102.00
25393	Lengthen radius & ulna		2,525.68	4	630.00		126.00
25400	Repair radius or ulna		1,544.67	3	510.00		102.00
25405	Repair/graft radius or ulna		1,544.67	4	630.00		126.00
25415	Repair radius & ulna		1,544.67	3	510.00		102.00
25420	Repair/graft radius & ulna		4,092.54	4	630.00		126.00
25425	Repair/graft radius or ulna		2,525.68	3	510.00		102.00
25426	Repair/graft radius & ulna		2,525.68	4	630.00		126.00
25440	Repair/graft wrist bone		4,092.54	4	630.00		126.00
25441	Reconstruct wrist joint		6,589.01	5	717.00		143.40
25442	Reconstruct wrist joint		6,589.01	5	717.00		143.40
25443	Reconstruct wrist joint		2,915.91	5	717.00		143.40
25444	Reconstruct wrist joint		2,915.91	5	717.00		143.40
25445	Reconstruct wrist joint		2,915.91	5	717.00		143.40
25446	Wrist replacement		6,589.01	7	995.00		199.00
25447	Repair wrist joint(s)		2,056.14	5	717.00		143.40
25449	Remove wrist joint implant		2,056.14	5	717.00		143.40
25450	Revision of wrist joint		2,525.68	3	510.00		102.00
25455	Revision of wrist joint		2,525.68	3	510.00		102.00
25490	Reinforce radius		2,525.68	3	510.00		102.00
25491	Reinforce ulna		2,525.68	3	510.00		102.00
25492	Reinforce radius and ulna		2,525.68	3	510.00		102.00
25505	Treat fracture of radius		103.62	1	103.62	Y	20.72
25515	Treat fracture of radius		2,307.40	3	510.00		102.00
25520	Treat fracture of radius		103.62	1	103.62	Y	20.72
25525	Treat fracture of radius		2,307.40	4	630.00		126.00
25526	Treat fracture of radius		2,307.40	5	717.00		143.40
25535	Treat fracture of ulna		103.62	1	103.62	Y	20.72
25545	Treat fracture of ulna		2,307.40	3	510.00		102.00
25565	Treat fracture radius & ulna		103.62	2	103.62	Y	20.72
25574	Treat fracture radius & ulna		3,517.03	3	510.00		102.00
25575	Treat fracture radius/ulna		3,517.03	3	510.00		102.00
25605	Treat fracture radius/ulna		103.62	3	103.62	Y	20.72
25606	Treat fx distal radial	A	1,569.06	3	510.00		102.00
25607	Treat fx rad extra-articul	A	3,517.03	5	717.00		143.40
25608	Treat fx rad intra-articul	A	3,517.03	5	717.00		143.40
25609	Treat fx radial 3+ frag	A	3,517.03	5	717.00		143.40
25611	Treat fracture radius/ulna	D		3	510.00		
25620	Treat fracture radius/ulna	D		5	717.00		
25624	Treat wrist bone fracture		103.62	2	103.62	Y	20.72
25628	Treat wrist bone fracture		2,307.40	3	510.00		102.00
25635	Treat wrist bone fracture		103.62	1	103.62	Y	20.72
25645	Treat wrist bone fracture		2,307.40	3	510.00		102.00
25660	Treat wrist dislocation		103.62	1	103.62	Y	20.72
25670	Treat wrist dislocation		1,569.06	3	510.00		102.00
25671	Pin radioulnar dislocation		1,569.06	1	333.00		66.60
25675	Treat wrist dislocation		103.62	1	103.62	Y	20.72
25676	Treat wrist dislocation		1,569.06	2	446.00		89.20
25680	Treat wrist fracture		103.62	2	103.62	Y	20.72
25685	Treat wrist fracture		1,569.06	3	510.00		102.00
25690	Treat wrist dislocation		103.62	1	103.62	Y	20.72
25695	Treat wrist dislocation		1,569.06	2	446.00		89.20
25800	Fusion of wrist joint		4,092.54	4	630.00		126.00
25805	Fusion/graft of wrist joint		2,525.68	5	717.00		143.40
25810	Fusion/graft of wrist joint		4,092.54	5	717.00		143.40
25820	Fusion of hand bones		992.95	4	630.00		126.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
25825	Fuse hand bones with graft		1,590.53	5	717.00		143.40
25830	Fusion, radioulnar jnt/ulna		4,092.54	5	717.00		143.40
25907	Amputation follow-up surgery		1,282.87	3	510.00		102.00
25922	Amputate hand at wrist		1,282.87	3	510.00		102.00
25929	Amputation follow-up surgery		862.68	3	510.00		102.00
26011	Drainage of finger abscess		685.58	1	333.00		66.60
26020	Drain hand tendon sheath		992.95	2	446.00		89.20
26025	Drainage of palm bursa		992.95	1	333.00		66.60
26030	Drainage of palm bursa(s)		992.95	2	446.00		89.20
26034	Treat hand bone lesion		992.95	2	446.00		89.20
26040	Release palm contracture		1,590.53	4	630.00		126.00
26045	Release palm contracture		1,590.53	3	510.00		102.00
26055	Incise finger tendon sheath		992.95	2	446.00		89.20
26060	Incision of finger tendon		992.95	2	446.00		89.20
26070	Explore/treat hand joint		992.95	2	446.00		89.20
26075	Explore/treat finger joint		992.95	4	630.00		126.00
26080	Explore/treat finger joint		992.95	4	630.00		126.00
26100	Biopsy hand joint lining		992.95	2	446.00		89.20
26105	Biopsy finger joint lining		992.95	1	333.00		66.60
26110	Biopsy finger joint lining		992.95	1	333.00		66.60
26115	Removal hand lesion subcut		1,233.39	2	446.00		89.20
26116	Removal hand lesion, deep		1,233.39	2	446.00		89.20
26117	Remove tumor, hand/finger		1,233.39	3	510.00		102.00
26121	Release palm contracture		1,590.53	4	630.00		126.00
26123	Release palm contracture		1,590.53	4	630.00		126.00
26125	Release palm contracture		992.95	4	630.00		126.00
26130	Remove wrist joint lining		992.95	3	510.00		102.00
26135	Revise finger joint, each		1,590.53	4	630.00		126.00
26140	Revise finger joint, each		992.95	2	446.00		89.20
26145	Tendon excision, palm/finger		992.95	3	510.00		102.00
26160	Remove tendon sheath lesion		992.95	3	510.00		102.00
26170	Removal of palm tendon, each		992.95	3	510.00		102.00
26180	Removal of finger tendon		992.95	3	510.00		102.00
26185	Remove finger bone		992.95	4	630.00		126.00
26200	Remove hand bone lesion		992.95	2	446.00		89.20
26205	Remove/graft bone lesion		1,590.53	3	510.00		102.00
26210	Removal of finger lesion		992.95	2	446.00		89.20
26215	Remove/graft finger lesion		992.95	3	510.00		102.00
26230	Partial removal of hand bone		992.95	7	992.95	Y	198.59
26235	Partial removal, finger bone		992.95	3	510.00		102.00
26236	Partial removal, finger bone		992.95	3	510.00		102.00
26250	Extensive hand surgery		992.95	3	510.00		102.00
26255	Extensive hand surgery		1,590.53	3	510.00		102.00
26260	Extensive finger surgery		992.95	3	510.00		102.00
26261	Extensive finger surgery		992.95	3	510.00		102.00
26262	Partial removal of finger		992.95	2	446.00		89.20
26320	Removal of implant from hand		928.31	2	446.00		89.20
26350	Repair finger/hand tendon		1,590.53	1	333.00		66.60
26352	Repair/graft hand tendon		1,590.53	4	630.00		126.00
26356	Repair finger/hand tendon		1,590.53	4	630.00		126.00
26357	Repair finger/hand tendon		1,590.53	4	630.00		126.00
26358	Repair/graft hand tendon		1,590.53	4	630.00		126.00
26370	Repair finger/hand tendon		1,590.53	4	630.00		126.00
26372	Repair/graft hand tendon		1,590.53	4	630.00		126.00
26373	Repair finger/hand tendon		1,590.53	3	510.00		102.00
26390	Revise hand/finger tendon		1,590.53	4	630.00		126.00
26392	Repair/graft hand tendon		1,590.53	3	510.00		102.00
26410	Repair hand tendon		992.95	3	510.00		102.00
26412	Repair/graft hand tendon		1,590.53	3	510.00		102.00
26415	Excision, hand/finger tendon		1,590.53	4	630.00		126.00
26416	Graft hand or finger tendon		1,590.53	3	510.00		102.00
26418	Repair finger tendon		992.95	4	630.00		126.00
26420	Repair/graft finger tendon		1,590.53	4	630.00		126.00
26426	Repair finger/hand tendon		1,590.53	3	510.00		102.00
26428	Repair/graft finger tendon		1,590.53	3	510.00		102.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
26432	Repair finger tendon		992.95	3	510.00		102.00
26433	Repair finger tendon		992.95	3	510.00		102.00
26434	Repair/graft finger tendon		1,590.53	3	510.00		102.00
26437	Realignment of tendons		992.95	3	510.00		102.00
26440	Release palm/finger tendon		992.95	3	510.00		102.00
26442	Release palm & finger tendon		1,590.53	3	510.00		102.00
26445	Release hand/finger tendon		992.95	3	510.00		102.00
26449	Release forearm/hand tendon		1,590.53	3	510.00		102.00
26450	Incision of palm tendon		992.95	3	510.00		102.00
26455	Incision of finger tendon		992.95	3	510.00		102.00
26460	Incise hand/finger tendon		992.95	3	510.00		102.00
26471	Fusion of finger tendons		992.95	2	446.00		89.20
26474	Fusion of finger tendons		992.95	2	446.00		89.20
26476	Tendon lengthening		992.95	1	333.00		66.60
26477	Tendon shortening		992.95	1	333.00		66.60
26478	Lengthening of hand tendon		992.95	1	333.00		66.60
26479	Shortening of hand tendon		992.95	1	333.00		66.60
26480	Transplant hand tendon		1,590.53	3	510.00		102.00
26483	Transplant/graft hand tendon		1,590.53	3	510.00		102.00
26485	Transplant palm tendon		1,590.53	2	446.00		89.20
26489	Transplant/graft palm tendon		1,590.53	3	510.00		102.00
26490	Revise thumb tendon		1,590.53	3	510.00		102.00
26492	Tendon transfer with graft		1,590.53	3	510.00		102.00
26494	Hand tendon/muscle transfer		1,590.53	3	510.00		102.00
26496	Revise thumb tendon		1,590.53	3	510.00		102.00
26497	Finger tendon transfer		1,590.53	3	510.00		102.00
26498	Finger tendon transfer		1,590.53	4	630.00		126.00
26499	Revision of finger		1,590.53	3	510.00		102.00
26500	Hand tendon reconstruction		992.95	4	630.00		126.00
26502	Hand tendon reconstruction		1,590.53	4	630.00		126.00
26504	Hand tendon reconstruction	D		4	630.00		
26508	Release thumb contracture		992.95	3	510.00		102.00
26510	Thumb tendon transfer		1,590.53	3	510.00		102.00
26516	Fusion of knuckle joint		1,590.53	1	333.00		66.60
26517	Fusion of knuckle joints		1,590.53	3	510.00		102.00
26518	Fusion of knuckle joints		1,590.53	3	510.00		102.00
26520	Release knuckle contracture		992.95	3	510.00		102.00
26525	Release finger contracture		992.95	3	510.00		102.00
26530	Revise knuckle joint		2,056.14	3	510.00		102.00
26531	Revise knuckle with implant		2,915.91	7	995.00		199.00
26535	Revise finger joint		2,056.14	5	717.00		143.40
26536	Revise/implant finger joint		2,915.91	5	717.00		143.40
26540	Repair hand joint		992.95	4	630.00		126.00
26541	Repair hand joint with graft		1,590.53	7	995.00		199.00
26542	Repair hand joint with graft		992.95	4	630.00		126.00
26545	Reconstruct finger joint		1,590.53	4	630.00		126.00
26546	Repair nonunion hand		1,590.53	4	630.00		126.00
26548	Reconstruct finger joint		1,590.53	4	630.00		126.00
26550	Construct thumb replacement		1,590.53	2	446.00		89.20
26555	Positional change of finger		1,590.53	3	510.00		102.00
26560	Repair of web finger		992.95	2	446.00		89.20
26561	Repair of web finger		1,590.53	3	510.00		102.00
26562	Repair of web finger		1,590.53	4	630.00		126.00
26565	Correct metacarpal flaw		1,590.53	5	717.00		143.40
26567	Correct finger deformity		1,590.53	5	717.00		143.40
26568	Lengthen metacarpal/finger		1,590.53	3	510.00		102.00
26580	Repair hand deformity		992.95	5	717.00		143.40
26587	Reconstruct extra finger		992.95	5	717.00		143.40
26590	Repair finger deformity		992.95	5	717.00		143.40
26591	Repair muscles of hand		1,590.53	3	510.00		102.00
26593	Release muscles of hand		992.95	3	510.00		102.00
26596	Excision constricting tissue		992.95	2	446.00		89.20
26605	Treat metacarpal fracture		103.62	2	103.62	Y	20.72
26607	Treat metacarpal fracture		103.62	2	103.62	Y	20.72
26608	Treat metacarpal fracture		1,569.06	4	630.00		126.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
26615	Treat metacarpal fracture		2,307.40	4	630.00		126.00
26645	Treat thumb fracture		103.62	1	103.62	Y	20.72
26650	Treat thumb fracture		1,569.06	2	446.00		89.20
26665	Treat thumb fracture		2,307.40	4	630.00		126.00
26675	Treat hand dislocation		103.62	2	103.62	Y	20.72
26676	Pin hand dislocation		1,569.06	2	446.00		89.20
26685	Treat hand dislocation		2,307.40	3	510.00		102.00
26686	Treat hand dislocation		3,517.03	3	510.00		102.00
26705	Treat knuckle dislocation		103.62	2	103.62	Y	20.72
26706	Pin knuckle dislocation		103.62	2	103.62	Y	20.72
26715	Treat knuckle dislocation		2,307.40	4	630.00		126.00
26727	Treat finger fracture, each		1,569.06	7	995.00		199.00
26735	Treat finger fracture, each		2,307.40	4	630.00		126.00
26742	Treat finger fracture, each		103.62	2	103.62	Y	20.72
26746	Treat finger fracture, each		2,307.40	5	717.00		143.40
26756	Pin finger fracture, each		1,569.06	2	446.00		89.20
26765	Treat finger fracture, each		2,307.40	4	630.00		126.00
26776	Pin finger dislocation		1,569.06	2	446.00		89.20
26785	Treat finger dislocation		1,569.06	2	446.00		89.20
26820	Thumb fusion with graft		1,590.53	5	717.00		143.40
26841	Fusion of thumb		1,590.53	4	630.00		126.00
26842	Thumb fusion with graft		1,590.53	4	630.00		126.00
26843	Fusion of hand joint		1,590.53	3	510.00		102.00
26844	Fusion/graft of hand joint		1,590.53	3	510.00		102.00
26850	Fusion of knuckle		1,590.53	4	630.00		126.00
26852	Fusion of knuckle with graft		1,590.53	4	630.00		126.00
26860	Fusion of finger joint		1,590.53	3	510.00		102.00
26861	Fusion of finger jnt, add-on		1,590.53	2	446.00		89.20
26862	Fusion/graft of finger joint		1,590.53	4	630.00		126.00
26863	Fuse/graft added joint		1,590.53	3	510.00		102.00
26910	Amputate metacarpal bone		1,590.53	3	510.00		102.00
26951	Amputation of finger/thumb		992.95	2	446.00		89.20
26952	Amputation of finger/thumb		992.95	4	630.00		126.00
26990	Drainage of pelvis lesion		1,282.87	1	333.00		66.60
26991	Drainage of pelvis bursa		1,282.87	1	333.00		66.60
27000	Incision of hip tendon		1,282.87	2	446.00		89.20
27001	Incision of hip tendon		1,544.67	3	510.00		102.00
27003	Incision of hip tendon		1,544.67	3	510.00		102.00
27033	Exploration of hip joint		2,525.68	3	510.00		102.00
27035	Denervation of hip joint		2,525.68	4	630.00		126.00
27040	Biopsy of soft tissues		418.49	1	333.00		66.60
27041	Biopsy of soft tissues		418.49	2	418.49	Y	83.70
27047	Remove hip/pelvis lesion		1,233.39	2	446.00		89.20
27048	Remove hip/pelvis lesion		1,233.39	3	510.00		102.00
27049	Remove tumor, hip/pelvis		1,233.39	3	510.00		102.00
27050	Biopsy of sacroiliac joint		1,282.87	3	510.00		102.00
27052	Biopsy of hip joint		1,282.87	3	510.00		102.00
27060	Removal of ischial bursa		1,282.87	5	717.00		143.40
27062	Remove femur lesion/bursa		1,282.87	5	717.00		143.40
27065	Removal of hip bone lesion		1,282.87	5	717.00		143.40
27066	Removal of hip bone lesion		1,544.67	5	717.00		143.40
27067	Remove/graft hip bone lesion		1,544.67	5	717.00		143.40
27080	Removal of tail bone		1,544.67	2	446.00		89.20
27086	Remove hip foreign body		418.49	1	333.00		66.60
27087	Remove hip foreign body		1,282.87	3	510.00		102.00
27097	Revision of hip tendon		1,544.67	3	510.00		102.00
27098	Transfer tendon to pelvis		1,544.67	3	510.00		102.00
27100	Transfer of abdominal muscle		2,525.68	4	630.00		126.00
27105	Transfer of spinal muscle		2,525.68	4	630.00		126.00
27110	Transfer of iliopsoas muscle		2,525.68	4	630.00		126.00
27111	Transfer of iliopsoas muscle		2,525.68	4	630.00		126.00
27193	Treat pelvic ring fracture		103.62	1	103.62	Y	20.72
27194	Treat pelvic ring fracture		897.11	2	446.00		89.20
27202	Treat tail bone fracture		2,307.40	2	446.00		89.20
27230	Treat thigh fracture		103.62	1	103.62	Y	20.72

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
27238	Treat thigh fracture		103.62	1	103.62	Y	20.72
27246	Treat thigh fracture		103.62	1	103.62	Y	20.72
27250	Treat hip dislocation		103.62	1	103.62	Y	20.72
27252	Treat hip dislocation		897.11	2	446.00		89.20
27257	Treat hip dislocation		897.11	3	510.00		102.00
27265	Treat hip dislocation		103.62	1	103.62	Y	20.72
27266	Treat hip dislocation		897.11	2	446.00		89.20
27275	Manipulation of hip joint		897.11	2	446.00		89.20
27301	Drain thigh/knee lesion		1,076.22	3	510.00		102.00
27305	Incise thigh tendon & fascia		1,282.87	2	446.00		89.20
27306	Incision of thigh tendon		1,282.87	3	510.00		102.00
27307	Incision of thigh tendons		1,282.87	3	510.00		102.00
27310	Exploration of knee joint		1,544.67	4	630.00		126.00
27315	Partial removal, thigh nerve	D		2	446.00		
27320	Partial removal, thigh nerve	D		2	446.00		
27323	Biopsy, thigh soft tissues		418.49	1	333.00		66.60
27324	Biopsy, thigh soft tissues		1,233.39	1	333.00		66.60
27325	Neurectomy, hamstring	A	1,097.20	2	446.00		89.20
27326	Neurectomy, popliteal	A	1,097.20	2	446.00		89.20
27327	Removal of thigh lesion		1,233.39	2	446.00		89.20
27328	Removal of thigh lesion		1,233.39	3	510.00		102.00
27329	Remove tumor, thigh/knee		1,233.39	4	630.00		126.00
27330	Biopsy, knee joint lining		1,544.67	4	630.00		126.00
27331	Explore/treat knee joint		1,544.67	4	630.00		126.00
27332	Removal of knee cartilage		1,544.67	4	630.00		126.00
27333	Removal of knee cartilage		1,544.67	4	630.00		126.00
27334	Remove knee joint lining		1,544.67	4	630.00		126.00
27335	Remove knee joint lining		1,544.67	4	630.00		126.00
27340	Removal of kneecap bursa		1,282.87	3	510.00		102.00
27345	Removal of knee cyst		1,282.87	4	630.00		126.00
27347	Remove knee cyst		1,282.87	4	630.00		126.00
27350	Removal of kneecap		1,544.67	4	630.00		126.00
27355	Remove femur lesion		1,544.67	3	510.00		102.00
27356	Remove femur lesion/graft		1,544.67	4	630.00		126.00
27357	Remove femur lesion/graft		1,544.67	5	717.00		143.40
27358	Remove femur lesion/fixation		1,544.67	5	717.00		143.40
27360	Partial removal, leg bone(s)		1,544.67	5	717.00		143.40
27372	Removal of foreign body		1,233.39	7	995.00		199.00
27380	Repair of kneecap tendon		1,282.87	1	333.00		66.60
27381	Repair/graft kneecap tendon		1,282.87	3	510.00		102.00
27385	Repair of thigh muscle		1,282.87	3	510.00		102.00
27386	Repair/graft of thigh muscle		1,282.87	3	510.00		102.00
27390	Incision of thigh tendon		1,282.87	1	333.00		66.60
27391	Incision of thigh tendons		1,282.87	2	446.00		89.20
27392	Incision of thigh tendons		1,282.87	3	510.00		102.00
27393	Lengthening of thigh tendon		1,544.67	2	446.00		89.20
27394	Lengthening of thigh tendons		1,544.67	3	510.00		102.00
27395	Lengthening of thigh tendons		2,525.68	3	510.00		102.00
27396	Transplant of thigh tendon		1,544.67	3	510.00		102.00
27397	Transplants of thigh tendons		2,525.68	3	510.00		102.00
27400	Revise thigh muscles/tendons		2,525.68	3	510.00		102.00
27403	Repair of knee cartilage		1,544.67	4	630.00		126.00
27405	Repair of knee ligament		2,525.68	4	630.00		126.00
27407	Repair of knee ligament		4,092.54	4	630.00		126.00
27409	Repair of knee ligaments		2,525.68	4	630.00		126.00
27418	Repair degenerated kneecap		2,525.68	3	510.00		102.00
27420	Revision of unstable kneecap		2,525.68	3	510.00		102.00
27422	Revision of unstable kneecap		2,525.68	7	995.00		199.00
27424	Revision/removal of kneecap		2,525.68	3	510.00		102.00
27425	Lat retinacular release open		1,544.67	7	995.00		199.00
27427	Reconstruction, knee		2,525.68	3	510.00		102.00
27428	Reconstruction, knee		4,092.54	4	630.00		126.00
27429	Reconstruction, knee		4,092.54	4	630.00		126.00
27430	Revision of thigh muscles		2,525.68	4	630.00		126.00
27435	Incision of knee joint		2,525.68	4	630.00		126.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
27437	Revise kneecap		2,056.14	4	630.00		126.00
27438	Revise kneecap with implant		2,915.91	5	717.00		143.40
27441	Revision of knee joint		2,056.14	5	717.00		143.40
27442	Revision of knee joint		2,056.14	5	717.00		143.40
27443	Revision of knee joint		2,056.14	5	717.00		143.40
27496	Decompression of thigh/knee		1,282.87	5	717.00		143.40
27497	Decompression of thigh/knee		1,282.87	3	510.00		102.00
27498	Decompression of thigh/knee		1,282.87	3	510.00		102.00
27499	Decompression of thigh/knee		1,282.87	3	510.00		102.00
27500	Treatment of thigh fracture		103.62	1	103.62	Y	20.72
27501	Treatment of thigh fracture		103.62	2	103.62	Y	20.72
27502	Treatment of thigh fracture		103.62	2	103.62	Y	20.72
27503	Treatment of thigh fracture		103.62	3	103.62	Y	20.72
27508	Treatment of thigh fracture		103.62	1	103.62	Y	20.72
27509	Treatment of thigh fracture		1,569.06	3	510.00		102.00
27510	Treatment of thigh fracture		103.62	1	103.62	Y	20.72
27516	Treat thigh fx growth plate		103.62	1	103.62	Y	20.72
27517	Treat thigh fx growth plate		103.62	1	103.62	Y	20.72
27520	Treat kneecap fracture		103.62	1	103.62	Y	20.72
27530	Treat knee fracture		103.62	1	103.62	Y	20.72
27532	Treat knee fracture		103.62	1	103.62	Y	20.72
27538	Treat knee fracture(s)		103.62	1	103.62	Y	20.72
27550	Treat knee dislocation		103.62	1	103.62	Y	20.72
27552	Treat knee dislocation		897.11	1	333.00		66.60
27560	Treat kneecap dislocation		103.62	1	103.62	Y	20.72
27562	Treat kneecap dislocation		897.11	1	333.00		66.60
27566	Treat kneecap dislocation		2,307.40	2	446.00		89.20
27570	Fixation of knee joint		897.11	1	333.00		66.60
27594	Amputation follow-up surgery		1,282.87	3	510.00		102.00
27600	Decompression of lower leg		1,282.87	3	510.00		102.00
27601	Decompression of lower leg		1,282.87	3	510.00		102.00
27602	Decompression of lower leg		1,282.87	3	510.00		102.00
27603	Drain lower leg lesion		1,076.22	2	446.00		89.20
27604	Drain lower leg bursa		1,282.87	2	446.00		89.20
27605	Incision of achilles tendon		1,255.56	1	333.00		66.60
27606	Incision of achilles tendon		1,282.87	1	333.00		66.60
27607	Treat lower leg bone lesion		1,282.87	2	446.00		89.20
27610	Explore/treat ankle joint		1,544.67	2	446.00		89.20
27612	Exploration of ankle joint		1,544.67	3	510.00		102.00
27614	Biopsy lower leg soft tissue		1,233.39	2	446.00		89.20
27615	Remove tumor, lower leg		1,544.67	3	510.00		102.00
27618	Remove lower leg lesion		928.31	2	446.00		89.20
27619	Remove lower leg lesion		1,233.39	3	510.00		102.00
27620	Explore/treat ankle joint		1,544.67	4	630.00		126.00
27625	Remove ankle joint lining		1,544.67	4	630.00		126.00
27626	Remove ankle joint lining		1,544.67	4	630.00		126.00
27630	Removal of tendon lesion		1,282.87	3	510.00		102.00
27635	Remove lower leg bone lesion		1,544.67	3	510.00		102.00
27637	Remove/graft leg bone lesion		1,544.67	3	510.00		102.00
27638	Remove/graft leg bone lesion		1,544.67	3	510.00		102.00
27640	Partial removal of tibia		2,525.68	2	446.00		89.20
27641	Partial removal of fibula		1,544.67	2	446.00		89.20
27647	Extensive ankle/heel surgery		2,525.68	3	510.00		102.00
27650	Repair achilles tendon		2,525.68	3	510.00		102.00
27652	Repair/graft achilles tendon		4,092.54	3	510.00		102.00
27654	Repair of achilles tendon		2,525.68	3	510.00		102.00
27656	Repair leg fascia defect		1,282.87	2	446.00		89.20
27658	Repair of leg tendon, each		1,282.87	1	333.00		66.60
27659	Repair of leg tendon, each		1,282.87	2	446.00		89.20
27664	Repair of leg tendon, each		1,282.87	2	446.00		89.20
27665	Repair of leg tendon, each		1,544.67	2	446.00		89.20
27675	Repair lower leg tendons		1,282.87	2	446.00		89.20
27676	Repair lower leg tendons		1,544.67	3	510.00		102.00
27680	Release of lower leg tendon		1,544.67	3	510.00		102.00
27681	Release of lower leg tendons		1,544.67	2	446.00		89.20

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
27685	Revision of lower leg tendon		1,544.67	3	510.00		102.00
27686	Revise lower leg tendons		1,544.67	3	510.00		102.00
27687	Revision of calf tendon		1,544.67	3	510.00		102.00
27690	Revise lower leg tendon		2,525.68	4	630.00		126.00
27691	Revise lower leg tendon		2,525.68	4	630.00		126.00
27692	Revise additional leg tendon		2,525.68	3	510.00		102.00
27695	Repair of ankle ligament		1,544.67	2	446.00		89.20
27696	Repair of ankle ligaments		1,544.67	2	446.00		89.20
27698	Repair of ankle ligament		1,544.67	2	446.00		89.20
27700	Revision of ankle joint		2,056.14	5	717.00		143.40
27704	Removal of ankle implant		1,282.87	2	446.00		89.20
27705	Incision of tibia		2,525.68	2	446.00		89.20
27707	Incision of fibula		1,282.87	2	446.00		89.20
27709	Incision of tibia & fibula		1,544.67	2	446.00		89.20
27730	Repair of tibia epiphysis		1,544.67	2	446.00		89.20
27732	Repair of fibula epiphysis		1,544.67	2	446.00		89.20
27734	Repair lower leg epiphyses		1,544.67	2	446.00		89.20
27740	Repair of leg epiphyses		1,544.67	2	446.00		89.20
27742	Repair of leg epiphyses		2,525.68	2	446.00		89.20
27745	Reinforce tibia		4,092.54	3	510.00		102.00
27750	Treatment of tibia fracture		103.62	1	103.62	Y	20.72
27752	Treatment of tibia fracture		103.62	1	103.62	Y	20.72
27756	Treatment of tibia fracture		1,569.06	3	510.00		102.00
27758	Treatment of tibia fracture		2,307.40	4	630.00		126.00
27759	Treatment of tibia fracture		3,517.03	4	630.00		126.00
27760	Treatment of ankle fracture		103.62	1	103.62	Y	20.72
27762	Treatment of ankle fracture		103.62	1	103.62	Y	20.72
27766	Treatment of ankle fracture		2,307.40	3	510.00		102.00
27780	Treatment of fibula fracture		103.62	1	103.62	Y	20.72
27781	Treatment of fibula fracture		103.62	1	103.62	Y	20.72
27784	Treatment of fibula fracture		2,307.40	3	510.00		102.00
27786	Treatment of ankle fracture		103.62	1	103.62	Y	20.72
27788	Treatment of ankle fracture		103.62	1	103.62	Y	20.72
27792	Treatment of ankle fracture		2,307.40	3	510.00		102.00
27808	Treatment of ankle fracture		103.62	1	103.62	Y	20.72
27810	Treatment of ankle fracture		103.62	1	103.62	Y	20.72
27814	Treatment of ankle fracture		2,307.40	3	510.00		102.00
27816	Treatment of ankle fracture		103.62	1	103.62	Y	20.72
27818	Treatment of ankle fracture		103.62	1	103.62	Y	20.72
27822	Treatment of ankle fracture		2,307.40	3	510.00		102.00
27823	Treatment of ankle fracture		3,517.03	3	510.00		102.00
27824	Treat lower leg fracture		103.62	1	103.62	Y	20.72
27825	Treat lower leg fracture		103.62	2	103.62	Y	20.72
27826	Treat lower leg fracture		2,307.40	3	510.00		102.00
27827	Treat lower leg fracture		3,517.03	3	510.00		102.00
27828	Treat lower leg fracture		3,517.03	4	630.00		126.00
27829	Treat lower leg joint		2,307.40	2	446.00		89.20
27830	Treat lower leg dislocation		103.62	1	103.62	Y	20.72
27831	Treat lower leg dislocation		103.62	1	103.62	Y	20.72
27832	Treat lower leg dislocation		2,307.40	2	446.00		89.20
27840	Treat ankle dislocation		103.62	1	103.62	Y	20.72
27842	Treat ankle dislocation		897.11	1	333.00		66.60
27846	Treat ankle dislocation		2,307.40	3	510.00		102.00
27848	Treat ankle dislocation		2,307.40	3	510.00		102.00
27860	Fixation of ankle joint		897.11	1	333.00		66.60
27870	Fusion of ankle joint, open		4,092.54	4	630.00		126.00
27871	Fusion of tibiofibular joint		4,092.54	4	630.00		126.00
27884	Amputation follow-up surgery		1,282.87	3	510.00		102.00
27889	Amputation of foot at ankle		1,544.67	3	510.00		102.00
27892	Decompression of leg		1,282.87	3	510.00		102.00
27893	Decompression of leg		1,282.87	3	510.00		102.00
27894	Decompression of leg		1,282.87	3	510.00		102.00
28002	Treatment of foot infection		1,282.87	3	510.00		102.00
28003	Treatment of foot infection		1,282.87	3	510.00		102.00
28005	Treat foot bone lesion		1,255.56	3	510.00		102.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
28008	Incision of foot fascia		1,255.56	3	510.00		102.00
28011	Incision of toe tendons		1,255.56	3	510.00		102.00
28020	Exploration of foot joint		1,255.56	2	446.00		89.20
28022	Exploration of foot joint		1,255.56	2	446.00		89.20
28024	Exploration of toe joint		1,255.56	2	446.00		89.20
28030	Removal of foot nerve	D		4	630.00		
28035	Decompression of tibia nerve		1,097.20	4	630.00		126.00
28043	Excision of foot lesion		1,233.39	2	446.00		89.20
28045	Excision of foot lesion		1,255.56	3	510.00		102.00
28046	Resection of tumor, foot		1,255.56	3	510.00		102.00
28050	Biopsy of foot joint lining		1,255.56	2	446.00		89.20
28052	Biopsy of foot joint lining		1,255.56	2	446.00		89.20
28054	Biopsy of toe joint lining		1,255.56	2	446.00		89.20
28055	Neurectomy, foot	A	1,097.20	4	630.00		126.00
28060	Partial removal, foot fascia		1,255.56	2	446.00		89.20
28062	Removal of foot fascia		1,255.56	3	510.00		102.00
28070	Removal of foot joint lining		1,255.56	3	510.00		102.00
28072	Removal of foot joint lining		1,255.56	3	510.00		102.00
28080	Removal of foot lesion		1,255.56	3	510.00		102.00
28086	Excise foot tendon sheath		1,255.56	2	446.00		89.20
28088	Excise foot tendon sheath		1,255.56	2	446.00		89.20
28090	Removal of foot lesion		1,255.56	3	510.00		102.00
28092	Removal of toe lesions		1,255.56	3	510.00		102.00
28100	Removal of ankle/heel lesion		1,255.56	2	446.00		89.20
28102	Remove/graft foot lesion		2,511.33	3	510.00		102.00
28103	Remove/graft foot lesion		2,511.33	3	510.00		102.00
28104	Removal of foot lesion		1,255.56	2	446.00		89.20
28106	Remove/graft foot lesion		2,511.33	3	510.00		102.00
28107	Remove/graft foot lesion		2,511.33	3	510.00		102.00
28108	Removal of toe lesions		1,255.56	2	446.00		89.20
28110	Part removal of metatarsal		1,255.56	3	510.00		102.00
28111	Part removal of metatarsal		1,255.56	3	510.00		102.00
28112	Part removal of metatarsal		1,255.56	3	510.00		102.00
28113	Part removal of metatarsal		1,255.56	3	510.00		102.00
28114	Removal of metatarsal heads		1,255.56	3	510.00		102.00
28116	Revision of foot		1,255.56	3	510.00		102.00
28118	Removal of heel bone		1,255.56	4	630.00		126.00
28119	Removal of heel spur		1,255.56	4	630.00		126.00
28120	Part removal of ankle/heel		1,255.56	7	995.00		199.00
28122	Partial removal of foot bone		1,255.56	3	510.00		102.00
28126	Partial removal of toe		1,255.56	3	510.00		102.00
28130	Removal of ankle bone		1,255.56	3	510.00		102.00
28140	Removal of metatarsal		1,255.56	3	510.00		102.00
28150	Removal of toe		1,255.56	3	510.00		102.00
28153	Partial removal of toe		1,255.56	3	510.00		102.00
28160	Partial removal of toe		1,255.56	3	510.00		102.00
28171	Extensive foot surgery		1,255.56	3	510.00		102.00
28173	Extensive foot surgery		1,255.56	3	510.00		102.00
28175	Extensive foot surgery		1,255.56	3	510.00		102.00
28192	Removal of foot foreign body		928.31	2	446.00		89.20
28193	Removal of foot foreign body		418.49	4	418.49	Y	83.70
28200	Repair of foot tendon		1,255.56	3	510.00		102.00
28202	Repair/graft of foot tendon		1,255.56	3	510.00		102.00
28208	Repair of foot tendon		1,255.56	3	510.00		102.00
28210	Repair/graft of foot tendon		2,511.33	3	510.00		102.00
28222	Release of foot tendons		1,255.56	1	333.00		66.60
28225	Release of foot tendon		1,255.56	1	333.00		66.60
28226	Release of foot tendons		1,255.56	1	333.00		66.60
28234	Incision of foot tendon		1,255.56	2	446.00		89.20
28238	Revision of foot tendon		2,511.33	3	510.00		102.00
28240	Release of big toe		1,255.56	2	446.00		89.20
28250	Revision of foot fascia		1,255.56	3	510.00		102.00
28260	Release of midfoot joint		1,255.56	3	510.00		102.00
28261	Revision of foot tendon		1,255.56	3	510.00		102.00
28262	Revision of foot and ankle		1,255.56	4	630.00		126.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
28264	Release of midfoot joint		2,511.33	1	333.00		66.60
28270	Release of foot contracture		1,255.56	3	510.00		102.00
28280	Fusion of toes		1,255.56	2	446.00		89.20
28285	Repair of hammertoe		1,255.56	3	510.00		102.00
28286	Repair of hammertoe		1,255.56	4	630.00		126.00
28288	Partial removal of foot bone		1,255.56	3	510.00		102.00
28289	Repair hallux rigidus		1,255.56	3	510.00		102.00
28290	Correction of bunion		1,735.54	2	446.00		89.20
28292	Correction of bunion		1,735.54	2	446.00		89.20
28293	Correction of bunion		1,735.54	3	510.00		102.00
28294	Correction of bunion		1,735.54	3	510.00		102.00
28296	Correction of bunion		1,735.54	3	510.00		102.00
28297	Correction of bunion		1,735.54	3	510.00		102.00
28298	Correction of bunion		1,735.54	3	510.00		102.00
28299	Correction of bunion		1,735.54	5	717.00		143.40
28300	Incision of heel bone		2,511.33	2	446.00		89.20
28302	Incision of ankle bone		1,255.56	2	446.00		89.20
28304	Incision of midfoot bones		2,511.33	2	446.00		89.20
28305	Incise/graft midfoot bones		2,511.33	3	510.00		102.00
28306	Incision of metatarsal		1,255.56	4	630.00		126.00
28307	Incision of metatarsal		1,255.56	4	630.00		126.00
28308	Incision of metatarsal		1,255.56	2	446.00		89.20
28309	Incision of metatarsals		2,511.33	4	630.00		126.00
28310	Revision of big toe		1,255.56	3	510.00		102.00
28312	Revision of toe		1,255.56	3	510.00		102.00
28313	Repair deformity of toe		1,255.56	2	446.00		89.20
28315	Removal of sesamoid bone		1,255.56	4	630.00		126.00
28320	Repair of foot bones		2,511.33	4	630.00		126.00
28322	Repair of metatarsals		2,511.33	4	630.00		126.00
28340	Resect enlarged toe tissue		1,255.56	4	630.00		126.00
28341	Resect enlarged toe		1,255.56	4	630.00		126.00
28344	Repair extra toe(s)		1,255.56	4	630.00		126.00
28345	Repair webbed toe(s)		1,255.56	4	630.00		126.00
28400	Treatment of heel fracture		103.62	1	103.62	Y	20.72
28405	Treatment of heel fracture		103.62	2	103.62	Y	20.72
28406	Treatment of heel fracture		1,569.06	2	446.00		89.20
28415	Treat heel fracture		2,307.40	3	510.00		102.00
28420	Treat/graft heel fracture		2,307.40	4	630.00		126.00
28435	Treatment of ankle fracture		103.62	2	103.62	Y	20.72
28436	Treatment of ankle fracture		1,569.06	2	446.00		89.20
28445	Treat ankle fracture		2,307.40	3	510.00		102.00
28456	Treat midfoot fracture		1,569.06	2	446.00		89.20
28465	Treat midfoot fracture, each		2,307.40	3	510.00		102.00
28476	Treat metatarsal fracture		1,569.06	2	446.00		89.20
28485	Treat metatarsal fracture		2,307.40	4	630.00		126.00
28496	Treat big toe fracture		1,569.06	2	446.00		89.20
28505	Treat big toe fracture		2,307.40	3	510.00		102.00
28525	Treat toe fracture		2,307.40	3	510.00		102.00
28531	Treat sesamoid bone fracture		2,307.40	3	510.00		102.00
28545	Treat foot dislocation		1,569.06	1	333.00		66.60
28546	Treat foot dislocation		1,569.06	2	446.00		89.20
28555	Repair foot dislocation		2,307.40	2	446.00		89.20
28575	Treat foot dislocation		103.62	1	103.62	Y	20.72
28576	Treat foot dislocation		1,569.06	3	510.00		102.00
28585	Repair foot dislocation		2,307.40	3	510.00		102.00
28605	Treat foot dislocation		103.62	1	103.62	Y	20.72
28606	Treat foot dislocation		1,569.06	2	446.00		89.20
28615	Repair foot dislocation		2,307.40	3	510.00		102.00
28635	Treat toe dislocation		897.11	1	333.00		66.60
28636	Treat toe dislocation		1,569.06	3	510.00		102.00
28645	Repair toe dislocation		2,307.40	3	510.00		102.00
28665	Treat toe dislocation		897.11	1	333.00		66.60
28666	Treat toe dislocation		1,569.06	3	510.00		102.00
28675	Repair of toe dislocation		2,307.40	3	510.00		102.00
28705	Fusion of foot bones		2,511.33	4	630.00		126.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
28715	Fusion of foot bones		2,511.33	4	630.00		126.00
28725	Fusion of foot bones		2,511.33	4	630.00		126.00
28730	Fusion of foot bones		2,511.33	4	630.00		126.00
28735	Fusion of foot bones		2,511.33	4	630.00		126.00
28737	Revision of foot bones		2,511.33	5	717.00		143.40
28740	Fusion of foot bones		2,511.33	4	630.00		126.00
28750	Fusion of big toe joint		2,511.33	4	630.00		126.00
28755	Fusion of big toe joint		1,255.56	4	630.00		126.00
28760	Fusion of big toe joint		2,511.33	4	630.00		126.00
28810	Amputation toe & metatarsal		1,255.56	2	446.00		89.20
28820	Amputation of toe		1,255.56	2	446.00		89.20
28825	Partial amputation of toe		1,255.56	2	446.00		89.20
29800	Jaw arthroscopy/surgery		1,759.49	3	510.00		102.00
29804	Jaw arthroscopy/surgery		1,759.49	3	510.00		102.00
29805	Shoulder arthroscopy, dx		1,759.49	3	510.00		102.00
29806	Shoulder arthroscopy/surgery		2,796.96	3	510.00		102.00
29807	Shoulder arthroscopy/surgery		2,796.96	3	510.00		102.00
29819	Shoulder arthroscopy/surgery		1,759.49	3	510.00		102.00
29820	Shoulder arthroscopy/surgery		1,759.49	3	510.00		102.00
29821	Shoulder arthroscopy/surgery		1,759.49	3	510.00		102.00
29822	Shoulder arthroscopy/surgery		1,759.49	3	510.00		102.00
29823	Shoulder arthroscopy/surgery		1,759.49	3	510.00		102.00
29824	Shoulder arthroscopy/surgery		1,759.49	5	717.00		143.40
29825	Shoulder arthroscopy/surgery		1,759.49	3	510.00		102.00
29826	Shoulder arthroscopy/surgery		2,796.96	3	510.00		102.00
29827	Arthroscop rotator cuff repr		2,796.96	5	717.00		143.40
29830	Elbow arthroscopy		1,759.49	3	510.00		102.00
29834	Elbow arthroscopy/surgery		1,759.49	3	510.00		102.00
29835	Elbow arthroscopy/surgery		1,759.49	3	510.00		102.00
29836	Elbow arthroscopy/surgery		1,759.49	3	510.00		102.00
29837	Elbow arthroscopy/surgery		1,759.49	3	510.00		102.00
29838	Elbow arthroscopy/surgery		1,759.49	3	510.00		102.00
29840	Wrist arthroscopy		1,759.49	3	510.00		102.00
29843	Wrist arthroscopy/surgery		1,759.49	3	510.00		102.00
29844	Wrist arthroscopy/surgery		1,759.49	3	510.00		102.00
29845	Wrist arthroscopy/surgery		1,759.49	3	510.00		102.00
29846	Wrist arthroscopy/surgery		1,759.49	3	510.00		102.00
29847	Wrist arthroscopy/surgery		1,759.49	3	510.00		102.00
29848	Wrist endoscopy/surgery		1,759.49	9	1,339.00		267.80
29850	Knee arthroscopy/surgery		1,759.49	4	630.00		126.00
29851	Knee arthroscopy/surgery		2,796.96	4	630.00		126.00
29855	Tibial arthroscopy/surgery		2,796.96	4	630.00		126.00
29856	Tibial arthroscopy/surgery		1,759.49	4	630.00		126.00
29860	Hip arthroscopy, dx		1,759.49	4	630.00		126.00
29861	Hip arthroscopy/surgery		1,759.49	4	630.00		126.00
29862	Hip arthroscopy/surgery		2,796.96	9	1,339.00		267.80
29863	Hip arthroscopy/surgery		2,796.96	4	630.00		126.00
29870	Knee arthroscopy, dx		1,759.49	3	510.00		102.00
29871	Knee arthroscopy/drainage		1,759.49	3	510.00		102.00
29873	Knee arthroscopy/surgery		1,759.49	3	510.00		102.00
29874	Knee arthroscopy/surgery		1,759.49	3	510.00		102.00
29875	Knee arthroscopy/surgery		1,759.49	4	630.00		126.00
29876	Knee arthroscopy/surgery		1,759.49	4	630.00		126.00
29877	Knee arthroscopy/surgery		1,759.49	4	630.00		126.00
29879	Knee arthroscopy/surgery		1,759.49	3	510.00		102.00
29880	Knee arthroscopy/surgery		1,759.49	4	630.00		126.00
29881	Knee arthroscopy/surgery		1,759.49	4	630.00		126.00
29882	Knee arthroscopy/surgery		1,759.49	3	510.00		102.00
29883	Knee arthroscopy/surgery		1,759.49	3	510.00		102.00
29884	Knee arthroscopy/surgery		1,759.49	3	510.00		102.00
29885	Knee arthroscopy/surgery		2,796.96	3	510.00		102.00
29886	Knee arthroscopy/surgery		1,759.49	3	510.00		102.00
29887	Knee arthroscopy/surgery		1,759.49	3	510.00		102.00
29888	Knee arthroscopy/surgery		2,796.96	3	510.00		102.00
29889	Knee arthroscopy/surgery		2,796.96	3	510.00		102.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
29891	Ankle arthroscopy/surgery		1,759.49	3	510.00		102.00
29892	Ankle arthroscopy/surgery		1,759.49	3	510.00		102.00
29893	Scope, plantar fasciotomy		1,255.56	9	1,255.56	Y	251.11
29894	Ankle arthroscopy/surgery		1,759.49	3	510.00		102.00
29895	Ankle arthroscopy/surgery		1,759.49	3	510.00		102.00
29897	Ankle arthroscopy/surgery		1,759.49	3	510.00		102.00
29898	Ankle arthroscopy/surgery		1,759.49	3	510.00		102.00
29899	Ankle arthroscopy/surgery		2,796.96	3	510.00		102.00
29900	Mcp joint arthroscopy, dx		992.95	3	510.00		102.00
29901	Mcp joint arthroscopy, surg		992.95	3	510.00		102.00
29902	Mcp joint arthroscopy, surg		992.95	3	510.00		102.00
30115	Removal of nose polyp(s)		1,009.71	2	446.00		89.20
30117	Removal of intranasal lesion		1,009.71	3	510.00		102.00
30118	Removal of intranasal lesion		1,434.04	3	510.00		102.00
30120	Revision of nose		1,009.71	1	333.00		66.60
30125	Removal of nose lesion		2,348.02	2	446.00		89.20
30130	Excise inferior turbinate		1,009.71	3	510.00		102.00
30140	Resect inferior turbinate		1,434.04	2	446.00		89.20
30150	Partial removal of nose		2,348.02	3	510.00		102.00
30160	Removal of nose		2,348.02	4	630.00		126.00
30220	Insert nasal septal button		464.15	3	464.15	Y	92.83
30310	Remove nasal foreign body		1,009.71	1	333.00		66.60
30320	Remove nasal foreign body		1,009.71	2	446.00		89.20
30400	Reconstruction of nose		2,348.02	4	630.00		126.00
30410	Reconstruction of nose		2,348.02	5	717.00		143.40
30420	Reconstruction of nose		2,348.02	5	717.00		143.40
30430	Revision of nose		1,434.04	3	510.00		102.00
30435	Revision of nose		2,348.02	5	717.00		143.40
30450	Revision of nose		2,348.02	7	995.00		199.00
30460	Revision of nose		2,348.02	7	995.00		199.00
30462	Revision of nose		2,348.02	9	1,339.00		267.80
30465	Repair nasal stenosis		2,348.02	9	1,339.00		267.80
30520	Repair of nasal septum		1,434.04	4	630.00		126.00
30540	Repair nasal defect		2,348.02	5	717.00		143.40
30545	Repair nasal defect		2,348.02	5	717.00		143.40
30560	Release of nasal adhesions		150.72	2	150.72	Y	30.14
30580	Repair upper jaw fistula		2,348.02	4	630.00		126.00
30600	Repair mouth/nose fistula		2,348.02	4	630.00		126.00
30620	Intranasal reconstruction		2,348.02	7	995.00		199.00
30630	Repair nasal septum defect		1,434.04	7	995.00		199.00
30801	Ablate inf turbinate, superf		464.15	1	333.00		66.60
30802	Cauterization, inner nose		464.15	1	333.00		66.60
30903	Control of nosebleed		72.48	1	72.48	Y	14.50
30905	Control of nosebleed		72.48	1	72.48	Y	14.50
30906	Repeat control of nosebleed		72.48	1	72.48	Y	14.50
30915	Ligation, nasal sinus artery		1,529.38	2	446.00		89.20
30920	Ligation, upper jaw artery		1,529.38	3	510.00		102.00
30930	Ther fx, nasal inf turbinate		1,009.71	4	630.00		126.00
31020	Exploration, maxillary sinus		1,434.04	2	446.00		89.20
31030	Exploration, maxillary sinus		2,348.02	3	510.00		102.00
31032	Explore sinus, remove polyps		2,348.02	4	630.00		126.00
31050	Exploration, sphenoid sinus		2,348.02	2	446.00		89.20
31051	Sphenoid sinus surgery		2,348.02	4	630.00		126.00
31070	Exploration of frontal sinus		1,434.04	2	446.00		89.20
31075	Exploration of frontal sinus		2,348.02	4	630.00		126.00
31080	Removal of frontal sinus		2,348.02	4	630.00		126.00
31081	Removal of frontal sinus		2,348.02	4	630.00		126.00
31084	Removal of frontal sinus		2,348.02	4	630.00		126.00
31085	Removal of frontal sinus		2,348.02	4	630.00		126.00
31086	Removal of frontal sinus		2,348.02	4	630.00		126.00
31087	Removal of frontal sinus		2,348.02	4	630.00		126.00
31090	Exploration of sinuses		2,348.02	5	717.00		143.40
31200	Removal of ethmoid sinus		2,348.02	2	446.00		89.20
31201	Removal of ethmoid sinus		2,348.02	5	717.00		143.40
31205	Removal of ethmoid sinus		2,348.02	3	510.00		102.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
31233	Nasal/sinus endoscopy, dx		86.39	2	86.39	Y	17.28
31235	Nasal/sinus endoscopy, dx		909.28	1	333.00		66.60
31237	Nasal/sinus endoscopy, surg		909.28	2	446.00		89.20
31238	Nasal/sinus endoscopy, surg		909.28	1	333.00		66.60
31239	Nasal/sinus endoscopy, surg		1,349.30	4	630.00		126.00
31240	Nasal/sinus endoscopy, surg		909.28	2	446.00		89.20
31254	Revision of ethmoid sinus		1,349.30	3	510.00		102.00
31255	Removal of ethmoid sinus		1,349.30	5	717.00		143.40
31256	Exploration maxillary sinus		1,349.30	3	510.00		102.00
31267	Endoscopy, maxillary sinus		1,349.30	3	510.00		102.00
31276	Sinus endoscopy, surgical		1,349.30	3	510.00		102.00
31287	Nasal/sinus endoscopy, surg		1,349.30	3	510.00		102.00
31288	Nasal/sinus endoscopy, surg		1,349.30	3	510.00		102.00
31300	Removal of larynx lesion		1,434.04	5	717.00		143.40
31320	Diagnostic incision, larynx		2,348.02	2	446.00		89.20
31400	Revision of larynx		2,348.02	2	446.00		89.20
31420	Removal of epiglottis		2,348.02	2	446.00		89.20
31510	Laryngoscopy with biopsy		909.28	2	446.00		89.20
31511	Remove foreign body, larynx		86.39	2	86.39	Y	17.28
31512	Removal of larynx lesion		909.28	2	446.00		89.20
31513	Injection into vocal cord		86.39	2	86.39	Y	17.28
31515	Laryngoscopy for aspiration		909.28	1	333.00		66.60
31525	Dx laryngoscopy excl nb		909.28	1	333.00		66.60
31526	Dx laryngoscopy w/oper scope		1,349.30	2	446.00		89.20
31527	Laryngoscopy for treatment		1,349.30	1	333.00		66.60
31528	Laryngoscopy and dilation		909.28	2	446.00		89.20
31529	Laryngoscopy and dilation		909.28	2	446.00		89.20
31530	Laryngoscopy w/fb removal		1,349.30	2	446.00		89.20
31531	Laryngoscopy w/fb & op scope		1,349.30	3	510.00		102.00
31535	Laryngoscopy w/biopsy		1,349.30	2	446.00		89.20
31536	Laryngoscopy w/bx & op scope		1,349.30	3	510.00		102.00
31540	Laryngoscopy w/exc of tumor		1,349.30	3	510.00		102.00
31541	Larynscop w/tumr exc + scope		1,349.30	4	630.00		126.00
31545	Remove vc lesion w/scope		1,349.30	4	630.00		126.00
31546	Remove vc lesion scope/graft		1,349.30	4	630.00		126.00
31560	Laryngoscop w/arytenoidectom		1,349.30	5	717.00		143.40
31561	Larynscop, remve cart + scop		1,349.30	5	717.00		143.40
31570	Laryngoscope w/vc inj		909.28	2	446.00		89.20
31571	Laryngoscop w/vc inj + scope		1,349.30	2	446.00		89.20
31576	Laryngoscopy with biopsy		1,349.30	2	446.00		89.20
31577	Remove foreign body, larynx		236.42	2	236.42	Y	47.28
31578	Removal of larynx lesion		1,349.30	2	446.00		89.20
31580	Revision of larynx		2,348.02	5	717.00		143.40
31582	Revision of larynx		2,348.02	5	717.00		143.40
31588	Revision of larynx		2,348.02	5	717.00		143.40
31590	Reinnervate larynx		2,348.02	5	717.00		143.40
31595	Larynx nerve surgery		2,348.02	2	446.00		89.20
31603	Incision of windpipe		464.15	1	333.00		66.60
31611	Surgery/speech prosthesis		1,434.04	3	510.00		102.00
31612	Puncture/clear windpipe		1,434.04	1	333.00		66.60
31613	Repair windpipe opening		1,434.04	2	446.00		89.20
31614	Repair windpipe opening		2,348.02	2	446.00		89.20
31615	Visualization of windpipe		585.35	1	333.00		66.60
31620	Endobronchial us add-on	A*	1,984.52	1	333.00		66.60
31622	Dx bronchoscope/wash		585.35	1	333.00		66.60
31623	Dx bronchoscope/brush		585.35	2	446.00		89.20
31624	Dx bronchoscope/lavage		585.35	2	446.00		89.20
31625	Bronchoscopy w/biopsy(s)		585.35	2	446.00		89.20
31628	Bronchoscopy/lung bx, each		585.35	2	446.00		89.20
31629	Bronchoscopy/needle bx, each		585.35	2	446.00		89.20
31630	Bronchoscopy dilate/fx repr		1,352.90	2	446.00		89.20
31631	Bronchoscopy, dilate w/stent		1,352.90	2	446.00		89.20
31635	Bronchoscopy w/fb removal		585.35	2	446.00		89.20
31636	Bronchoscopy, bronch stents		1,352.90	2	446.00		89.20
31637	Bronchoscopy, stent add-on		585.35	1	333.00		66.60

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
31638	Bronchoscopy, revise stent		1,352.90	2	446.00		89.20
31640	Bronchoscopy w/tumor excise		1,352.90	2	446.00		89.20
31641	Bronchoscopy, treat blockage		1,352.90	2	446.00		89.20
31643	Diag bronchoscope/catheter		585.35	2	446.00		89.20
31645	Bronchoscopy, clear airways		585.35	1	333.00		66.60
31646	Bronchoscopy, reclear airway		585.35	1	333.00		66.60
31656	Bronchoscopy, inj for x-ray		585.35	1	333.00		66.60
31700	Insertion of airway catheter	D		1	333.00		
31717	Bronchial brush biopsy		236.42	1	236.42	Y	47.28
31720	Clearance of airways		47.32	1	47.32	Y	9.46
31730	Intro, windpipe wire/tube		236.42	1	236.42	Y	47.28
31750	Repair of windpipe		2,348.02	5	717.00		143.40
31755	Repair of windpipe		2,348.02	2	446.00		89.20
31820	Closure of windpipe lesion		1,009.71	1	333.00		66.60
31825	Repair of windpipe defect		1,434.04	2	446.00		89.20
31830	Revise windpipe scar		1,434.04	2	446.00		89.20
32000	Drainage of chest		222.78	1	222.78	Y	44.56
32400	Needle biopsy chest lining		377.32	1	333.00		66.60
32405	Biopsy, lung or mediastinum		377.32	1	333.00		66.60
32420	Puncture/clear lung		222.78	1	222.78	Y	44.56
33010	Drainage of heart sac		222.78	2	222.78	Y	44.56
33011	Repeat drainage of heart sac		222.78	2	222.78	Y	44.56
33212	Insertion of pulse generator		6,042.45	3	510.00		102.00
33213	Insertion of pulse generator		6,931.86	3	510.00		102.00
33222	Revise pocket, pacemaker		1,317.27	2	446.00		89.20
33223	Revise pocket, pacing-defib		1,317.27	2	446.00		89.20
33233	Removal of pacemaker system		1,574.45	2	446.00		89.20
35188	Repair blood vessel lesion		2,319.75	4	630.00		126.00
35207	Repair blood vessel lesion		2,319.75	4	630.00		126.00
35875	Removal of clot in graft		2,319.75	9	1,339.00		267.80
35876	Removal of clot in graft		2,319.75	9	1,339.00		267.80
36260	Insertion of infusion pump		1,752.03	3	510.00		102.00
36261	Revision of infusion pump		1,752.03	2	446.00		89.20
36262	Removal of infusion pump		1,393.26	1	333.00		66.60
36475	Endovenous rf, 1st vein		2,134.71	9	1,339.00		267.80
36476	Endovenous rf, vein add-on		2,134.71	9	1,339.00		267.80
36478	Endovenous laser, 1st vein		1,529.38	9	1,339.00		267.80
36479	Endovenous laser vein addon		1,529.38	9	1,339.00		267.80
36555	Insert non-tunnel cv cath		539.97	1	333.00		66.60
36556	Insert non-tunnel cv cath		539.97	1	333.00		66.60
36557	Insert tunneled cv cath		1,393.26	2	446.00		89.20
36558	Insert tunneled cv cath		1,393.26	2	446.00		89.20
36560	Insert tunneled cv cath		1,752.03	3	510.00		102.00
36561	Insert tunneled cv cath		1,752.03	3	510.00		102.00
36563	Insert tunneled cv cath		1,752.03	3	510.00		102.00
36565	Insert tunneled cv cath		1,752.03	3	510.00		102.00
36566	Insert tunneled cv cath		5,130.17	3	510.00		102.00
36568	Insert picc cath		539.97	1	333.00		66.60
36569	Insert picc cath		539.97	1	333.00		66.60
36570	Insert picvad cath		1,393.26	3	510.00		102.00
36571	Insert picvad cath		1,393.26	3	510.00		102.00
36575	Repair tunneled cv cath		539.97	2	446.00		89.20
36576	Repair tunneled cv cath		539.97	2	446.00		89.20
36578	Replace tunneled cv cath		1,393.26	2	446.00		89.20
36580	Replace cvad cath		539.97	1	333.00		66.60
36581	Replace tunneled cv cath		1,393.26	2	446.00		89.20
36582	Replace tunneled cv cath		1,752.03	3	510.00		102.00
36583	Replace tunneled cv cath		1,752.03	3	510.00		102.00
36584	Replace picc cath		539.97	1	333.00		66.60
36585	Replace picvad cath		1,393.26	3	510.00		102.00
36589	Removal tunneled cv cath		539.97	1	333.00		66.60
36590	Removal tunneled cv cath		539.97	1	333.00		66.60
36640	Insertion catheter, artery		1,752.03	1	333.00		66.60
36800	Insertion of cannula		1,795.68	3	510.00		102.00
36810	Insertion of cannula		1,795.68	3	510.00		102.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
36815	Insertion of cannula		1,795.68	3	510.00		102.00
36818	Av fuse, uppr arm, cephalic	A*	2,319.75	3	510.00		102.00
36819	Av fuse, uppr arm, basilic		2,319.75	3	510.00		102.00
36820	Av fusion/forearm vein		2,319.75	3	510.00		102.00
36821	Av fusion direct any site		2,319.75	3	510.00		102.00
36825	Artery-vein autograft		2,319.75	4	630.00		126.00
36830	Artery-vein nonautograft		2,319.75	4	630.00		126.00
36831	Open thrombect av fistula		2,319.75	9	1,339.00		267.80
36832	Av fistula revision, open		2,319.75	4	630.00		126.00
36833	Av fistula revision		2,319.75	4	630.00		126.00
36834	Repair A-V aneurysm		2,319.75	3	510.00		102.00
36835	Artery to vein shunt		1,795.68	4	630.00		126.00
36860	External cannula declotting		127.40	2	127.40	Y	25.48
36861	Cannula declotting		1,795.68	3	510.00		102.00
36870	Percut thrombect av fistula		1,990.44	9	1,339.00		267.80
37500	Endoscopy ligate perf veins		2,134.71	3	510.00		102.00
37607	Ligation of a-v fistula		1,529.38	3	510.00		102.00
37609	Temporal artery procedure		928.31	2	446.00		89.20
37650	Revision of major vein		1,529.38	2	446.00		89.20
37700	Revise leg vein		2,134.71	2	446.00		89.20
37718	Ligate/strip short leg vein		2,134.71	3	510.00		102.00
37722	Ligate/strip long leg vein		2,134.71	3	510.00		102.00
37735	Removal of leg veins/lesion		2,134.71	3	510.00		102.00
37760	Ligation, leg veins, open		1,529.38	3	510.00		102.00
37780	Revision of leg vein		1,529.38	3	510.00		102.00
37785	Ligate/divide/excise vein		1,529.38	3	510.00		102.00
37790	Penile venous occlusion		2,027.66	3	510.00		102.00
38300	Drainage, lymph node lesion		685.58	1	333.00		66.60
38305	Drainage, lymph node lesion		1,076.22	2	446.00		89.20
38308	Incision of lymph channels		1,306.94	2	446.00		89.20
38500	Biopsy/removal, lymph nodes		1,306.94	2	446.00		89.20
38505	Needle biopsy, lymph nodes		240.00	1	240.00	Y	48.00
38510	Biopsy/removal, lymph nodes		1,306.94	2	446.00		89.20
38520	Biopsy/removal, lymph nodes		1,306.94	2	446.00		89.20
38525	Biopsy/removal, lymph nodes		1,306.94	2	446.00		89.20
38530	Biopsy/removal, lymph nodes		1,306.94	2	446.00		89.20
38542	Explore deep node(s), neck		2,318.72	2	446.00		89.20
38550	Removal, neck/armpit lesion		1,306.94	3	510.00		102.00
38555	Removal, neck/armpit lesion		1,306.94	4	630.00		126.00
38570	Laparoscopy, lymph node biop		2,676.86	9	1,339.00		267.80
38571	Laparoscopy, lymphadenectomy		4,333.90	9	1,339.00		267.80
38572	Laparoscopy, lymphadenectomy		2,676.86	9	1,339.00		267.80
38740	Remove armpit lymph nodes		2,318.72	2	446.00		89.20
38745	Remove armpit lymph nodes		2,318.72	4	630.00		126.00
38760	Remove groin lymph nodes		1,306.94	2	446.00		89.20
40500	Partial excision of lip		1,009.71	2	446.00		89.20
40510	Partial excision of lip		1,434.04	2	446.00		89.20
40520	Partial excision of lip		1,009.71	2	446.00		89.20
40525	Reconstruct lip with flap		1,434.04	2	446.00		89.20
40527	Reconstruct lip with flap		1,434.04	2	446.00		89.20
40530	Partial removal of lip		1,434.04	2	446.00		89.20
40650	Repair lip		464.15	3	464.15	Y	92.83
40652	Repair lip		464.15	3	464.15	Y	92.83
40654	Repair lip		464.15	3	464.15	Y	92.83
40700	Repair cleft lip/nasal		2,348.02	7	995.00		199.00
40701	Repair cleft lip/nasal		2,348.02	7	995.00		199.00
40720	Repair cleft lip/nasal		2,348.02	7	995.00		199.00
40761	Repair cleft lip/nasal		2,348.02	3	510.00		102.00
40801	Drainage of mouth lesion		464.15	2	446.00		89.20
40814	Excise/repair mouth lesion		1,009.71	2	446.00		89.20
40816	Excision of mouth lesion		1,434.04	2	446.00		89.20
40818	Excise oral mucosa for graft		150.72	1	150.72	Y	30.14
40819	Excise lip or cheek fold		464.15	1	333.00		66.60
40831	Repair mouth laceration		464.15	1	333.00		66.60
40840	Reconstruction of mouth		1,434.04	2	446.00		89.20

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
40842	Reconstruction of mouth		1,434.04	3	510.00		102.00
40843	Reconstruction of mouth		1,434.04	3	510.00		102.00
40844	Reconstruction of mouth		2,348.02	5	717.00		143.40
40845	Reconstruction of mouth		2,348.02	5	717.00		143.40
41005	Drainage of mouth lesion		150.72	1	150.72	Y	30.14
41006	Drainage of mouth lesion		1,434.04	1	333.00		66.60
41007	Drainage of mouth lesion		1,009.71	1	333.00		66.60
41008	Drainage of mouth lesion		1,009.71	1	333.00		66.60
41009	Drainage of mouth lesion		150.72	1	150.72	Y	30.14
41010	Incision of tongue fold		464.15	1	333.00		66.60
41015	Drainage of mouth lesion		150.72	1	150.72	Y	30.14
41016	Drainage of mouth lesion		464.15	1	333.00		66.60
41017	Drainage of mouth lesion		464.15	1	333.00		66.60
41018	Drainage of mouth lesion		464.15	1	333.00		66.60
41112	Excision of tongue lesion		1,009.71	2	446.00		89.20
41113	Excision of tongue lesion		1,009.71	2	446.00		89.20
41114	Excision of tongue lesion		1,434.04	2	446.00		89.20
41116	Excision of mouth lesion		1,009.71	1	333.00		66.60
41120	Partial removal of tongue		1,434.04	5	717.00		143.40
41250	Repair tongue laceration		150.72	2	150.72	Y	30.14
41251	Repair tongue laceration		150.72	2	150.72	Y	30.14
41252	Repair tongue laceration		464.15	2	446.00		89.20
41500	Fixation of tongue		1,434.04	1	333.00		66.60
41510	Tongue to lip surgery		1,009.71	1	333.00		66.60
41520	Reconstruction, tongue fold		464.15	2	446.00		89.20
41800	Drainage of gum lesion		88.46	1	88.46	Y	17.69
41827	Excision of gum lesion		1,434.04	2	446.00		89.20
42000	Drainage mouth roof lesion		150.72	2	150.72	Y	30.14
42107	Excision lesion, mouth roof		1,434.04	2	446.00		89.20
42120	Remove palate/lesion		2,348.02	4	630.00		126.00
42140	Excision of uvula		464.15	2	446.00		89.20
42145	Repair palate, pharynx/uvula		1,434.04	5	717.00		143.40
42180	Repair palate		150.72	1	150.72	Y	30.14
42182	Repair palate		2,348.02	2	446.00		89.20
42200	Reconstruct cleft palate		2,348.02	5	717.00		143.40
42205	Reconstruct cleft palate		2,348.02	5	717.00		143.40
42210	Reconstruct cleft palate		2,348.02	5	717.00		143.40
42215	Reconstruct cleft palate		2,348.02	7	995.00		199.00
42220	Reconstruct cleft palate		2,348.02	5	717.00		143.40
42226	Lengthening of palate		2,348.02	5	717.00		143.40
42235	Repair palate		1,009.71	5	717.00		143.40
42260	Repair nose to lip fistula		1,434.04	4	630.00		126.00
42300	Drainage of salivary gland		1,009.71	1	333.00		66.60
42305	Drainage of salivary gland		1,009.71	2	446.00		89.20
42310	Drainage of salivary gland		150.72	1	150.72	Y	30.14
42320	Drainage of salivary gland		150.72	1	150.72	Y	30.14
42340	Removal of salivary stone		1,009.71	2	446.00		89.20
42405	Biopsy of salivary gland		1,009.71	2	446.00		89.20
42408	Excision of salivary cyst		1,009.71	3	510.00		102.00
42409	Drainage of salivary cyst		1,009.71	3	510.00		102.00
42410	Excise parotid gland/lesion		2,348.02	3	510.00		102.00
42415	Excise parotid gland/lesion		2,348.02	7	995.00		199.00
42420	Excise parotid gland/lesion		2,348.02	7	995.00		199.00
42425	Excise parotid gland/lesion		2,348.02	7	995.00		199.00
42440	Excise submaxillary gland		2,348.02	3	510.00		102.00
42450	Excise sublingual gland		1,434.04	2	446.00		89.20
42500	Repair salivary duct		1,434.04	3	510.00		102.00
42505	Repair salivary duct		2,348.02	4	630.00		126.00
42507	Parotid duct diversion		2,348.02	3	510.00		102.00
42508	Parotid duct diversion		2,348.02	4	630.00		126.00
42509	Parotid duct diversion		2,348.02	4	630.00		126.00
42510	Parotid duct diversion		2,348.02	4	630.00		126.00
42600	Closure of salivary fistula		1,009.71	1	333.00		66.60
42665	Ligation of salivary duct		1,434.04	7	995.00		199.00
42700	Drainage of tonsil abscess		150.72	1	150.72	Y	30.14

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
42720	Drainage of throat abscess		1,009.71	1	333.00		66.60
42725	Drainage of throat abscess		2,348.02	2	446.00		89.20
42802	Biopsy of throat		1,009.71	1	333.00		66.60
42804	Biopsy of upper nose/throat		1,009.71	1	333.00		66.60
42806	Biopsy of upper nose/throat		1,434.04	2	446.00		89.20
42808	Excise pharynx lesion		1,009.71	2	446.00		89.20
42810	Excision of neck cyst		1,434.04	3	510.00		102.00
42815	Excision of neck cyst		2,348.02	5	717.00		143.40
42820	Remove tonsils and adenoids		1,359.46	3	510.00		102.00
42821	Remove tonsils and adenoids		1,359.46	5	717.00		143.40
42825	Removal of tonsils		1,359.46	4	630.00		126.00
42826	Removal of tonsils		1,359.46	4	630.00		126.00
42830	Removal of adenoids		1,359.46	4	630.00		126.00
42831	Removal of adenoids		1,359.46	4	630.00		126.00
42835	Removal of adenoids		1,359.46	4	630.00		126.00
42836	Removal of adenoids		1,359.46	4	630.00		126.00
42860	Excision of tonsil tags		1,359.46	3	510.00		102.00
42870	Excision of lingual tonsil		1,359.46	3	510.00		102.00
42890	Partial removal of pharynx		2,348.02	7	995.00		199.00
42892	Revision of pharyngeal walls		2,348.02	7	995.00		199.00
42900	Repair throat wound		464.15	1	333.00		66.60
42950	Reconstruction of throat		1,434.04	2	446.00		89.20
42955	Surgical opening of throat		1,434.04	2	446.00		89.20
42960	Control throat bleeding		72.48	1	72.48	Y	14.50
42962	Control throat bleeding		2,348.02	2	446.00		89.20
42972	Control nose/throat bleeding		1,009.71	3	510.00		102.00
43200	Esophagus endoscopy		511.26	1	333.00		66.60
43201	Esoph scope w/submucous inj		511.26	1	333.00		66.60
43202	Esophagus endoscopy, biopsy		511.26	1	333.00		66.60
43204	Esoph scope w/sclerosis inj		511.26	1	333.00		66.60
43205	Esophagus endoscopy/ligation		511.26	1	333.00		66.60
43215	Esophagus endoscopy		511.26	1	333.00		66.60
43216	Esophagus endoscopy/lesion		511.26	1	333.00		66.60
43217	Esophagus endoscopy		511.26	1	333.00		66.60
43219	Esophagus endoscopy		1,410.54	1	333.00		66.60
43220	Esoph endoscopy, dilation		511.26	1	333.00		66.60
43226	Esoph endoscopy, dilation		511.26	1	333.00		66.60
43227	Esoph endoscopy, repair		511.26	2	446.00		89.20
43228	Esoph endoscopy, ablation		1,583.12	2	446.00		89.20
43231	Esoph endoscopy w/us exam		511.26	2	446.00		89.20
43232	Esoph endoscopy w/us fn bx		511.26	2	446.00		89.20
43234	Upper GI endoscopy, exam		511.26	1	333.00		66.60
43235	Uppr gi endoscopy, diagnosis		511.26	1	333.00		66.60
43236	Uppr gi scope w/submuc inj		511.26	2	446.00		89.20
43237	Endoscopic us exam, esoph		511.26	2	446.00		89.20
43238	Uppr gi endoscopy w/us fn bx		511.26	2	446.00		89.20
43239	Upper GI endoscopy, biopsy		511.26	2	446.00		89.20
43240	Esoph endoscope w/drain cyst		511.26	2	446.00		89.20
43241	Upper GI endoscopy with tube		511.26	2	446.00		89.20
43242	Uppr gi endoscopy w/us fn bx		511.26	2	446.00		89.20
43243	Upper gi endoscopy & inject		511.26	2	446.00		89.20
43244	Upper GI endoscopy/ligation		511.26	2	446.00		89.20
43245	Uppr gi scope dilate strictr		511.26	2	446.00		89.20
43246	Place gastrostomy tube		511.26	2	446.00		89.20
43247	Operative upper GI endoscopy		511.26	2	446.00		89.20
43248	Uppr gi endoscopy/guide wire		511.26	2	446.00		89.20
43249	Esoph endoscopy, dilation		511.26	2	446.00		89.20
43250	Upper GI endoscopy/tumor		511.26	2	446.00		89.20
43251	Operative upper GI endoscopy		511.26	2	446.00		89.20
43255	Operative upper GI endoscopy		511.26	2	446.00		89.20
43256	Uppr gi endoscopy w/stent		1,410.54	3	510.00		102.00
43257	Uppr gi scope w/thrml txmnt	A*	1,583.12	3	510.00		102.00
43258	Operative upper GI endoscopy		511.26	3	510.00		102.00
43259	Endoscopic ultrasound exam		511.26	3	510.00		102.00
43260	Endo cholangiopancreatograph		1,219.41	2	446.00		89.20

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
43261	Endo cholangiopancreatograph		1,219.41	2	446.00		89.20
43262	Endo cholangiopancreatograph		1,219.41	2	446.00		89.20
43263	Endo cholangiopancreatograph		1,219.41	2	446.00		89.20
43264	Endo cholangiopancreatograph		1,219.41	2	446.00		89.20
43265	Endo cholangiopancreatograph		1,219.41	2	446.00		89.20
43267	Endo cholangiopancreatograph		1,219.41	2	446.00		89.20
43268	Endo cholangiopancreatograph		1,410.54	2	446.00		89.20
43269	Endo cholangiopancreatograph		1,410.54	2	446.00		89.20
43271	Endo cholangiopancreatograph		1,219.41	2	446.00		89.20
43272	Endo cholangiopancreatograph		1,219.41	2	446.00		89.20
43450	Dilate esophagus		335.41	1	333.00		66.60
43453	Dilate esophagus		335.41	1	333.00		66.60
43456	Dilate esophagus		335.41	2	335.41	Y	67.08
43458	Dilate esophagus		335.41	2	335.41	Y	67.08
43600	Biopsy of stomach		511.26	1	333.00		66.60
43653	Laparoscopy, gastrostomy		2,676.86	9	1,339.00		267.80
43750	Place gastrostomy tube		511.26	2	446.00		89.20
43760	Change gastrostomy tube		144.98	1	144.98	Y	29.00
43761	Reposition gastrostomy tube	A*	459.78	1	333.00		66.60
43870	Repair stomach opening		511.26	1	333.00		66.60
44100	Biopsy of bowel		511.26	1	333.00		66.60
44312	Revision of ileostomy		1,317.27	1	333.00		66.60
44340	Revision of colostomy		1,317.27	3	510.00		102.00
44360	Small bowel endoscopy		583.61	2	446.00		89.20
44361	Small bowel endoscopy/biopsy		583.61	2	446.00		89.20
44363	Small bowel endoscopy		583.61	2	446.00		89.20
44364	Small bowel endoscopy		583.61	2	446.00		89.20
44365	Small bowel endoscopy		583.61	2	446.00		89.20
44366	Small bowel endoscopy		583.61	2	446.00		89.20
44369	Small bowel endoscopy		583.61	2	446.00		89.20
44370	Small bowel endoscopy/stent		1,410.54	9	1,339.00		267.80
44372	Small bowel endoscopy		583.61	2	446.00		89.20
44373	Small bowel endoscopy		583.61	2	446.00		89.20
44376	Small bowel endoscopy		583.61	2	446.00		89.20
44377	Small bowel endoscopy/biopsy		583.61	2	446.00		89.20
44378	Small bowel endoscopy		583.61	2	446.00		89.20
44379	Sbowel endoscope w/stent		1,410.54	9	1,339.00		267.80
44380	Small bowel endoscopy		583.61	1	333.00		66.60
44382	Small bowel endoscopy		583.61	1	333.00		66.60
44383	Ileoscopy w/stent		1,410.54	9	1,339.00		267.80
44385	Endoscopy of bowel pouch		538.99	1	333.00		66.60
44386	Endoscopy, bowel pouch/biop		538.99	1	333.00		66.60
44388	Colonoscopy		538.99	1	333.00		66.60
44389	Colonoscopy with biopsy		538.99	1	333.00		66.60
44390	Colonoscopy for foreign body		538.99	1	333.00		66.60
44391	Colonoscopy for bleeding		538.99	1	333.00		66.60
44392	Colonoscopy & polypectomy		538.99	1	333.00		66.60
44393	Colonoscopy, lesion removal		538.99	1	333.00		66.60
44394	Colonoscopy w/snare		538.99	1	333.00		66.60
44397	Colonoscopy w/stent		1,410.54	1	333.00		66.60
45000	Drainage of pelvic abscess		312.07	1	312.07	Y	62.41
45005	Drainage of rectal abscess		783.03	2	446.00		89.20
45020	Drainage of rectal abscess		783.03	2	446.00		89.20
45100	Biopsy of rectum		1,368.78	1	333.00		66.60
45108	Removal of anorectal lesion		1,368.78	2	446.00		89.20
45150	Excision of rectal stricture		1,368.78	2	446.00		89.20
45160	Excision of rectal lesion		1,368.78	2	446.00		89.20
45170	Excision of rectal lesion		1,368.78	2	446.00		89.20
45190	Destruction, rectal tumor		1,368.78	9	1,339.00		267.80
45305	Proctosigmoidoscopy w/bx		525.41	1	333.00		66.60
45307	Proctosigmoidoscopy fb		1,268.55	1	333.00		66.60
45308	Proctosigmoidoscopy removal		525.41	1	333.00		66.60
45309	Proctosigmoidoscopy removal		525.41	1	333.00		66.60
45315	Proctosigmoidoscopy removal		525.41	1	333.00		66.60
45317	Proctosigmoidoscopy bleed		525.41	1	333.00		66.60

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
45320	Proctosigmoidoscopy ablate		1,268.55	1	333.00		66.60
45321	Proctosigmoidoscopy volvul		1,268.55	1	333.00		66.60
45327	Proctosigmoidoscopy w/stent		1,410.54	1	333.00		66.60
45331	Sigmoidoscopy and biopsy		299.24	1	299.24	Y	59.85
45332	Sigmoidoscopy w/fb removal		299.24	1	299.24	Y	59.85
45333	Sigmoidoscopy & polypectomy		525.41	1	333.00		66.60
45334	Sigmoidoscopy for bleeding		525.41	1	333.00		66.60
45335	Sigmoidoscopy w/submuc inj		299.24	1	299.24	Y	59.85
45337	Sigmoidoscopy & decompress		299.24	1	299.24	Y	59.85
45338	Sigmoidoscopy w/tumr remove		525.41	1	333.00		66.60
45339	Sigmoidoscopy w/ablate tumr		525.41	1	333.00		66.60
45340	Sig w/balloon dilation		525.41	1	333.00		66.60
45341	Sigmoidoscopy w/ultrasound		525.41	1	333.00		66.60
45342	Sigmoidoscopy w/us guide bx		525.41	1	333.00		66.60
45345	Sigmoidoscopy w/stent		1,410.54	1	333.00		66.60
45355	Surgical colonoscopy		538.99	1	333.00		66.60
45378	Diagnostic colonoscopy		538.99	2	446.00		89.20
45379	Colonoscopy w/fb removal		538.99	2	446.00		89.20
45380	Colonoscopy and biopsy		538.99	2	446.00		89.20
45381	Colonoscopy, submucous inj		538.99	2	446.00		89.20
45382	Colonoscopy/control bleeding		538.99	2	446.00		89.20
45383	Lesion removal colonoscopy		538.99	2	446.00		89.20
45384	Lesion remove colonoscopy		538.99	2	446.00		89.20
45385	Lesion removal colonoscopy		538.99	2	446.00		89.20
45386	Colonoscopy dilate stricture		538.99	2	446.00		89.20
45387	Colonoscopy w/stent		1,410.54	1	333.00		66.60
45391	Colonoscopy w/endoscope us		538.99	2	446.00		89.20
45392	Colonoscopy w/endoscopic fnb		538.99	2	446.00		89.20
45500	Repair of rectum		1,368.78	2	446.00		89.20
45505	Repair of rectum		1,820.61	2	446.00		89.20
45560	Repair of rectocele		1,820.61	2	446.00		89.20
45900	Reduction of rectal prolapse		312.07	1	312.07	Y	62.41
45905	Dilation of anal sphincter		1,368.78	1	333.00		66.60
45910	Dilation of rectal narrowing		1,368.78	1	333.00		66.60
45915	Remove rectal obstruction		312.07	1	312.07	Y	62.41
45990	Surg dx exam, anorectal		312.07	2	312.07	Y	62.41
46020	Placement of seton		1,368.78	3	510.00		102.00
46030	Removal of rectal marker		312.07	1	312.07	Y	62.41
46040	Incision of rectal abscess		1,368.78	3	510.00		102.00
46045	Incision of rectal abscess		1,368.78	2	446.00		89.20
46050	Incision of anal abscess		312.07	1	312.07	Y	62.41
46060	Incision of rectal abscess		1,368.78	2	446.00		89.20
46080	Incision of anal sphincter		1,368.78	3	510.00		102.00
46200	Removal of anal fissure		1,368.78	2	446.00		89.20
46210	Removal of anal crypt		1,368.78	2	446.00		89.20
46211	Removal of anal crypts		1,368.78	2	446.00		89.20
46220	Removal of anal tag		1,368.78	1	333.00		66.60
46230	Removal of anal tags		1,368.78	1	333.00		66.60
46250	Hemorrhoidectomy		1,368.78	3	510.00		102.00
46255	Hemorrhoidectomy		1,368.78	3	510.00		102.00
46257	Remove hemorrhoids & fissure		1,368.78	3	510.00		102.00
46258	Remove hemorrhoids & fistula		1,368.78	3	510.00		102.00
46260	Hemorrhoidectomy		1,368.78	3	510.00		102.00
46261	Remove hemorrhoids & fissure		1,368.78	4	630.00		126.00
46262	Remove hemorrhoids & fistula		1,368.78	4	630.00		126.00
46270	Removal of anal fistula		1,368.78	3	510.00		102.00
46275	Removal of anal fistula		1,368.78	3	510.00		102.00
46280	Removal of anal fistula		1,368.78	4	630.00		126.00
46285	Removal of anal fistula		1,368.78	1	333.00		66.60
46288	Repair anal fistula		1,368.78	4	630.00		126.00
46608	Anoscopy, remove for body		525.41	1	333.00		66.60
46610	Anoscopy, remove lesion		1,268.55	1	333.00		66.60
46611	Anoscopy		525.41	1	333.00		66.60
46612	Anoscopy, remove lesions		1,268.55	1	333.00		66.60
46615	Anoscopy		1,268.55	2	446.00		89.20

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
46700	Repair of anal stricture		1,368.78	3	510.00		102.00
46706	Repr of anal fistula w/glue		1,820.61	1	333.00		66.60
46750	Repair of anal sphincter		2,329.58	3	510.00		102.00
46753	Reconstruction of anus		1,368.78	3	510.00		102.00
46754	Removal of suture from anus		1,368.78	2	446.00		89.20
46760	Repair of anal sphincter		2,329.58	2	446.00		89.20
46761	Repair of anal sphincter		2,329.58	3	510.00		102.00
46762	Implant artificial sphincter		2,329.58	7	995.00		199.00
46917	Laser surgery, anal lesions		1,255.64	1	333.00		66.60
46922	Excision of anal lesion(s)		1,255.64	1	333.00		66.60
46924	Destruction, anal lesion(s)		1,255.64	1	333.00		66.60
46937	Cryotherapy of rectal lesion		1,368.78	2	446.00		89.20
46938	Cryotherapy of rectal lesion		1,820.61	2	446.00		89.20
46946	Ligation of hemorrhoids	A*	783.03	1	333.00		66.60
46947	Hemorrhoidopexy by stapling		1,820.61	7	995.00		199.00
47000	Needle biopsy of liver		377.32	1	333.00		66.60
47510	Insert catheter, bile duct		1,245.85	2	446.00		89.20
47511	Insert bile duct drain		1,245.85	9	1,245.85	Y	249.17
47525	Change bile duct catheter		716.56	1	333.00		66.60
47530	Revise/reinsert bile tube		716.56	1	333.00		66.60
47552	Biliary endoscopy thru skin		1,245.85	2	446.00		89.20
47553	Biliary endoscopy thru skin		1,245.85	3	510.00		102.00
47554	Biliary endoscopy thru skin		1,245.85	3	510.00		102.00
47555	Biliary endoscopy thru skin		1,245.85	3	510.00		102.00
47556	Biliary endoscopy thru skin		1,245.85	9	1,245.85	Y	249.17
47560	Laparoscopy w/cholangio		1,974.60	3	510.00		102.00
47561	Laparo w/cholangio/biopsy		1,974.60	3	510.00		102.00
47630	Remove bile duct stone		1,245.85	3	510.00		102.00
48102	Needle biopsy, pancreas		377.32	1	333.00		66.60
49080	Puncture, peritoneal cavity		222.78	2	222.78	Y	44.56
49081	Removal of abdominal fluid		222.78	2	222.78	Y	44.56
49085	Remove abdomen foreign body	D		2	446.00		
49180	Biopsy, abdominal mass		377.32	1	333.00		66.60
49250	Excision of umbilicus		1,357.41	4	630.00		126.00
49320	Diag laparo separate proc		1,974.60	3	510.00		102.00
49321	Laparoscopy, biopsy		1,974.60	4	630.00		126.00
49322	Laparoscopy, aspiration		1,974.60	4	630.00		126.00
49402	Remove foreign body, adbomen	A	1,357.41	2	446.00		89.20
49419	Insrt abdom cath for chemotx		1,795.68	1	333.00		66.60
49420	Insert abdom drain, temp		1,815.86	1	333.00		66.60
49421	Insert abdom drain, perm		1,815.86	1	333.00		66.60
49422	Remove perm cannula/catheter		1,574.45	1	333.00		66.60
49426	Revise abdomen-venous shunt		1,357.41	2	446.00		89.20
49495	Rpr ing hernia baby, reduc		1,795.98	4	630.00		126.00
49496	Rpr ing hernia baby, blocked		1,795.98	4	630.00		126.00
49500	Rpr ing hernia, init, reduce		1,795.98	4	630.00		126.00
49501	Rpr ing hernia, init blocked		1,795.98	9	1,339.00		267.80
49505	Prp i/hern init reduc >5 yr		1,795.98	4	630.00		126.00
49507	Prp i/hern init block >5 yr		1,795.98	9	1,339.00		267.80
49520	Rerepair ing hernia, reduce		1,795.98	7	995.00		199.00
49521	Rerepair ing hernia, blocked		1,795.98	9	1,339.00		267.80
49525	Repair ing hernia, sliding		1,795.98	4	630.00		126.00
49540	Repair lumbar hernia		1,795.98	2	446.00		89.20
49550	Rpr rem hernia, init, reduce		1,795.98	5	717.00		143.40
49553	Rpr fem hernia, init blocked		1,795.98	9	1,339.00		267.80
49555	Rerepair fem hernia, reduce		1,795.98	5	717.00		143.40
49557	Rerepair fem hernia, blocked		1,795.98	9	1,339.00		267.80
49560	Rpr ventral hern init, reduc		1,795.98	4	630.00		126.00
49561	Rpr ventral hern init, block		1,795.98	9	1,339.00		267.80
49565	Rerepair ventrl hern, reduce		1,795.98	4	630.00		126.00
49566	Rerepair ventrl hern, block		1,795.98	9	1,339.00		267.80
49568	Hernia repair w/mesh		1,795.98	7	995.00		199.00
49570	Rpr epigastric hern, reduce		1,795.98	4	630.00		126.00
49572	Rpr epigastric hern, blocked		1,795.98	9	1,339.00		267.80
49580	Rpr umbil hern, reduc < 5 yr		1,795.98	4	630.00		126.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
49582	Rpr umbil hern, block < 5 yr		1,795.98	9	1,339.00		267.80
49585	Rpr umbil hern, reduc > 5 yr		1,795.98	4	630.00		126.00
49587	Rpr umbil hern, block > 5 yr		1,795.98	9	1,339.00		267.80
49590	Repair spigelian hernia		1,795.98	3	510.00		102.00
49600	Repair umbilical lesion		1,795.98	4	630.00		126.00
49650	Laparo hernia repair initial		2,676.86	4	630.00		126.00
49651	Laparo hernia repair recur		2,676.86	7	995.00		199.00
50200	Biopsy of kidney		377.32	1	333.00		66.60
50390	Drainage of kidney lesion		377.32	1	333.00		66.60
50392	Insert kidney drain		1,181.73	1	333.00		66.60
50393	Insert ureteral tube		1,181.73	1	333.00		66.60
50395	Create passage to kidney		1,181.73	1	333.00		66.60
50396	Measure kidney pressure		131.50	1	131.50	Y	26.30
50398	Change kidney tube		459.78	1	333.00		66.60
50551	Kidney endoscopy		399.24	1	333.00		66.60
50553	Kidney endoscopy		1,181.73	1	333.00		66.60
50555	Kidney endoscopy & biopsy		399.24	1	333.00		66.60
50557	Kidney endoscopy & treatment		1,467.24	1	333.00		66.60
50561	Kidney endoscopy & treatment		1,181.73	1	333.00		66.60
50688	Change of ureter tube/stent		459.78	1	333.00		66.60
50947	Laparo new ureter/bladder		2,676.86	9	1,339.00		267.80
50948	Laparo new ureter/bladder		2,676.86	9	1,339.00		267.80
50951	Endoscopy of ureter		399.24	1	333.00		66.60
50953	Endoscopy of ureter		399.24	1	333.00		66.60
50955	Ureter endoscopy & biopsy		1,181.73	1	333.00		66.60
50957	Ureter endoscopy & treatment		1,181.73	1	333.00		66.60
50961	Ureter endoscopy & treatment		1,181.73	1	333.00		66.60
50970	Ureter endoscopy		399.24	1	333.00		66.60
50972	Ureter endoscopy & catheter		399.24	1	333.00		66.60
50974	Ureter endoscopy & biopsy		1,181.73	1	333.00		66.60
50976	Ureter endoscopy & treatment		1,181.73	1	333.00		66.60
50980	Ureter endoscopy & treatment		1,181.73	1	333.00		66.60
51010	Drainage of bladder		1,116.74	1	333.00		66.60
51020	Incise & treat bladder		1,467.24	4	630.00		126.00
51030	Incise & treat bladder		1,467.24	4	630.00		126.00
51040	Incise & drain bladder		1,467.24	4	630.00		126.00
51045	Incise bladder/drain ureter		399.24	4	399.24	Y	79.85
51050	Removal of bladder stone		1,467.24	4	630.00		126.00
51065	Remove ureter calculus		1,467.24	4	630.00		126.00
51080	Drainage of bladder abscess		1,076.22	1	333.00		66.60
51500	Removal of bladder cyst		1,795.98	4	630.00		126.00
51520	Removal of bladder lesion		1,467.24	4	630.00		126.00
51710	Change of bladder tube		459.78	1	333.00		66.60
51715	Endoscopic injection/implant		1,784.13	3	510.00		102.00
51726	Complex cystometrogram		209.48	1	209.48	Y	41.90
51772	Urethra pressure profile		131.50	1	131.50	Y	26.30
51785	Anal/urinary muscle study		66.92	1	66.92	Y	13.38
51880	Repair of bladder opening		1,467.24	1	333.00		66.60
51992	Laparo sling operation		2,676.86	5	717.00		143.40
52000	Cystoscopy		399.24	1	333.00		66.60
52001	Cystoscopy, removal of clots		399.24	2	399.24	Y	79.85
52005	Cystoscopy & ureter catheter		1,181.73	2	446.00		89.20
52007	Cystoscopy and biopsy		1,181.73	2	446.00		89.20
52010	Cystoscopy & duct catheter		399.24	2	399.24	Y	79.85
52204	Cystoscopy w/biopsy(s)		1,181.73	2	446.00		89.20
52214	Cystoscopy and treatment		1,467.24	2	446.00		89.20
52224	Cystoscopy and treatment		1,467.24	2	446.00		89.20
52234	Cystoscopy and treatment		1,467.24	2	446.00		89.20
52235	Cystoscopy and treatment		1,467.24	3	510.00		102.00
52240	Cystoscopy and treatment		1,467.24	3	510.00		102.00
52250	Cystoscopy and radiotracer		1,467.24	4	630.00		126.00
52260	Cystoscopy and treatment		1,181.73	2	446.00		89.20
52270	Cystoscopy & revise urethra		1,181.73	2	446.00		89.20
52275	Cystoscopy & revise urethra		1,181.73	2	446.00		89.20
52276	Cystoscopy and treatment		1,181.73	3	510.00		102.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
52277	Cystoscopy and treatment		1,467.24	2	446.00		89.20
52281	Cystoscopy and treatment		1,181.73	2	446.00		89.20
52282	Cystoscopy, implant stent		2,146.84	9	1,339.00		267.80
52283	Cystoscopy and treatment		1,181.73	2	446.00		89.20
52285	Cystoscopy and treatment		1,181.73	2	446.00		89.20
52290	Cystoscopy and treatment		1,181.73	2	446.00		89.20
52300	Cystoscopy and treatment		1,181.73	2	446.00		89.20
52301	Cystoscopy and treatment		1,181.73	3	510.00		102.00
52305	Cystoscopy and treatment		1,181.73	2	446.00		89.20
52310	Cystoscopy and treatment		399.24	2	399.24	Y	79.85
52315	Cystoscopy and treatment		1,181.73	2	446.00		89.20
52317	Remove bladder stone		1,467.24	1	333.00		66.60
52318	Remove bladder stone		1,467.24	2	446.00		89.20
52320	Cystoscopy and treatment		1,467.24	5	717.00		143.40
52325	Cystoscopy, stone removal		1,467.24	4	630.00		126.00
52327	Cystoscopy, inject material		1,467.24	2	446.00		89.20
52330	Cystoscopy and treatment		1,467.24	2	446.00		89.20
52332	Cystoscopy and treatment		1,467.24	2	446.00		89.20
52334	Create passage to kidney		1,467.24	3	510.00		102.00
52341	Cysto w/ureter stricture tx		1,467.24	3	510.00		102.00
52342	Cysto w/up stricture tx		1,467.24	3	510.00		102.00
52343	Cysto w/renal stricture tx		1,467.24	3	510.00		102.00
52344	Cysto/uretero, stricture tx		1,467.24	3	510.00		102.00
52345	Cysto/uretero w/up stricture		1,467.24	3	510.00		102.00
52346	Cystouretero w/renal strict		1,467.24	3	510.00		102.00
52351	Cystouretero & or pyeloscope		1,181.73	3	510.00		102.00
52352	Cystouretero w/stone remove		1,467.24	4	630.00		126.00
52353	Cystouretero w/lithotripsy		2,146.84	4	630.00		126.00
52354	Cystouretero w/biopsy		1,467.24	4	630.00		126.00
52355	Cystouretero w/excise tumor		1,467.24	4	630.00		126.00
52400	Cystouretero w/congen repr		1,467.24	3	510.00		102.00
52402	Cystourethro cut ejacul duct		1,467.24	3	510.00		102.00
52450	Incision of prostate		1,467.24	3	510.00		102.00
52500	Revision of bladder neck		1,467.24	3	510.00		102.00
52510	Dilation prostatic urethra		1,181.73	3	510.00		102.00
52601	Prostatectomy (TURP)		2,146.84	4	630.00		126.00
52606	Control postop bleeding		1,467.24	1	333.00		66.60
52612	Prostatectomy, first stage		2,146.84	2	446.00		89.20
52614	Prostatectomy, second stage		2,146.84	1	333.00		66.60
52620	Remove residual prostate		2,146.84	1	333.00		66.60
52630	Remove prostate regrowth		2,146.84	2	446.00		89.20
52640	Relieve bladder contracture		1,467.24	2	446.00		89.20
52647	Laser surgery of prostate		2,649.30	9	1,339.00		267.80
52648	Laser surgery of prostate		2,649.30	9	1,339.00		267.80
52700	Drainage of prostate abscess		1,467.24	2	446.00		89.20
53000	Incision of urethra		1,130.77	1	333.00		66.60
53010	Incision of urethra		1,130.77	1	333.00		66.60
53020	Incision of urethra		1,130.77	1	333.00		66.60
53040	Drainage of urethra abscess		1,130.77	2	446.00		89.20
53080	Drainage of urinary leakage		1,130.77	3	510.00		102.00
53200	Biopsy of urethra		1,130.77	1	333.00		66.60
53210	Removal of urethra		1,784.13	5	717.00		143.40
53215	Removal of urethra		1,130.77	5	717.00		143.40
53220	Treatment of urethra lesion		1,784.13	2	446.00		89.20
53230	Removal of urethra lesion		1,784.13	2	446.00		89.20
53235	Removal of urethra lesion		1,130.77	3	510.00		102.00
53240	Surgery for urethra pouch		1,784.13	2	446.00		89.20
53250	Removal of urethra gland		1,130.77	2	446.00		89.20
53260	Treatment of urethra lesion		1,130.77	2	446.00		89.20
53265	Treatment of urethra lesion		1,130.77	2	446.00		89.20
53270	Removal of urethra gland		1,130.77	2	446.00		89.20
53275	Repair of urethra defect		1,130.77	2	446.00		89.20
53400	Revise urethra, stage 1		1,784.13	3	510.00		102.00
53405	Revise urethra, stage 2		1,784.13	2	446.00		89.20
53410	Reconstruction of urethra		1,784.13	2	446.00		89.20

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
53420	Reconstruct urethra, stage 1		1,784.13	3	510.00		102.00
53425	Reconstruct urethra, stage 2		1,784.13	2	446.00		89.20
53430	Reconstruction of urethra		1,784.13	2	446.00		89.20
53431	Reconstruct urethra/bladder		1,784.13	2	446.00		89.20
53440	Male sling procedure		4,868.83	2	446.00		89.20
53442	Remove/revise male sling		1,784.13	1	333.00		66.60
53444	Insert tandem cuff		4,868.83	2	446.00		89.20
53445	Insert uro/ves nck sphincter		8,445.07	1	333.00		66.60
53446	Remove uro sphincter		1,784.13	1	333.00		66.60
53447	Remove/replace ur sphincter		8,445.07	1	333.00		66.60
53449	Repair uro sphincter		1,784.13	1	333.00		66.60
53450	Revision of urethra		1,784.13	1	333.00		66.60
53460	Revision of urethra		1,130.77	1	333.00		66.60
53502	Repair of urethra injury		1,130.77	2	446.00		89.20
53505	Repair of urethra injury		1,784.13	2	446.00		89.20
53510	Repair of urethra injury		1,130.77	2	446.00		89.20
53515	Repair of urethra injury		1,784.13	2	446.00		89.20
53520	Repair of urethra defect		1,784.13	2	446.00		89.20
53605	Dilate urethra stricture		1,181.73	2	446.00		89.20
53665	Dilation of urethra		1,130.77	1	333.00		66.60
54000	Slitting of prepuce		1,130.77	2	446.00		89.20
54001	Slitting of prepuce		1,130.77	2	446.00		89.20
54015	Drain penis lesion		1,076.22	4	630.00		126.00
54057	Laser surg, penis lesion(s)		1,072.14	1	333.00		66.60
54060	Excision of penis lesion(s)		1,072.14	1	333.00		66.60
54065	Destruction, penis lesion(s)		1,255.64	1	333.00		66.60
54100	Biopsy of penis		928.31	1	333.00		66.60
54105	Biopsy of penis		1,233.39	1	333.00		66.60
54110	Treatment of penis lesion		2,027.66	2	446.00		89.20
54111	Treat penis lesion, graft		2,027.66	2	446.00		89.20
54112	Treat penis lesion, graft		2,027.66	2	446.00		89.20
54115	Treatment of penis lesion		1,076.22	1	333.00		66.60
54120	Partial removal of penis		2,027.66	2	446.00		89.20
54150	Circumcision w/regionl block		1,263.25	1	333.00		66.60
54152	Circumcision		1,263.25	1	333.00		66.60
54160	Circumcision, neonate		1,263.25	2	446.00		89.20
54161	Circum 28 days or older		1,263.25	2	446.00		89.20
54162	Lysis penil circumic lesion		1,263.25	2	446.00		89.20
54163	Repair of circumcision		1,263.25	2	446.00		89.20
54164	Frenulotomy of penis		1,263.25	2	446.00		89.20
54205	Treatment of penis lesion		2,027.66	4	630.00		126.00
54220	Treatment of penis lesion		131.50	1	131.50	Y	26.30
54300	Revision of penis		2,027.66	3	510.00		102.00
54304	Revision of penis		2,027.66	3	510.00		102.00
54308	Reconstruction of urethra		2,027.66	3	510.00		102.00
54312	Reconstruction of urethra		2,027.66	3	510.00		102.00
54316	Reconstruction of urethra		2,027.66	3	510.00		102.00
54318	Reconstruction of urethra		2,027.66	3	510.00		102.00
54322	Reconstruction of urethra		2,027.66	3	510.00		102.00
54324	Reconstruction of urethra		2,027.66	3	510.00		102.00
54326	Reconstruction of urethra		2,027.66	3	510.00		102.00
54328	Revise penis/urethra		2,027.66	3	510.00		102.00
54340	Secondary urethral surgery		2,027.66	3	510.00		102.00
54344	Secondary urethral surgery		2,027.66	3	510.00		102.00
54348	Secondary urethral surgery		2,027.66	3	510.00		102.00
54352	Reconstruct urethra/penis		2,027.66	3	510.00		102.00
54360	Penis plastic surgery		2,027.66	3	510.00		102.00
54380	Repair penis		2,027.66	3	510.00		102.00
54385	Repair penis		2,027.66	3	510.00		102.00
54400	Insert semi-rigid prosthesis		4,868.83	3	510.00		102.00
54401	Insert self-contd prosthesis		8,445.07	3	510.00		102.00
54405	Insert multi-comp penis pros		8,445.07	3	510.00		102.00
54406	Remove muti-comp penis pros		2,027.66	3	510.00		102.00
54408	Repair multi-comp penis pros		2,027.66	3	510.00		102.00
54410	Remove/replace penis prosth		8,445.07	3	510.00		102.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
54415	Remove self-contd penis pros		2,027.66	3	510.00		102.00
54416	Remv/repl penis contain pros		8,445.07	3	510.00		102.00
54420	Revision of penis		2,027.66	4	630.00		126.00
54435	Revision of penis		2,027.66	4	630.00		126.00
54440	Repair of penis		2,027.66	4	630.00		126.00
54450	Preputial stretching		209.48	1	209.48	Y	41.90
54500	Biopsy of testis		631.00	1	333.00		66.60
54505	Biopsy of testis		1,446.40	1	333.00		66.60
54512	Excise lesion testis		1,446.40	2	446.00		89.20
54520	Removal of testis		1,446.40	3	510.00		102.00
54522	Orchiectomy, partial		1,446.40	3	510.00		102.00
54530	Removal of testis		1,795.98	4	630.00		126.00
54550	Exploration for testis		1,795.98	4	630.00		126.00
54600	Reduce testis torsion		1,446.40	4	630.00		126.00
54620	Suspension of testis		1,446.40	3	510.00		102.00
54640	Suspension of testis		1,795.98	4	630.00		126.00
54660	Revision of testis		1,446.40	2	446.00		89.20
54670	Repair testis injury		1,446.40	3	510.00		102.00
54680	Relocation of testis(es)		1,446.40	3	510.00		102.00
54690	Laparoscopy, orchiectomy		2,676.86	9	1,339.00		267.80
54700	Drainage of scrotum		1,446.40	2	446.00		89.20
54800	Biopsy of epididymis		127.16	1	127.16	Y	25.43
54820	Exploration of epididymis	D		1	333.00		
54830	Remove epididymis lesion		1,446.40	3	510.00		102.00
54840	Remove epididymis lesion		1,446.40	4	630.00		126.00
54860	Removal of epididymis		1,446.40	3	510.00		102.00
54861	Removal of epididymis		1,446.40	4	630.00		126.00
54865	Explore epididymis	A	1,446.40	1	333.00		66.60
54900	Fusion of spermatic ducts		1,446.40	4	630.00		126.00
54901	Fusion of spermatic ducts		1,446.40	4	630.00		126.00
55040	Removal of hydrocele		1,795.98	3	510.00		102.00
55041	Removal of hydroceles		1,795.98	5	717.00		143.40
55060	Repair of hydrocele		1,446.40	4	630.00		126.00
55100	Drainage of scrotum abscess		685.58	1	333.00		66.60
55110	Explore scrotum		1,446.40	2	446.00		89.20
55120	Removal of scrotum lesion		1,446.40	2	446.00		89.20
55150	Removal of scrotum		1,446.40	1	333.00		66.60
55175	Revision of scrotum		1,446.40	1	333.00		66.60
55180	Revision of scrotum		1,446.40	2	446.00		89.20
55200	Incision of sperm duct		1,446.40	2	446.00		89.20
55250	Removal of sperm duct(s)		1,446.40	2	446.00		89.20
55400	Repair of sperm duct		1,446.40	1	333.00		66.60
55500	Removal of hydrocele		1,446.40	3	510.00		102.00
55520	Removal of sperm cord lesion		1,446.40	4	630.00		126.00
55530	Revise spermatic cord veins		1,446.40	4	630.00		126.00
55535	Revise spermatic cord veins		1,795.98	4	630.00		126.00
55540	Revise hernia & sperm veins		1,795.98	5	717.00		143.40
55550	Laparo ligate spermatic vein		2,676.86	9	1,339.00		267.80
55680	Remove sperm pouch lesion		1,446.40	1	333.00		66.60
55700	Biopsy of prostate		345.83	2	345.83	Y	69.17
55705	Biopsy of prostate		345.83	2	345.83	Y	69.17
55720	Drainage of prostate abscess		1,467.24	1	333.00		66.60
55725	Drainage of prostate abscess		1,467.24	2	446.00		89.20
55859	Percut/needle insert, pros	D		9	1,339.00		
55873	Cryoablate prostate		6,685.05	9	1,339.00		267.80
55875	Transperi needle place, pros	A	2,146.84	9	1,339.00		267.80
56440	Surgery for vulva lesion		1,260.59	2	446.00		89.20
56441	Lysis of labial lesion(s)		912.73	1	333.00		66.60
56442	Hymenotomy	A	912.73	1	333.00		66.60
56515	Destroy vulva lesion/s compl		1,255.64	3	510.00		102.00
56620	Partial removal of vulva		1,752.42	5	717.00		143.40
56625	Complete removal of vulva		1,752.42	7	995.00		199.00
56700	Partial removal of hymen		1,260.59	1	333.00		66.60
56720	Incision of hymen	D		1	333.00		
56740	Remove vagina gland lesion		1,260.59	3	510.00		102.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
56800	Repair of vagina		1,260.59	3	510.00		102.00
56810	Repair of perineum		1,260.59	5	717.00		143.40
57000	Exploration of vagina		912.73	1	333.00		66.60
57010	Drainage of pelvic abscess		912.73	2	446.00		89.20
57020	Drainage of pelvic fluid		409.33	2	409.33	Y	81.87
57023	I & d vag hematoma, non-ob		1,076.22	1	333.00		66.60
57065	Destroy vag lesions, complex		1,260.59	1	333.00		66.60
57105	Biopsy of vagina		1,260.59	2	446.00		89.20
57130	Remove vagina lesion		1,260.59	2	446.00		89.20
57135	Remove vagina lesion		1,260.59	2	446.00		89.20
57155	Insert uteri tandems/ovoids		409.33	2	409.33	Y	81.87
57180	Treat vaginal bleeding		178.05	1	178.05	Y	35.61
57200	Repair of vagina		1,260.59	1	333.00		66.60
57210	Repair vagina/perineum		1,260.59	2	446.00		89.20
57220	Revision of urethra		2,642.48	3	510.00		102.00
57230	Repair of urethral lesion		1,752.42	3	510.00		102.00
57240	Repair bladder & vagina		1,752.42	5	717.00		143.40
57250	Repair rectum & vagina		1,752.42	5	717.00		143.40
57260	Repair of vagina		1,752.42	5	717.00		143.40
57265	Extensive repair of vagina		2,642.48	7	995.00		199.00
57267	Insert mesh/pelvic flr addon	A*	1,752.42	7	995.00		199.00
57268	Repair of bowel bulge		1,752.42	3	510.00		102.00
57288	Repair bladder defect		2,642.48	5	717.00		143.40
57289	Repair bladder & vagina		1,752.42	5	717.00		143.40
57291	Construction of vagina		1,752.42	5	717.00		143.40
57300	Repair rectum-vagina fistula		1,752.42	3	510.00		102.00
57400	Dilation of vagina		1,260.59	2	446.00		89.20
57410	Pelvic examination		912.73	2	446.00		89.20
57415	Remove vaginal foreign body		1,260.59	2	446.00		89.20
57513	Laser surgery of cervix		912.73	2	446.00		89.20
57520	Conization of cervix		1,260.59	2	446.00		89.20
57522	Conization of cervix		1,752.42	2	446.00		89.20
57530	Removal of cervix		1,752.42	3	510.00		102.00
57550	Removal of residual cervix		1,752.42	3	510.00		102.00
57556	Remove cervix, repair bowel		2,642.48	5	717.00		143.40
57558	D&c of cervical stump	A	1,091.05	3	510.00		102.00
57700	Revision of cervix		1,260.59	1	333.00		66.60
57720	Revision of cervix		1,260.59	3	510.00		102.00
57820	D & c of residual cervix	D		3	510.00		
58120	Dilation and curettage		1,091.05	2	446.00		89.20
58145	Myomectomy vag method		1,752.42	5	717.00		143.40
58346	Insert heyman uteri capsule		912.73	2	446.00		89.20
58350	Reopen fallopian tube		1,752.42	3	510.00		102.00
58353	Endometr ablate, thermal		1,752.42	7	995.00		199.00
58545	Laparoscopic myomectomy		1,974.60	9	1,339.00		267.80
58546	Laparo-myomectomy, complex		2,676.86	9	1,339.00		267.80
58550	Laparo-asst vag hysterectomy		4,333.90	9	1,339.00		267.80
58555	Hysteroscopy, dx, sep proc		1,312.87	1	333.00		66.60
58558	Hysteroscopy, biopsy		1,312.87	3	510.00		102.00
58559	Hysteroscopy, lysis		1,312.87	2	446.00		89.20
58560	Hysteroscopy, resect septum		2,090.86	3	510.00		102.00
58561	Hysteroscopy, remove myoma		2,090.86	3	510.00		102.00
58562	Hysteroscopy, remove fb		1,312.87	3	510.00		102.00
58563	Hysteroscopy, ablation		2,090.86	9	1,339.00		267.80
58565	Hysteroscopy, sterilization		2,642.48	9	1,339.00		267.80
58660	Laparoscopy, lysis		2,676.86	5	717.00		143.40
58661	Laparoscopy, remove adnexa		2,676.86	5	717.00		143.40
58662	Laparoscopy, excise lesions		2,676.86	5	717.00		143.40
58670	Laparoscopy, tubal cautery		2,676.86	3	510.00		102.00
58671	Laparoscopy, tubal block		2,676.86	3	510.00		102.00
58672	Laparoscopy, fimbrioplasty		2,676.86	5	717.00		143.40
58673	Laparoscopy, salpingostomy		2,676.86	5	717.00		143.40
58800	Drainage of ovarian cyst(s)		912.73	3	510.00		102.00
58820	Drain ovary abscess, open		1,752.42	3	510.00		102.00
58900	Biopsy of ovary(s)		912.73	3	510.00		102.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
58970	Retrieval of oocyte		245.92	1	245.92	Y	49.18
58974	Transfer of embryo		245.92	1	245.92	Y	49.18
58976	Transfer of embryo		245.92	1	245.92	Y	49.18
59160	D& c after delivery		1,091.05	3	510.00		102.00
59320	Revision of cervix		1,260.59	1	333.00		66.60
59812	Treatment of miscarriage		1,138.39	5	717.00		143.40
59820	Care of miscarriage		1,138.39	5	717.00		143.40
59821	Treatment of miscarriage		1,138.39	5	717.00		143.40
59840	Abortion		1,040.83	5	717.00		143.40
59841	Abortion		1,040.83	5	717.00		143.40
59870	Evacuate mole of uterus		1,138.39	5	717.00		143.40
59871	Remove cerclage suture		1,260.59	5	717.00		143.40
60000	Drain thyroid/tongue cyst		464.15	1	333.00		66.60
60200	Remove thyroid lesion		2,318.72	2	446.00		89.20
60280	Remove thyroid duct lesion		2,318.72	4	630.00		126.00
60281	Remove thyroid duct lesion		2,318.72	4	630.00		126.00
61020	Remove brain cavity fluid		183.83	1	183.83	Y	36.77
61026	Injection into brain canal		183.83	1	183.83	Y	36.77
61050	Remove brain canal fluid		183.83	1	183.83	Y	36.77
61055	Injection into brain canal		183.83	1	183.83	Y	36.77
61070	Brain canal shunt procedure		183.83	1	183.83	Y	36.77
61215	Insert brain-fluid device		2,891.10	3	510.00		102.00
61790	Treat trigeminal nerve		1,097.20	3	510.00		102.00
61791	Treat trigeminal tract		351.92	3	351.92	Y	70.38
61795	Brain surgery using computer	A*	302.04	1	302.04	Y	60.41
61885	Insrt/redo neurostim 1 array		11,518.00	2	446.00		89.20
61886	Implant neurostim arrays		14,932.81	3	510.00		102.00
61888	Revise/remove neuroreceiver		2,186.43	1	333.00		66.60
62194	Replace/irrigate catheter		716.56	1	333.00		66.60
62225	Replace/irrigate catheter		716.56	1	333.00		66.60
62230	Replace/revise brain shunt		2,891.10	2	446.00		89.20
62263	Epidural lysis mult sessions		748.08	1	333.00		66.60
62264	Epidural lysis on single day		748.08	1	333.00		66.60
62268	Drain spinal cord cyst		183.83	1	183.83	Y	36.77
62269	Needle biopsy, spinal cord		377.32	1	333.00		66.60
62270	Spinal fluid tap, diagnostic		139.00	1	139.00	Y	27.80
62272	Drain cerebro spinal fluid		139.00	1	139.00	Y	27.80
62273	Inject epidural patch		351.92	1	333.00		66.60
62280	Treat spinal cord lesion		390.95	1	333.00		66.60
62281	Treat spinal cord lesion		390.95	1	333.00		66.60
62282	Treat spinal canal lesion		390.95	1	333.00		66.60
62287	Percutaneous diskectomy		2,037.79	9	1,339.00		267.80
62294	Injection into spinal artery		183.83	3	183.83	Y	36.77
62310	Inject spine c/t		390.95	1	333.00		66.60
62311	Inject spine l/s (cd)		390.95	1	333.00		66.60
62318	Inject spine w/cath, c/t		390.95	1	333.00		66.60
62319	Inject spine w/cath l/s (cd)		390.95	1	333.00		66.60
62350	Implant spinal canal cath		1,895.64	2	446.00		89.20
62355	Remove spinal canal catheter		748.08	2	446.00		89.20
62360	Insert spine infusion device		6,923.28	2	446.00		89.20
62361	Implant spine infusion pump		10,720.36	2	446.00		89.20
62362	Implant spine infusion pump		10,720.36	2	446.00		89.20
62365	Remove spine infusion device		2,037.79	2	446.00		89.20
63600	Remove spinal cord lesion		1,097.20	2	446.00		89.20
63610	Stimulation of spinal cord		1,097.20	1	333.00		66.60
63650	Implant neuroelectrodes		3,477.28	2	446.00		89.20
63660	Revise/remove neuroelectrode		1,096.18	1	333.00		66.60
63685	Insrt/redo spine n generator		11,164.12	2	446.00		89.20
63688	Revise/remove neuroreceiver		2,186.43	1	333.00		66.60
63744	Revision of spinal shunt		2,413.44	3	510.00		102.00
63746	Removal of spinal shunt		675.64	2	446.00		89.20
64410	Nblock inj, phrenic		351.92	1	333.00		66.60
64415	Nblock inj, brachial plexus		139.00	1	139.00	Y	27.80
64417	Nblock inj, axillary		139.00	1	139.00	Y	27.80
64420	Nblock inj, intercost, sng		139.00	1	139.00	Y	27.80

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
64421	Nblock inj, intercost, mlt		351.92	1	333.00		66.60
64430	Nblock inj, pudendal		139.00	1	139.00	Y	27.80
64470	Inj paravertebral c/t		390.95	1	333.00		66.60
64472	Inj paravertebral c/t add-on		351.92	1	333.00		66.60
64475	Inj paravertebral l/s		390.95	1	333.00		66.60
64476	Inj paravertebral l/s add-on		351.92	1	333.00		66.60
64479	Inj foramen epidural c/t		390.95	1	333.00		66.60
64480	Inj foramen epidural add-on		390.95	1	333.00		66.60
64483	Inj foramen epidural l/s		390.95	1	333.00		66.60
64484	Inj foramen epidural add-on		390.95	1	333.00		66.60
64510	Nblock, stellate ganglion		390.95	1	333.00		66.60
64517	Nblock inj, hypogas plxs		139.00	2	139.00	Y	27.80
64520	Nblock, lumbar/thoracic		390.95	1	333.00		66.60
64530	Nblock inj, celiac pelus		390.95	1	333.00		66.60
64553	Implant neuroelectrodes		13,593.72	1	333.00		66.60
64561	Implant neuroelectrodes		3,477.28	3	510.00		102.00
64573	Implant neuroelectrodes		13,593.72	1	333.00		66.60
64575	Implant neuroelectrodes		5,175.40	1	333.00		66.60
64577	Implant neuroelectrodes		5,175.40	1	333.00		66.60
64580	Implant neuroelectrodes		5,175.40	1	333.00		66.60
64581	Implant neuroelectrodes		5,175.40	3	510.00		102.00
64585	Revise/remove neuroelectrode		1,096.18	1	333.00		66.60
64590	Insrt/redo pn/gastr stimul		11,164.12	2	446.00		89.20
64595	Revise/rmv pn/gastr stimul		2,186.43	1	333.00		66.60
64600	Injection treatment of nerve		748.08	1	333.00		66.60
64605	Injection treatment of nerve		748.08	1	333.00		66.60
64610	Injection treatment of nerve		748.08	1	333.00		66.60
64620	Injection treatment of nerve		748.08	1	333.00		66.60
64622	Destr paravertebrl nerve l/s		748.08	1	333.00		66.60
64623	Destr paravertebral n add-on		390.95	1	333.00		66.60
64626	Destr paravertebrl nerve c/t		748.08	1	333.00		66.60
64627	Destr paravertebral n add-on		390.95	1	333.00		66.60
64630	Injection treatment of nerve		351.92	2	351.92	Y	70.38
64680	Injection treatment of nerve		390.95	2	390.95	Y	78.19
64681	Injection treatment of nerve		748.08	2	446.00		89.20
64702	Revise finger/toe nerve		1,097.20	1	333.00		66.60
64704	Revise hand/foot nerve		1,097.20	1	333.00		66.60
64708	Revise arm/leg nerve		1,097.20	2	446.00		89.20
64712	Revision of sciatic nerve		1,097.20	2	446.00		89.20
64713	Revision of arm nerve(s)		1,097.20	2	446.00		89.20
64714	Revise low back nerve(s)		1,097.20	2	446.00		89.20
64716	Revision of cranial nerve		1,097.20	3	510.00		102.00
64718	Revise ulnar nerve at elbow		1,097.20	2	446.00		89.20
64719	Revise ulnar nerve at wrist		1,097.20	2	446.00		89.20
64721	Carpal tunnel surgery		1,097.20	2	446.00		89.20
64722	Relieve pressure on nerve(s)		1,097.20	1	333.00		66.60
64726	Release foot/toe nerve		1,097.20	1	333.00		66.60
64727	Internal nerve revision		1,097.20	1	333.00		66.60
64732	Incision of brow nerve		1,097.20	2	446.00		89.20
64734	Incision of cheek nerve		1,097.20	2	446.00		89.20
64736	Incision of chin nerve		1,097.20	2	446.00		89.20
64738	Incision of jaw nerve		1,097.20	2	446.00		89.20
64740	Incision of tongue nerve		1,097.20	2	446.00		89.20
64742	Incision of facial nerve		1,097.20	2	446.00		89.20
64744	Incise nerve, back of head		1,097.20	2	446.00		89.20
64746	Incise diaphragm nerve		1,097.20	2	446.00		89.20
64771	Sever cranial nerve		1,097.20	2	446.00		89.20
64772	Incision of spinal nerve		1,097.20	2	446.00		89.20
64774	Remove skin nerve lesion		1,097.20	2	446.00		89.20
64776	Remove digit nerve lesion		1,097.20	3	510.00		102.00
64778	Digit nerve surgery add-on		1,097.20	2	446.00		89.20
64782	Remove limb nerve lesion		1,097.20	3	510.00		102.00
64783	Limb nerve surgery add-on		1,097.20	2	446.00		89.20
64784	Remove nerve lesion		1,097.20	3	510.00		102.00
64786	Remove sciatic nerve lesion		2,037.79	3	510.00		102.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
64787	Implant nerve end		1,097.20	2	446.00		89.20
64788	Remove skin nerve lesion		1,097.20	3	510.00		102.00
64790	Removal of nerve lesion		1,097.20	3	510.00		102.00
64792	Removal of nerve lesion		2,037.79	3	510.00		102.00
64795	Biopsy of nerve		1,097.20	2	446.00		89.20
64802	Remove sympathetic nerves		1,097.20	2	446.00		89.20
64821	Remove sympathetic nerves		1,590.53	4	630.00		126.00
64831	Repair of digit nerve		2,037.79	4	630.00		126.00
64832	Repair nerve add-on		2,037.79	1	333.00		66.60
64834	Repair of hand or foot nerve		2,037.79	2	446.00		89.20
64835	Repair of hand or foot nerve		2,037.79	3	510.00		102.00
64836	Repair of hand or foot nerve		2,037.79	3	510.00		102.00
64837	Repair nerve add-on		2,037.79	1	333.00		66.60
64840	Repair of leg nerve		2,037.79	2	446.00		89.20
64856	Repair/transpose nerve		2,037.79	2	446.00		89.20
64857	Repair arm/leg nerve		2,037.79	2	446.00		89.20
64858	Repair sciatic nerve		2,037.79	2	446.00		89.20
64859	Nerve surgery		2,037.79	1	333.00		66.60
64861	Repair of arm nerves		2,037.79	3	510.00		102.00
64862	Repair of low back nerves		2,037.79	3	510.00		102.00
64864	Repair of facial nerve		2,037.79	3	510.00		102.00
64865	Repair of facial nerve		2,037.79	4	630.00		126.00
64870	Fusion of facial/other nerve		2,037.79	4	630.00		126.00
64872	Subsequent repair of nerve		2,037.79	2	446.00		89.20
64874	Repair & revise nerve add-on		2,037.79	3	510.00		102.00
64876	Repair nerve/shorten bone		2,037.79	3	510.00		102.00
64885	Nerve graft, head or neck		2,037.79	2	446.00		89.20
64886	Nerve graft, head or neck		2,037.79	2	446.00		89.20
64890	Nerve graft, hand or foot		2,037.79	2	446.00		89.20
64891	Nerve graft, hand or foot		2,037.79	2	446.00		89.20
64892	Nerve graft, arm or leg		2,037.79	2	446.00		89.20
64893	Nerve graft, arm or leg		2,037.79	2	446.00		89.20
64895	Nerve graft, hand or foot		2,037.79	3	510.00		102.00
64896	Nerve graft, hand or foot		2,037.79	3	510.00		102.00
64897	Nerve graft, arm or leg		2,037.79	3	510.00		102.00
64898	Nerve graft, arm or leg		2,037.79	3	510.00		102.00
64901	Nerve graft add-on		2,037.79	2	446.00		89.20
64902	Nerve graft add-on		2,037.79	2	446.00		89.20
64905	Nerve pedicle transfer		2,037.79	2	446.00		89.20
64907	Nerve pedicle transfer		2,037.79	1	333.00		66.60
65091	Revise eye		2,165.47	3	510.00		102.00
65093	Revise eye with implant		2,165.47	3	510.00		102.00
65101	Removal of eye		2,165.47	3	510.00		102.00
65103	Remove eye/insert implant		2,165.47	3	510.00		102.00
65105	Remove eye/attach implant		2,165.47	4	630.00		126.00
65110	Removal of eye		2,165.47	5	717.00		143.40
65112	Remove eye/revise socket		2,165.47	7	995.00		199.00
65114	Remove eye/revise socket		2,165.47	7	995.00		199.00
65130	Insert ocular implant		1,552.37	3	510.00		102.00
65135	Insert ocular implant		1,552.37	2	446.00		89.20
65140	Attach ocular implant		2,165.47	3	510.00		102.00
65150	Revise ocular implant		1,552.37	2	446.00		89.20
65155	Reinsert ocular implant		2,165.47	3	510.00		102.00
65175	Removal of ocular implant		1,052.60	1	333.00		66.60
65235	Remove foreign body from eye		935.91	2	446.00		89.20
65260	Remove foreign body from eye		1,015.69	3	510.00		102.00
65265	Remove foreign body from eye		1,696.64	4	630.00		126.00
65270	Repair of eye wound		1,052.60	2	446.00		89.20
65272	Repair of eye wound		1,413.58	2	446.00		89.20
65275	Repair of eye wound		1,413.58	4	630.00		126.00
65280	Repair of eye wound		1,015.69	4	630.00		126.00
65285	Repair of eye wound		2,300.69	4	630.00		126.00
65290	Repair of eye socket wound		1,308.05	3	510.00		102.00
65400	Removal of eye lesion		935.91	1	333.00		66.60
65410	Biopsy of cornea		935.91	2	446.00		89.20

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
65420	Removal of eye lesion		935.91	2	446.00		89.20
65426	Removal of eye lesion		1,413.58	5	717.00		143.40
65710	Corneal transplant		2,352.42	7	995.00		199.00
65730	Corneal transplant		2,352.42	7	995.00		199.00
65750	Corneal transplant		2,352.42	7	995.00		199.00
65755	Corneal transplant		2,352.42	7	995.00		199.00
65770	Revise cornea with implant		3,195.68	7	995.00		199.00
65772	Correction of astigmatism		935.91	4	630.00		126.00
65775	Correction of astigmatism		935.91	4	630.00		126.00
65780	Ocular reconst, transplant		2,352.42	5	717.00		143.40
65781	Ocular reconst, transplant		2,352.42	5	717.00		143.40
65782	Ocular reconst, transplant		2,352.42	5	717.00		143.40
65800	Drainage of eye		935.91	1	333.00		66.60
65805	Drainage of eye		935.91	1	333.00		66.60
65810	Drainage of eye		1,413.58	3	510.00		102.00
65815	Drainage of eye		1,413.58	2	446.00		89.20
65820	Relieve inner eye pressure		372.94	1	333.00		66.60
65850	Incision of eye		1,413.58	4	630.00		126.00
65865	Incise inner eye adhesions		935.91	1	333.00		66.60
65870	Incise inner eye adhesions		1,413.58	4	630.00		126.00
65875	Incise inner eye adhesions		1,413.58	4	630.00		126.00
65880	Incise inner eye adhesions		935.91	4	630.00		126.00
65900	Remove eye lesion		935.91	5	717.00		143.40
65920	Remove implant of eye		1,413.58	7	995.00		199.00
65930	Remove blood clot from eye		1,413.58	5	717.00		143.40
66020	Injection treatment of eye		935.91	1	333.00		66.60
66030	Injection treatment of eye		372.94	1	333.00		66.60
66130	Remove eye lesion		1,413.58	7	995.00		199.00
66150	Glaucoma surgery		1,413.58	4	630.00		126.00
66155	Glaucoma surgery		1,413.58	4	630.00		126.00
66160	Glaucoma surgery		1,413.58	2	446.00		89.20
66165	Glaucoma surgery		1,413.58	4	630.00		126.00
66170	Glaucoma surgery		1,413.58	4	630.00		126.00
66172	Incision of eye		1,413.58	4	630.00		126.00
66180	Implant eye shunt		2,329.43	5	717.00		143.40
66185	Revise eye shunt		2,329.43	2	446.00		89.20
66220	Repair eye lesion		2,300.69	3	510.00		102.00
66225	Repair/graft eye lesion		2,329.43	4	630.00		126.00
66250	Follow-up surgery of eye		935.91	2	446.00		89.20
66500	Incision of iris		372.94	1	333.00		66.60
66505	Incision of iris		372.94	1	333.00		66.60
66600	Remove iris and lesion		1,413.58	3	510.00		102.00
66605	Removal of iris		1,413.58	3	510.00		102.00
66625	Removal of iris		372.94	3	372.94	Y	74.59
66630	Removal of iris		1,413.58	3	510.00		102.00
66635	Removal of iris		1,413.58	3	510.00		102.00
66680	Repair iris & ciliary body		1,413.58	3	510.00		102.00
66682	Repair iris & ciliary body		1,413.58	2	446.00		89.20
66700	Destruction, ciliary body		935.91	2	446.00		89.20
66710	Ciliary transsleral therapy		935.91	2	446.00		89.20
66711	Ciliary endoscopic ablation		935.91	2	446.00		89.20
66720	Destruction, ciliary body		935.91	2	446.00		89.20
66740	Destruction, ciliary body		1,413.58	2	446.00		89.20
66821	After cataract laser surgery		312.50	2	312.50	Y	62.50
66825	Reposition intraocular lens		1,413.58	4	630.00		126.00
66830	Removal of lens lesion		372.94	4	372.94	Y	74.59
66840	Removal of lens material		914.04	4	630.00		126.00
66850	Removal of lens material		1,796.59	7	995.00		199.00
66852	Removal of lens material		1,796.59	4	630.00		126.00
66920	Extraction of lens		1,796.59	4	630.00		126.00
66930	Extraction of lens		1,796.59	5	717.00		143.40
66940	Extraction of lens		914.04	5	717.00		143.40
66982	Cataract surgery, complex		1,452.57	8	973.00		194.60
66983	Cataract surg w/iol, 1 stage		1,452.57	8	973.00		194.60
66984	Cataract surg w/iol, 1 stage		1,452.57	8	973.00		194.60

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
66985	Insert lens prosthesis		1,452.57	6	826.00		165.20
66986	Exchange lens prosthesis		1,452.57	6	826.00		165.20
67005	Partial removal of eye fluid		1,696.64	4	630.00		126.00
67010	Partial removal of eye fluid		1,696.64	4	630.00		126.00
67015	Release of eye fluid		1,696.64	1	333.00		66.60
67025	Replace eye fluid		1,696.64	1	333.00		66.60
67027	Implant eye drug system		2,300.69	4	630.00		126.00
67030	Incise inner eye strands		1,015.69	1	333.00		66.60
67031	Laser surgery, eye strands		312.50	2	312.50	Y	62.50
67036	Removal of inner eye fluid		2,300.69	4	630.00		126.00
67038	Strip retinal membrane		2,300.69	5	717.00		143.40
67039	Laser treatment of retina		2,300.69	7	995.00		199.00
67040	Laser treatment of retina		2,300.69	7	995.00		199.00
67107	Repair detached retina		2,300.69	5	717.00		143.40
67108	Repair detached retina		2,300.69	7	995.00		199.00
67112	Rerepair detached retina		2,300.69	7	995.00		199.00
67115	Release encircling material		1,015.69	2	446.00		89.20
67120	Remove eye implant material		1,015.69	2	446.00		89.20
67121	Remove eye implant material		1,696.64	2	446.00		89.20
67141	Treatment of retina		241.77	2	241.77	Y	48.35
67218	Treatment of retinal lesion		1,015.69	5	717.00		143.40
67227	Treatment of retinal lesion		1,696.64	1	333.00		66.60
67250	Reinforce eye wall		1,052.60	3	510.00		102.00
67255	Reinforce/graft eye wall		1,696.64	3	510.00		102.00
67311	Revise eye muscle		1,308.05	3	510.00		102.00
67312	Revise two eye muscles		1,308.05	4	630.00		126.00
67314	Revise eye muscle		1,308.05	4	630.00		126.00
67316	Revise two eye muscles		1,308.05	4	630.00		126.00
67318	Revise eye muscle(s)		1,308.05	4	630.00		126.00
67320	Revise eye muscle(s) add-on		1,308.05	4	630.00		126.00
67331	Eye surgery follow-up add-on		1,308.05	4	630.00		126.00
67332	Rerevise eye muscles add-on		1,308.05	4	630.00		126.00
67334	Revise eye muscle w/suture		1,308.05	4	630.00		126.00
67335	Eye suture during surgery		1,308.05	4	630.00		126.00
67340	Revise eye muscle add-on		1,308.05	4	630.00		126.00
67343	Release eye tissue		1,308.05	7	995.00		199.00
67346	Biopsy, eye muscle	A	884.19	1	333.00		66.60
67350	Biopsy eye muscle	D		1	333.00		
67400	Explore/biopsy eye socket		1,552.37	3	510.00		102.00
67405	Explore/drain eye socket		1,552.37	4	630.00		126.00
67412	Explore/treat eye socket		1,552.37	5	717.00		143.40
67413	Explore/treat eye socket		1,552.37	5	717.00		143.40
67415	Aspiration, orbital contents		1,052.60	1	333.00		66.60
67420	Explore/treat eye socket		2,165.47	5	717.00		143.40
67430	Explore/treat eye socket		2,165.47	5	717.00		143.40
67440	Explore/drain eye socket		2,165.47	5	717.00		143.40
67445	Explr/decompress eye socket		2,165.47	5	717.00		143.40
67450	Explore/biopsy eye socket		2,165.47	5	717.00		143.40
67550	Insert eye socket implant		2,165.47	4	630.00		126.00
67560	Revise eye socket implant		1,552.37	2	446.00		89.20
67570	Decompress optic nerve		2,165.47	4	630.00		126.00
67715	Incision of eyelid fold		1,052.60	1	333.00		66.60
67808	Remove eyelid lesion(s)		1,052.60	2	446.00		89.20
67830	Revise eyelashes		447.60	2	446.00		89.20
67835	Revise eyelashes		1,052.60	2	446.00		89.20
67880	Revision of eyelid		935.91	3	510.00		102.00
67882	Revision of eyelid		1,052.60	3	510.00		102.00
67900	Repair brow defect		1,052.60	4	630.00		126.00
67901	Repair eyelid defect		1,052.60	5	717.00		143.40
67902	Repair eyelid defect		1,052.60	5	717.00		143.40
67903	Repair eyelid defect		1,052.60	4	630.00		126.00
67904	Repair eyelid defect		1,052.60	4	630.00		126.00
67906	Repair eyelid defect		1,052.60	5	717.00		143.40
67908	Repair eyelid defect		1,052.60	4	630.00		126.00
67909	Revise eyelid defect		1,052.60	4	630.00		126.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
67911	Revise eyelid defect		1,052.60	3	510.00		102.00
67912	Correction eyelid w/implant		1,052.60	3	510.00		102.00
67914	Repair eyelid defect		1,052.60	3	510.00		102.00
67916	Repair eyelid defect		1,052.60	4	630.00		126.00
67917	Repair eyelid defect		1,052.60	4	630.00		126.00
67921	Repair eyelid defect		1,052.60	3	510.00		102.00
67923	Repair eyelid defect		1,052.60	4	630.00		126.00
67924	Repair eyelid defect		1,052.60	4	630.00		126.00
67935	Repair eyelid wound		1,052.60	2	446.00		89.20
67950	Revision of eyelid		1,052.60	2	446.00		89.20
67961	Revision of eyelid		1,052.60	3	510.00		102.00
67966	Revision of eyelid		1,052.60	3	510.00		102.00
67971	Reconstruction of eyelid		1,552.37	3	510.00		102.00
67973	Reconstruction of eyelid		1,552.37	3	510.00		102.00
67974	Reconstruction of eyelid		1,552.37	3	510.00		102.00
67975	Reconstruction of eyelid		1,052.60	3	510.00		102.00
68115	Remove eyelid lining lesion		1,052.60	2	446.00		89.20
68130	Remove eyelid lining lesion		935.91	2	446.00		89.20
68320	Revise/graft eyelid lining		1,052.60	4	630.00		126.00
68325	Revise/graft eyelid lining		1,552.37	4	630.00		126.00
68326	Revise/graft eyelid lining		1,552.37	4	630.00		126.00
68328	Revise/graft eyelid lining		1,552.37	4	630.00		126.00
68330	Revise eyelid lining		1,413.58	4	630.00		126.00
68335	Revise/graft eyelid lining		1,552.37	4	630.00		126.00
68340	Separate eyelid adhesions		1,052.60	4	630.00		126.00
68360	Revise eyelid lining		1,413.58	2	446.00		89.20
68362	Revise eyelid lining		1,413.58	2	446.00		89.20
68371	Harvest eye tissue, alograft		935.91	2	446.00		89.20
68500	Removal of tear gland		1,552.37	3	510.00		102.00
68505	Partial removal, tear gland		1,552.37	3	510.00		102.00
68510	Biopsy of tear gland		1,052.60	1	333.00		66.60
68520	Removal of tear sac		1,552.37	3	510.00		102.00
68525	Biopsy of tear sac		1,052.60	1	333.00		66.60
68540	Remove tear gland lesion		1,552.37	3	510.00		102.00
68550	Remove tear gland lesion		1,552.37	3	510.00		102.00
68700	Repair tear ducts		1,552.37	2	446.00		89.20
68720	Create tear sac drain		1,552.37	4	630.00		126.00
68745	Create tear duct drain		1,552.37	4	630.00		126.00
68750	Create tear duct drain		1,552.37	4	630.00		126.00
68770	Close tear system fistula		1,052.60	4	630.00		126.00
68810	Probe nasolacrimal duct		131.86	1	131.86	Y	26.37
68811	Probe nasolacrimal duct		1,052.60	2	446.00		89.20
68815	Probe nasolacrimal duct		1,052.60	2	446.00		89.20
69110	Remove external ear, partial		928.31	1	333.00		66.60
69120	Removal of external ear		1,434.04	2	446.00		89.20
69140	Remove ear canal lesion(s)		1,434.04	2	446.00		89.20
69145	Remove ear canal lesion(s)		928.31	2	446.00		89.20
69150	Extensive ear canal surgery		464.15	3	464.15	Y	92.83
69205	Clear outer ear canal		1,233.39	1	333.00		66.60
69300	Revise external ear		1,434.04	3	510.00		102.00
69310	Rebuild outer ear canal		2,348.02	3	510.00		102.00
69320	Rebuild outer ear canal		2,348.02	7	995.00		199.00
69421	Incision of eardrum		1,009.71	3	510.00		102.00
69436	Create eardrum opening		1,009.71	3	510.00		102.00
69440	Exploration of middle ear		1,434.04	3	510.00		102.00
69450	Eardrum revision		2,348.02	1	333.00		66.60
69501	Mastoidectomy		2,348.02	7	995.00		199.00
69502	Mastoidectomy		1,434.04	7	995.00		199.00
69505	Remove mastoid structures		2,348.02	7	995.00		199.00
69511	Extensive mastoid surgery		2,348.02	7	995.00		199.00
69530	Extensive mastoid surgery		2,348.02	7	995.00		199.00
69550	Remove ear lesion		2,348.02	5	717.00		143.40
69552	Remove ear lesion		2,348.02	7	995.00		199.00
69601	Mastoid surgery revision		2,348.02	7	995.00		199.00
69602	Mastoid surgery revision		2,348.02	7	995.00		199.00

ADDENDUM AA.—LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES, INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DEFICIT REDUCTION ACT OF 2005—Continued

HCPCS	Short descriptor	A*=new to list; 2007 CPT Changes: A=Add D=Delete	OPPS payment rate ($)	ASC payment group	ASC payment rate ($)	DRA cap	ASC copayment amount ($)
69603	Mastoid surgery revision		2,348.02	7	995.00		199.00
69604	Mastoid surgery revision		2,348.02	7	995.00		199.00
69605	Mastoid surgery revision		2,348.02	7	995.00		199.00
69620	Repair of eardrum		1,434.04	2	446.00		89.20
69631	Repair eardrum structures		2,348.02	5	717.00		143.40
69632	Rebuild eardrum structures		2,348.02	5	717.00		143.40
69633	Rebuild eardrum structures		2,348.02	5	717.00		143.40
69635	Repair eardrum structures		2,348.02	7	995.00		199.00
69636	Rebuild eardrum structures		2,348.02	7	995.00		199.00
69637	Rebuild eardrum structures		2,348.02	7	995.00		199.00
69641	Revise middle ear & mastoid		2,348.02	7	995.00		199.00
69642	Revise middle ear & mastoid		2,348.02	7	995.00		199.00
69643	Revise middle ear & mastoid		2,348.02	7	995.00		199.00
69644	Revise middle ear & mastoid		2,348.02	7	995.00		199.00
69645	Revise middle ear & mastoid		2,348.02	7	995.00		199.00
69646	Revise middle ear & mastoid		2,348.02	7	995.00		199.00
69650	Release middle ear bone		1,434.04	7	995.00		199.00
69660	Revise middle ear bone		2,348.02	5	717.00		143.40
69661	Revise middle ear bone		2,348.02	5	717.00		143.40
69662	Revise middle ear bone		2,348.02	5	717.00		143.40
69666	Repair middle ear structures		2,348.02	4	630.00		126.00
69667	Repair middle ear structures		2,348.02	4	630.00		126.00
69670	Remove mastoid air cells		2,348.02	3	510.00		102.00
69676	Remove middle ear nerve		2,348.02	3	510.00		102.00
69700	Close mastoid fistula		2,348.02	3	510.00		102.00
69711	Remove/repair hearing aid		2,348.02	1	333.00		66.60
69714	Implant temple bone w/stimul		2,348.02	9	1,339.00		267.80
69715	Temple bne implnt w/stimulat		2,348.02	9	1,339.00		267.80
69717	Temple bone implant revision		2,348.02	9	1,339.00		267.80
69718	Revise temple bone implant		2,348.02	9	1,339.00		267.80
69720	Release facial nerve		2,348.02	5	717.00		143.40
69740	Repair facial nerve		2,348.02	5	717.00		143.40
69745	Repair facial nerve		2,348.02	5	717.00		143.40
69801	Incise inner ear		2,348.02	5	717.00		143.40
69802	Incise inner ear		2,348.02	7	995.00		199.00
69805	Explore inner ear		2,348.02	7	995.00		199.00
69806	Explore inner ear		2,348.02	7	995.00		199.00
69820	Establish inner ear window		2,348.02	5	717.00		143.40
69840	Revise inner ear window		2,348.02	5	717.00		143.40
69905	Remove inner ear		2,348.02	7	995.00		199.00
69910	Remove inner ear & mastoid		2,348.02	7	995.00		199.00
69915	Incise inner ear nerve		2,348.02	7	995.00		199.00
69930	Implant cochlear device		25,499.72	7	995.00		199.00
0176T	Aqu canal dilat w/o retent	A	2,329.43	9	1,339.00		267.80
0177T	Aqu canal dilat w retent	A	2,329.43	9	1,339.00		267.80
G0105	Colorectal scrn; hi risk ind		446.00	2	446.00		111.50
G0121	Colon ca scrn not hi rsk ind		446.00	2	446.00		111.50
G0260	Inj for sacroiliac jt anesth		351.92	1	333.00		66.60
G0392	AV fistula or graft arterial	A	2,624.19	9	1,339.00		334.75
G0393	AV fistula or graft venous	A	2,624.19	9	1,339.00		334.75

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00100	Anesth, salivary gland		N					
00102	Anesth, repair of cleft lip		N					
00103	Anesth, blepharoplasty		N					
00104	Anesth, electroshock		N					
00120	Anesth, ear surgery		N					
00124	Anesth, ear exam		N					
00126	Anesth, tympanotomy		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00140	Anesth, procedures on eye		N					
00142	Anesth, lens surgery		N					
00144	Anesth, corneal transplant		N					
00145	Anesth, vitreoretinal surg		N					
00147	Anesth, iridectomy		N					
00148	Anesth, eye exam		N					
00160	Anesth, nose/sinus surgery		N					
00162	Anesth, nose/sinus surgery		N					
00164	Anesth, biopsy of nose		N					
00170	Anesth, procedure on mouth		N					
00172	Anesth, cleft palate repair		N					
00174	Anesth, pharyngeal surgery		N					
00190	Anesth, face/skull bone surg		N					
00210	Anesth, open head surgery		N					
00212	Anesth, skull drainage		N					
00216	Anesth, head vessel surgery		N					
00218	Anesth, special head surgery		N					
00220	Anesth, intrcrn nerve		N					
00222	Anesth, head nerve surgery		N					
00300	Anesth, head/neck/ptrunk		N					
00320	Anesth, neck organ, 1 & over		N					
00322	Anesth, biopsy of thyroid		N					
00326	Anesth, larynx/trach, < 1 yr		N					
00350	Anesth, neck vessel surgery		N					
00352	Anesth, neck vessel surgery		N					
00400	Anesth, skin, ext/per/atrunk		N					
00402	Anesth, surgery of breast		N					
00404	Anesth, surgery of breast	CH	N					
00406	Anesth, surgery of breast	CH	N					
00410	Anesth, correct heart rhythm		N					
00450	Anesth, surgery of shoulder		N					
00454	Anesth, collar bone biopsy		N					
00470	Anesth, removal of rib		N					
00472	Anesth, chest wall repair		N					
00500	Anesth, esophageal surgery		N					
00520	Anesth, chest procedure		N					
00522	Anesth, chest lining biopsy		N					
00528	Anesth, chest partition view		N					
00529	Anesth, chest partition view		N					
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					
00541	Anesth, one lung ventilation		N					
00548	Anesth, trachea,bronchi surg		N					
00550	Anesth, sternal debridement		N					
00563	Anesth, heart surg w/arrest		N					
00566	Anesth, cabg w/o pump		N					
00600	Anesth, spine, cord surgery		N					
00620	Anesth, spine, cord surgery		N					
00625	Anes spine tranthor w/o vent	NI	N					
00626	Anes, spine transthor w/vent	NI	N					
00630	Anesth, spine, cord surgery		N					
00634	Anesth for chemonucleolysis		N					
00635	Anesth, lumbar puncture		N					
00640	Anesth, spine manipulation		N					
00700	Anesth, abdominal wall surg		N					
00702	Anesth, for liver biopsy		N					
00730	Anesth, abdominal wall surg		N					
00740	Anesth, upper gi visualize		N					
00750	Anesth, repair of hernia		N					
00752	Anesth, repair of hernia		N					
00754	Anesth, repair of hernia		N					
00756	Anesth, repair of hernia		N					
00770	Anesth, blood vessel repair		N					
00790	Anesth, surg upper abdomen		N					
00797	Anesth, surgery for obesity		N					
00800	Anesth, abdominal wall surg		N					
00810	Anesth, low intestine scope		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
00851	Anesth, tubal ligation		N					
00860	Anesth, surgery of abdomen		N					
00862	Anesth, kidney/ureter surg		N					
00870	Anesth, bladder stone surg		N					
00872	Anesth kidney stone destruct		N					
00873	Anesth kidney stone destruct		N					
00880	Anesth, abdomen vessel surg		N					
00902	Anesth, anorectal surgery		N					
00906	Anesth, removal of vulva		N					
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					
00930	Anesth, testis suspension		N					
00938	Anesth, insert penis device		N					
00940	Anesth, vaginal procedures		N					
00942	Anesth, surg on vag/urethral		N					
00948	Anesth, repair of cervix		N					
00950	Anesth, vaginal endoscopy		N					
00952	Anesth, hysteroscope/graph		N					
01112	Anesth, bone aspirate/bx		N					
01120	Anesth, pelvis surgery		N					
01130	Anesth, body cast procedure		N					
01160	Anesth, pelvis procedure		N					
01170	Anesth, pelvis surgery		N					
01173	Anesth, fx repair, pelvis		N					
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					
01215	Anesth, revise hip repair		N					
01220	Anesth, procedure on femur		N					
01230	Anesth, surgery of femur		N					
01250	Anesth, upper leg surgery		N					
01260	Anesth, upper leg veins surg		N					
01270	Anesth, thigh arteries surg		N					
01320	Anesth, knee area surgery		N					
01340	Anesth, knee area procedure		N					
01360	Anesth, knee area surgery		N					
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					
01420	Anesth, knee joint casting		N					
01430	Anesth, knee veins surgery		N					
01432	Anesth, knee vessel surg		N					
01440	Anesth, knee arteries surg		N					
01462	Anesth, lower leg procedure		N					
01464	Anesth, ankle/ft arthroscopy		N					
01470	Anesth, lower leg surgery		N					
01472	Anesth, achilles tendon surg		N					
01474	Anesth, lower leg surgery		N					
01480	Anesth, lower leg bone surg		N					
01482	Anesth, radical leg surgery		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01484	Anesth, lower leg revision		N					
01490	Anesth, lower leg casting		N					
01500	Anesth, leg arteries surg		N					
01520	Anesth, lower leg vein surg		N					
01522	Anesth, lower leg vein surg		N					
01610	Anesth, surgery of shoulder		N					
01620	Anesth, shoulder procedure		N					
01622	Anes dx shoulder arthroscopy		N					
01630	Anesth, surgery of shoulder		N					
01650	Anesth, shoulder artery surg		N					
01670	Anesth, shoulder vein surg		N					
01680	Anesth, shoulder casting		N					
01682	Anesth, airplane cast		N					
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					
01730	Anesth, uppr arm procedure		N					
01732	Anesth, dx elbow arthroscopy		N					
01740	Anesth, upper arm surgery		N					
01742	Anesth, humerus surgery		N					
01744	Anesth, humerus repair		N					
01758	Anesth, humeral lesion surg		N					
01760	Anesth, elbow replacement		N					
01770	Anesth, uppr arm artery surg		N					
01772	Anesth, uppr arm embolectomy		N					
01780	Anesth, upper arm vein surg		N					
01782	Anesth, uppr arm vein repair		N					
01810	Anesth, lower arm surgery		N					
01820	Anesth, lower arm procedure		N					
01829	Anesth, dx wrist arthroscopy		N					
01830	Anesth, lower arm surgery		N					
01832	Anesth, wrist replacement		N					
01840	Anesth, lwr arm artery surg		N					
01842	Anesth, lwr arm embolectomy		N					
01844	Anesth, vascular shunt surg		N					
01850	Anesth, lower arm vein surg		N					
01852	Anesth, lwr arm vein repair		N					
01860	Anesth, lower arm casting		N					
01905	Anes, spine inject, x-ray/re		N					
01916	Anesth, dx arteriography		N					
01920	Anesth, catheterize heart		N					
01922	Anesth, cat or MRI scan		N					
01924	Anes, ther interven rad, art		N					
01925	Anes, ther interven rad, car		N					
01926	Anes, tx interv rad hrt/cran		N					
01930	Anes, ther interven rad, vei		N					
01931	Anes, ther interven rad, tip		N					
01932	Anes, tx interv rad, th vein		N					
01933	Anes, tx interv rad, cran v		N					
01951	Anesth, burn, less 4 percent		N					
01952	Anesth, burn, 4–9 percent		N					
01953	Anesth, burn, each 9 percent		N					
01958	Anesth, antepartum manipul		N					
01960	Anesth, vaginal delivery		N					
01961	Anesth, cs delivery		N					
01962	Anesth, emer hysterectomy		N					
01963	Anesth, cs hysterectomy		N					
01965	Anesth, inc/missed ab proc		N					
01966	Anesth, induced ab procedure		N					
01967	Anesth/analg, vag delivery		N					
01968	Anes/analg cs deliver add-on		N					
01969	Anesth/analg cs hyst add-on		N					
01991	Anesth, nerve block/inj		N					
01992	Anesth, n block/inj, prone		N					
01995	Regional anesthesia limb	CH	D					
01996	Hosp manage cont drug admin		N					
01999	Unlisted anesth procedure		N					
10021	Fna w/o image		T	0002	1.0995	67.58		13.52
10022	Fna w/image		T	0036	2.0738	127.47		25.49

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
10040	Acne surgery		T	0010	0.476	29.26	8.02	5.85
10060	Drainage of skin abscess		T	0006	1.4392	88.46		17.69
10061	Drainage of skin abscess		T	0006	1.4392	88.46		17.69
10080	Drainage of pilonidal cyst		T	0006	1.4392	88.46		17.69
10081	Drainage of pilonidal cyst		T	0007	11.1535	685.58		137.12
10120	Remove foreign body		T	0006	1.4392	88.46		17.69
10121	Remove foreign body		T	0021	15.1024	928.31	219.48	185.66
10140	Drainage of hematoma/fluid		T	0007	11.1535	685.58		137.12
10160	Puncture drainage of lesion		T	0018	1.0259	63.06	15.44	12.61
10180	Complex drainage, wound		T	0008	17.5086	1,076.22		215.24
11000	Debride infected skin		T	0013	1.0918	67.11		13.42
11001	Debride infected skin add-on		T	0012	0.8432	51.83	11.18	10.37
11010	Debride skin, fx		T	0019	4.0919	251.52	71.87	50.30
11011	Debride skin/muscle, fx		T	0019	4.0919	251.52	71.87	50.30
11012	Debride skin/muscle/bone, fx		T	0019	4.0919	251.52	71.87	50.30
11040	Debride skin, partial		T	0015	1.6241	99.83	20.13	19.97
11041	Debride skin, full		T	0015	1.6241	99.83	20.13	19.97
11042	Debride skin/tissue		T	0016	2.6749	164.42		32.88
11043	Debride tissue/muscle		T	0016	2.6749	164.42		32.88
11044	Debride tissue/muscle/bone		T	0682	6.8832	423.10	158.65	84.62
11055	Trim skin lesion		T	0012	0.8432	51.83	11.18	10.37
11056	Trim skin lesions, 2 to 4		T	0012	0.8432	51.83	11.18	10.37
11057	Trim skin lesions, over 4		T	0013	1.0918	67.11		13.42
11100	Biopsy, skin lesion		T	0018	1.0259	63.06	15.44	12.61
11101	Biopsy, skin add-on		T	0018	1.0259	63.06	15.44	12.61
11200	Removal of skin tags		T	0013	1.0918	67.11		13.42
11201	Remove skin tags add-on		T	0015	1.6241	99.83	20.13	19.97
11300	Shave skin lesion		T	0012	0.8432	51.83	11.18	10.37
11301	Shave skin lesion		T	0012	0.8432	51.83	11.18	10.37
11302	Shave skin lesion		T	0013	1.0918	67.11		13.42
11303	Shave skin lesion		T	0015	1.6241	99.83	20.13	19.97
11305	Shave skin lesion		T	0013	1.0918	67.11		13.42
11306	Shave skin lesion		T	0013	1.0918	67.11		13.42
11307	Shave skin lesion		T	0013	1.0918	67.11		13.42
11308	Shave skin lesion		T	0013	1.0918	67.11		13.42
11310	Shave skin lesion		T	0013	1.0918	67.11		13.42
11311	Shave skin lesion		T	0013	1.0918	67.11		13.42
11312	Shave skin lesion		T	0013	1.0918	67.11		13.42
11313	Shave skin lesion		T	0016	2.6749	164.42		32.88
11400	Exc tr-ext b9+marg 0.5 < cm		T	0019	4.0919	251.52	71.87	50.30
11401	Exc tr-ext b9+marg 0.6–1 cm		T	0019	4.0919	251.52	71.87	50.30
11402	Exc tr-ext b9+marg 1.1–2 cm		T	0019	4.0919	251.52	71.87	50.30
11403	Exc tr-ext b9+marg 2.1–3 cm		T	0020	6.8083	418.49	107.67	83.70
11404	Exc tr-ext b9+marg 3.1–4 cm		T	0021	15.1024	928.31	219.48	185.66
11406	Exc tr-ext b9+marg > 4.0 cm		T	0021	15.1024	928.31	219.48	185.66
11420	Exc h-f-nk-sp b9+marg 0.5 <		T	0020	6.8083	418.49	107.67	83.70
11421	Exc h-f-nk-sp b9+marg 0.6–1		T	0020	6.8083	418.49	107.67	83.70
11422	Exc h-f-nk-sp b9+marg 1.1–2		T	0020	6.8083	418.49	107.67	83.70
11423	Exc h-f-nk-sp b9+marg 2.1–3		T	0021	15.1024	928.31	219.48	185.66
11424	Exc h-f-nk-sp b9+marg 3.1–4		T	0021	15.1024	928.31	219.48	185.66
11426	Exc h-f-nk-sp b9+marg > 4 cm		T	0022	20.0656	1,233.39	354.45	246.68
11440	Exc face-mm b9+marg 0.5 < cm		T	0019	4.0919	251.52	71.87	50.30
11441	Exc face-mm b9+marg 0.6–1 cm		T	0019	4.0919	251.52	71.87	50.30
11442	Exc face-mm b9+marg 1.1–2 cm		T	0020	6.8083	418.49	107.67	83.70
11443	Exc face-mm b9+marg 2.1–3 cm		T	0020	6.8083	418.49	107.67	83.70
11444	Exc face-mm b9+marg 3.1–4 cm		T	0020	6.8083	418.49	107.67	83.70
11446	Exc face-mm b9+marg > 4 cm		T	0022	20.0656	1,233.39	354.45	246.68
11450	Removal, sweat gland lesion		T	0022	20.0656	1,233.39	354.45	246.68
11451	Removal, sweat gland lesion		T	0022	20.0656	1,233.39	354.45	246.68
11462	Removal, sweat gland lesion		T	0022	20.0656	1,233.39	354.45	246.68
11463	Removal, sweat gland lesion		T	0022	20.0656	1,233.39	354.45	246.68
11470	Removal, sweat gland lesion		T	0022	20.0656	1,233.39	354.45	246.68
11471	Removal, sweat gland lesion		T	0022	20.0656	1,233.39	354.45	246.68
11600	Exc tr-ext mlg+marg 0.5 < cm		T	0019	4.0919	251.52	71.87	50.30
11601	Exc tr-ext mlg+marg 0.6–1 cm		T	0019	4.0919	251.52	71.87	50.30
11602	Exc tr-ext mlg+marg 1.1–2 cm		T	0019	4.0919	251.52	71.87	50.30
11603	Exc tr-ext mlg+marg 2.1–3 cm		T	0020	6.8083	418.49	107.67	83.70
11604	Exc tr-ext mlg+marg 3.1–4 cm		T	0020	6.8083	418.49	107.67	83.70
11606	Exc tr-ext mlg+marg > 4 cm		T	0021	15.1024	928.31	219.48	185.66
11620	Exc h-f-nk-sp mlg+marg 0.5 <		T	0020	6.8083	418.49	107.67	83.70

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11621	Exc h-f-nk-sp mlg+marg 0.6–1		T	0019	4.0919	251.52	71.87	50.30
11622	Exc h-f-nk-sp mlg+marg 1.1–2		T	0020	6.8083	418.49	107.67	83.70
11623	Exc h-f-nk-sp mlg+marg 2.1–3		T	0021	15.1024	928.31	219.48	185.66
11624	Exc h-f-nk-sp mlg+marg 3.1–4		T	0021	15.1024	928.31	219.48	185.66
11626	Exc h-f-nk-sp mlg+mar > 4 cm		T	0022	20.0656	1,233.39	354.45	246.68
11640	Exc face-mm malig+marg 0.5 <		T	0020	6.8083	418.49	107.67	83.70
11641	Exc face-mm malig+marg 0.6–1		T	0020	6.8083	418.49	107.67	83.70
11642	Exc face-mm malig+marg 1.1–2		T	0020	6.8083	418.49	107.67	83.70
11643	Exc face-mm malig+marg 2.1–3		T	0020	6.8083	418.49	107.67	83.70
11644	Exc face-mm malig+marg 3.1–4		T	0021	15.1024	928.31	219.48	185.66
11646	Exc face-mm mlg+marg > 4 cm		T	0022	20.0656	1,233.39	354.45	246.68
11719	Trim nail(s)		T	0009	0.7744	47.60		9.52
11720	Debride nail, 1–5		T	0009	0.7744	47.60		9.52
11721	Debride nail, 6 or more		T	0009	0.7744	47.60		9.52
11730	Removal of nail plate		T	0013	1.0918	67.11		13.42
11732	Remove nail plate, add-on		T	0012	0.8432	51.83	11.18	10.37
11740	Drain blood from under nail		T	0009	0.7744	47.60		9.52
11750	Removal of nail bed		T	0019	4.0919	251.52	71.87	50.30
11752	Remove nail bed/finger tip		T	0022	20.0656	1,233.39	354.45	246.68
11755	Biopsy, nail unit		T	0019	4.0919	251.52	71.87	50.30
11760	Repair of nail bed		T	0024	1.4843	91.24	29.88	18.25
11762	Reconstruction of nail bed		T	0024	1.4843	91.24	29.88	18.25
11765	Excision of nail fold, toe		T	0015	1.6241	99.83	20.13	19.97
11770	Removal of pilonidal lesion		T	0022	20.0656	1,233.39	354.45	246.68
11771	Removal of pilonidal lesion		T	0022	20.0656	1,233.39	354.45	246.68
11772	Removal of pilonidal lesion		T	0022	20.0656	1,233.39	354.45	246.68
11900	Injection into skin lesions		T	0012	0.8432	51.83	11.18	10.37
11901	Added skin lesions injection		T	0012	0.8432	51.83	11.18	10.37
11920	Correct skin color defects		T	0024	1.4843	91.24	29.88	18.25
11921	Correct skin color defects		T	0024	1.4843	91.24	29.88	18.25
11922	Correct skin color defects		T	0024	1.4843	91.24	29.88	18.25
11950	Therapy for contour defects		T	0024	1.4843	91.24	29.88	18.25
11951	Therapy for contour defects		T	0024	1.4843	91.24	29.88	18.25
11952	Therapy for contour defects		T	0024	1.4843	91.24	29.88	18.25
11954	Therapy for contour defects		T	0024	1.4843	91.24	29.88	18.25
11960	Insert tissue expander(s)		T	0027	21.4302	1,317.27	329.72	263.45
11970	Replace tissue expander	CH	T	0051	41.0893	2,525.68		505.14
11971	Remove tissue expander(s)		T	0022	20.0656	1,233.39	354.45	246.68
11976	Removal of contraceptive cap		T	0019	4.0919	251.52	71.87	50.30
11980	Implant hormone pellet(s)		X	0340	0.6102	37.51		7.50
11981	Insert drug implant device		X	0340	0.6102	37.51		7.50
11982	Remove drug implant device		X	0340	0.6102	37.51		7.50
11983	Remove/insert drug implant		X	0340	0.6102	37.51		7.50
12001	Repair superficial wound(s)		T	0024	1.4843	91.24	29.88	18.25
12002	Repair superficial wound(s)		T	0024	1.4843	91.24	29.88	18.25
12004	Repair superficial wound(s)		T	0024	1.4843	91.24	29.88	18.25
12005	Repair superficial wound(s)		T	0024	1.4843	91.24	29.88	18.25
12006	Repair superficial wound(s)		T	0024	1.4843	91.24	29.88	18.25
12007	Repair superficial wound(s)		T	0024	1.4843	91.24	29.88	18.25
12011	Repair superficial wound(s)		T	0024	1.4843	91.24	29.88	18.25
12013	Repair superficial wound(s)		T	0024	1.4843	91.24	29.88	18.25
12014	Repair superficial wound(s)		T	0024	1.4843	91.24	29.88	18.25
12015	Repair superficial wound(s)		T	0024	1.4843	91.24	29.88	18.25
12016	Repair superficial wound(s)		T	0024	1.4843	91.24	29.88	18.25
12017	Repair superficial wound(s)		T	0024	1.4843	91.24	29.88	18.25
12018	Repair superficial wound(s)		T	0024	1.4843	91.24	29.88	18.25
12020	Closure of split wound		T	0024	1.4843	91.24	29.88	18.25
12021	Closure of split wound		T	0024	1.4843	91.24	29.88	18.25
12031	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12032	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12034	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12035	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12036	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12037	Layer closure of wound(s)		T	0025	5.2594	323.28	101.85	64.66
12041	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12042	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12044	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12045	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12046	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12047	Layer closure of wound(s)		T	0025	5.2594	323.28	101.85	64.66

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
12051	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12052	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12053	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12054	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12055	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12056	Layer closure of wound(s)		T	0024	1.4843	91.24	29.88	18.25
12057	Layer closure of wound(s)		T	0025	5.2594	323.28	101.85	64.66
13100	Repair of wound or lesion		T	0025	5.2594	323.28	101.85	64.66
13101	Repair of wound or lesion		T	0025	5.2594	323.28	101.85	64.66
13102	Repair wound/lesion add-on		T	0024	1.4843	91.24	29.88	18.25
13120	Repair of wound or lesion		T	0024	1.4843	91.24	29.88	18.25
13121	Repair of wound or lesion		T	0024	1.4843	91.24	29.88	18.25
13122	Repair wound/lesion add-on		T	0024	1.4843	91.24	29.88	18.25
13131	Repair of wound or lesion		T	0024	1.4843	91.24	29.88	18.25
13132	Repair of wound or lesion		T	0024	1.4843	91.24	29.88	18.25
13133	Repair wound/lesion add-on		T	0024	1.4843	91.24	29.88	18.25
13150	Repair of wound or lesion		T	0025	5.2594	323.28	101.85	64.66
13151	Repair of wound or lesion	CH	T	0025	5.2594	323.28	101.85	64.66
13152	Repair of wound or lesion		T	0025	5.2594	323.28	101.85	64.66
13153	Repair wound/lesion add-on		T	0024	1.4843	91.24	29.88	18.25
13160	Late closure of wound		T	0027	21.4302	1,317.27	329.72	263.45
14000	Skin tissue rearrangement		T	0686	14.0346	862.68		172.54
14001	Skin tissue rearrangement		T	0027	21.4302	1,317.27	329.72	263.45
14020	Skin tissue rearrangement		T	0686	14.0346	862.68		172.54
14021	Skin tissue rearrangement	CH	T	0686	14.0346	862.68		172.54
14040	Skin tissue rearrangement		T	0686	14.0346	862.68		172.54
14041	Skin tissue rearrangement	CH	T	0686	14.0346	862.68		172.54
14060	Skin tissue rearrangement	CH	T	0686	14.0346	862.68		172.54
14061	Skin tissue rearrangement		T	0686	14.0346	862.68		172.54
14300	Skin tissue rearrangement		T	0027	21.4302	1,317.27	329.72	263.45
14350	Skin tissue rearrangement		T	0027	21.4302	1,317.27	329.72	263.45
15000	Wound prep, 1st 100 sq cm	CH	D					
15001	Wound prep, addl 100 sq cm	CH	D					
15002	Wnd prep, ch/inf, trk/arm/lg	NI	T	0025	5.2594	323.28	101.85	64.66
15003	Wnd prep, ch/inf addl 100 cm	NI	T	0025	5.2594	323.28	101.85	64.66
15004	Wnd prep ch/inf, f/n/hf/g	NI	T	0025	5.2594	323.28	101.85	64.66
15005	Wnd prep, f/n/hf/g, addl cm	NI	T	0025	5.2594	323.28	101.85	64.66
15040	Harvest cultured skin graft		T	0024	1.4843	91.24	29.88	18.25
15050	Skin pinch graft		T	0025	5.2594	323.28	101.85	64.66
15100	Skin splt grft, trnk/arm/leg		T	0027	21.4302	1,317.27	329.72	263.45
15101	Skin splt grft t/a/l, add-on		T	0027	21.4302	1,317.27	329.72	263.45
15110	Epidrm autogrft trnk/arm/leg		T	0027	21.4302	1,317.27	329.72	263.45
15111	Epidrm autogrft t/a/l add-on		T	0027	21.4302	1,317.27	329.72	263.45
15115	Epidrm a-grft face/nck/hf/g		T	0027	21.4302	1,317.27	329.72	263.45
15116	Epidrm a-grft f/n/hf/g addl		T	0027	21.4302	1,317.27	329.72	263.45
15120	Skn splt a-grft fac/nck/hf/g		T	0027	21.4302	1,317.27	329.72	263.45
15121	Skn splt a-grft f/n/hf/g add		T	0027	21.4302	1,317.27	329.72	263.45
15130	Derm autograft, trnk/arm/leg		T	0027	21.4302	1,317.27	329.72	263.45
15131	Derm autograft t/a/l add-on		T	0027	21.4302	1,317.27	329.72	263.45
15135	Derm autograft face/nck/hf/g		T	0027	21.4302	1,317.27	329.72	263.45
15136	Derm autograft, f/n/hf/g add		T	0027	21.4302	1,317.27	329.72	263.45
15150	Cult epiderm grft t/arm/leg		T	0027	21.4302	1,317.27	329.72	263.45
15151	Cult epiderm grft t/a/l addl		T	0027	21.4302	1,317.27	329.72	263.45
15152	Cult epiderm graft t/a/l +%		T	0027	21.4302	1,317.27	329.72	263.45
15155	Cult epiderm graft, f/n/hf/g		T	0027	21.4302	1,317.27	329.72	263.45
15156	Cult epidrm grft f/n/hfg add		T	0027	21.4302	1,317.27	329.72	263.45
15157	Cult epiderm grft f/n/hfg +%		T	0027	21.4302	1,317.27	329.72	263.45
15170	Acell graft trunk/arms/legs	CH	T	0025	5.2594	323.28	101.85	64.66
15171	Acell graft t/arm/leg add-on	CH	T	0025	5.2594	323.28	101.85	64.66
15175	Acellular graft, f/n/hf/g	CH	T	0025	5.2594	323.28	101.85	64.66
15176	Acell graft, f/n/hf/g add-on	CH	T	0025	5.2594	323.28	101.85	64.66
15200	Skin full graft, trunk	CH	T	0686	14.0346	862.68		172.54
15201	Skin full graft trunk add-on		T	0025	5.2594	323.28	101.85	64.66
15220	Skin full graft sclp/arm/leg	CH	T	0686	14.0346	862.68		172.54
15221	Skin full graft add-on		T	0025	5.2594	323.28	101.85	64.66
15240	Skin full grft face/genit/hf		T	0686	14.0346	862.68		172.54
15241	Skin full graft add-on		T	0025	5.2594	323.28	101.85	64.66
15260	Skin full graft een & lips		T	0686	14.0346	862.68		172.54
15261	Skin full graft add-on		T	0025	5.2594	323.28	101.85	64.66
15300	Apply skinallogrft, t/arm/lg	CH	T	0025	5.2594	323.28	101.85	64.66

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15301	Apply sknallogrft t/a/l addl		T	0025	5.2594	323.28	101.85	64.66
15320	Apply skin allogrft f/n/hf/g		T	0025	5.2594	323.28	101.85	64.66
15321	Aply sknallogrft f/n/hfg add		T	0025	5.2594	323.28	101.85	64.66
15330	Aply acell alogrft t/arm/leg		T	0025	5.2594	323.28	101.85	64.66
15331	Aply acell grft t/a/l add-on		T	0025	5.2594	323.28	101.85	64.66
15335	Apply acell graft, f/n/hf/g		T	0025	5.2594	323.28	101.85	64.66
15336	Aply acell grft f/n/hf/g add		T	0025	5.2594	323.28	101.85	64.66
15340	Apply cult skin substitute	CH	T	0025	5.2594	323.28	101.85	64.66
15341	Apply cult skin sub add-on	CH	T	0025	5.2594	323.28	101.85	64.66
15360	Apply cult derm sub, t/a/l	CH	T	0025	5.2594	323.28	101.85	64.66
15361	Aply cult derm sub t/a/l add	CH	T	0025	5.2594	323.28	101.85	64.66
15365	Apply cult derm sub f/n/hf/g	CH	T	0025	5.2594	323.28	101.85	64.66
15366	Apply cult derm f/hf/g add	CH	T	0025	5.2594	323.28	101.85	64.66
15400	Apply skin xenograft, t/a/l		T	0025	5.2594	323.28	101.85	64.66
15401	Apply skn xenogrft t/a/l add		T	0025	5.2594	323.28	101.85	64.66
15420	Apply skin xgraft, f/n/hf/g		T	0025	5.2594	323.28	101.85	64.66
15421	Apply skn xgrft f/n/hf/g add		T	0025	5.2594	323.28	101.85	64.66
15430	Apply acellular xenograft		T	0025	5.2594	323.28	101.85	64.66
15431	Apply acellular xgraft add		T	0025	5.2594	323.28	101.85	64.66
15570	Form skin pedicle flap		T	0027	21.4302	1,317.27	329.72	263.45
15572	Form skin pedicle flap		T	0027	21.4302	1,317.27	329.72	263.45
15574	Form skin pedicle flap		T	0027	21.4302	1,317.27	329.72	263.45
15576	Form skin pedicle flap		T	0686	14.0346	862.68		172.54
15600	Skin graft		T	0027	21.4302	1,317.27	329.72	263.45
15610	Skin graft		T	0027	21.4302	1,317.27	329.72	263.45
15620	Skin graft		T	0027	21.4302	1,317.27	329.72	263.45
15630	Skin graft		T	0027	21.4302	1,317.27	329.72	263.45
15650	Transfer skin pedicle flap		T	0027	21.4302	1,317.27	329.72	263.45
15731	Forehead flap w/vasc pedicle	NI	T	0686	14.0346	862.68		172.54
15732	Muscle-skin graft, head/neck		T	0027	21.4302	1,317.27	329.72	263.45
15734	Muscle-skin graft, trunk		T	0027	21.4302	1,317.27	329.72	263.45
15736	Muscle-skin graft, arm		T	0027	21.4302	1,317.27	329.72	263.45
15738	Muscle-skin graft, leg		T	0027	21.4302	1,317.27	329.72	263.45
15740	Island pedicle flap graft		T	0686	14.0346	862.68		172.54
15750	Neurovascular pedicle graft		T	0027	21.4302	1,317.27	329.72	263.45
15760	Composite skin graft		T	0027	21.4302	1,317.27	329.72	263.45
15770	Derma-fat-fascia graft		T	0027	21.4302	1,317.27	329.72	263.45
15775	Hair transplant punch grafts		T	0025	5.2594	323.28	101.85	64.66
15776	Hair transplant punch grafts		T	0025	5.2594	323.28	101.85	64.66
15780	Abrasion treatment of skin		T	0022	20.0656	1,233.39	354.45	246.68
15781	Abrasion treatment of skin		T	0019	4.0919	251.52	71.87	50.30
15782	Abrasion treatment of skin		T	0019	4.0919	251.52	71.87	50.30
15783	Abrasion treatment of skin		T	0016	2.6749	164.42		32.88
15786	Abrasion, lesion, single		T	0013	1.0918	67.11		13.42
15787	Abrasion, lesions, add-on		T	0013	1.0918	67.11		13.42
15788	Chemical peel, face, epiderm		T	0012	0.8432	51.83	11.18	10.37
15789	Chemical peel, face, dermal		T	0015	1.6241	99.83	20.13	19.97
15792	Chemical peel, nonfacial		T	0013	1.0918	67.11		13.42
15793	Chemical peel, nonfacial		T	0012	0.8432	51.83	11.18	10.37
15819	Plastic surgery, neck		T	0025	5.2594	323.28	101.85	64.66
15820	Revision of lower eyelid		T	0027	21.4302	1,317.27	329.72	263.45
15821	Revision of lower eyelid		T	0027	21.4302	1,317.27	329.72	263.45
15822	Revision of upper eyelid		T	0027	21.4302	1,317.27	329.72	263.45
15823	Revision of upper eyelid	CH	T	0686	14.0346	862.68		172.54
15824	Removal of forehead wrinkles		T	0027	21.4302	1,317.27	329.72	263.45
15825	Removal of neck wrinkles		T	0027	21.4302	1,317.27	329.72	263.45
15826	Removal of brow wrinkles		T	0027	21.4302	1,317.27	329.72	263.45
15828	Removal of face wrinkles		T	0027	21.4302	1,317.27	329.72	263.45
15829	Removal of skin wrinkles		T	0027	21.4302	1,317.27	329.72	263.45
15830	Exc skin abd	NI	T	0022	20.0656	1,233.39	354.45	246.68
15831	Excise excessive skin tissue	CH	D					
15832	Excise excessive skin tissue		T	0022	20.0656	1,233.39	354.45	246.68
15833	Excise excessive skin tissue		T	0022	20.0656	1,233.39	354.45	246.68
15834	Excise excessive skin tissue		T	0022	20.0656	1,233.39	354.45	246.68
15835	Excise excessive skin tissue		T	0025	5.2594	323.28	101.85	64.66
15836	Excise excessive skin tissue		T	0021	15.1024	928.31	219.48	185.66
15837	Excise excessive skin tissue		T	0021	15.1024	928.31	219.48	185.66
15838	Excise excessive skin tissue		T	0021	15.1024	928.31	219.48	185.66
15839	Excise excessive skin tissue		T	0021	15.1024	928.31	219.48	185.66
15840	Graft for face nerve palsy		T	0027	21.4302	1,317.27	329.72	263.45

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15841	Graft for face nerve palsy		T	0027	21.4302	1,317.27	329.72	263.45
15842	Flap for face nerve palsy		T	0686	14.0346	862.68		172.54
15845	Skin and muscle repair, face		T	0027	21.4302	1,317.27	329.72	263.45
15847	Exc skin abd add-on	NI	T	0022	20.0656	1,233.39	354.45	246.68
15850	Removal of sutures		T	0016	2.6749	164.42		32.88
15851	Removal of sutures		T	0016	2.6749	164.42		32.88
15852	Dressing change not for burn		X	0340	0.6102	37.51		7.50
15860	Test for blood flow in graft	CH	X	0340	0.6102	37.51		7.50
15876	Suction assisted lipectomy		T	0027	21.4302	1,317.27	329.72	263.45
15877	Suction assisted lipectomy		T	0027	21.4302	1,317.27	329.72	263.45
15878	Suction assisted lipectomy		T	0686	14.0346	862.68		172.54
15879	Suction assisted lipectomy		T	0027	21.4302	1,317.27	329.72	263.45
15920	Removal of tail bone ulcer		T	0019	4.0919	251.52	71.87	50.30
15922	Removal of tail bone ulcer		T	0027	21.4302	1,317.27	329.72	263.45
15931	Remove sacrum pressure sore		T	0022	20.0656	1,233.39	354.45	246.68
15933	Remove sacrum pressure sore		T	0022	20.0656	1,233.39	354.45	246.68
15934	Remove sacrum pressure sore		T	0027	21.4302	1,317.27	329.72	263.45
15935	Remove sacrum pressure sore		T	0027	21.4302	1,317.27	329.72	263.45
15936	Remove sacrum pressure sore		T	0027	21.4302	1,317.27	329.72	263.45
15937	Remove sacrum pressure sore		T	0027	21.4302	1,317.27	329.72	263.45
15940	Remove hip pressure sore		T	0022	20.0656	1,233.39	354.45	246.68
15941	Remove hip pressure sore		T	0022	20.0656	1,233.39	354.45	246.68
15944	Remove hip pressure sore		T	0027	21.4302	1,317.27	329.72	263.45
15945	Remove hip pressure sore		T	0027	21.4302	1,317.27	329.72	263.45
15946	Remove hip pressure sore		T	0027	21.4302	1,317.27	329.72	263.45
15950	Remove thigh pressure sore		T	0022	20.0656	1,233.39	354.45	246.68
15951	Remove thigh pressure sore		T	0022	20.0656	1,233.39	354.45	246.68
15952	Remove thigh pressure sore		T	0027	21.4302	1,317.27	329.72	263.45
15953	Remove thigh pressure sore		T	0027	21.4302	1,317.27	329.72	263.45
15956	Remove thigh pressure sore		T	0027	21.4302	1,317.27	329.72	263.45
15958	Remove thigh pressure sore		T	0027	21.4302	1,317.27	329.72	263.45
15999	Removal of pressure sore		T	0019	4.0919	251.52	71.87	50.30
16000	Initial treatment of burn(s)		T	0012	0.8432	51.83	11.18	10.37
16020	Dress/debrid p-thick burn, s		T	0013	1.0918	67.11		13.42
16025	Dress/debrid p-thick burn, m		T	0013	1.0918	67.11		13.42
16030	Dress/debrid p-thick burn, l		T	0015	1.6241	99.83	20.13	19.97
16035	Incision of burn scab, initi	CH	T	0016	2.6749	164.42		32.88
17000	Destruct premalg lesion		T	0010	0.476	29.26	8.02	5.85
17003	Destruct premalg les, 2–14		T	0010	0.476	29.26	8.02	5.85
17004	Destroy premlg lesions 15+		T	0011	2.5665	157.76		31.55
17106	Destruction of skin lesions		T	0011	2.5665	157.76		31.55
17107	Destruction of skin lesions		T	0011	2.5665	157.76		31.55
17108	Destruction of skin lesions		T	0011	2.5665	157.76		31.55
17110	Destruct b9 lesion, 1–14	CH	T	0012	0.8432	51.83	11.18	10.37
17111	Destruct lesion, 15 or more		T	0013	1.0918	67.11		13.42
17250	Chemical cautery, tissue		T	0013	1.0918	67.11		13.42
17260	Destruction of skin lesions		T	0015	1.6241	99.83	20.13	19.97
17261	Destruction of skin lesions		T	0015	1.6241	99.83	20.13	19.97
17262	Destruction of skin lesions		T	0015	1.6241	99.83	20.13	19.97
17263	Destruction of skin lesions		T	0015	1.6241	99.83	20.13	19.97
17264	Destruction of skin lesions		T	0015	1.6241	99.83	20.13	19.97
17266	Destruction of skin lesions		T	0016	2.6749	164.42		32.88
17270	Destruction of skin lesions		T	0015	1.6241	99.83	20.13	19.97
17271	Destruction of skin lesions		T	0013	1.0918	67.11		13.42
17272	Destruction of skin lesions		T	0015	1.6241	99.83	20.13	19.97
17273	Destruction of skin lesions		T	0015	1.6241	99.83	20.13	19.97
17274	Destruction of skin lesions		T	0016	2.6749	164.42		32.88
17276	Destruction of skin lesions		T	0016	2.6749	164.42		32.88
17280	Destruction of skin lesions		T	0015	1.6241	99.83	20.13	19.97
17281	Destruction of skin lesions		T	0015	1.6241	99.83	20.13	19.97
17282	Destruction of skin lesions		T	0015	1.6241	99.83	20.13	19.97
17283	Destruction of skin lesions		T	0015	1.6241	99.83	20.13	19.97
17284	Destruction of skin lesions		T	0016	2.6749	164.42		32.88
17286	Destruction of skin lesions		T	0015	1.6241	99.83	20.13	19.97
17304	1 stage mohs, up to 5 spec	CH	D					
17305	2 stage mohs, up to 5 spec	CH	D					
17306	3 stage mohs, up to 5 spec	CH	D					
17307	Mohs addl stage up to 5 spec	CH	D					
17310	Mohs any stage > 5 spec each	CH	D					
17311	Mohs, 1 stage, h/n/hf/g	NI	T	0694	3.7292	229.23	91.69	45.85

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
17312	Mohs addl stage	NI	T	0694	3.7292	229.23	91.69	45.85
17313	Mohs, 1 stage, t/a/l	NI	T	0694	3.7292	229.23	91.69	45.85
17314	Mohs, addl stage, t/a/l	NI	T	0694	3.7292	229.23	91.69	45.85
17315	Mohs surg, addl block	NI	T	0694	3.7292	229.23	91.69	45.85
17340	Cryotherapy of skin	CH	T	0016	2.6749	164.42		32.88
17360	Skin peel therapy		T	0013	1.0918	67.11		13.42
17380	Hair removal by electrolysis		T	0013	1.0918	67.11		13.42
17999	Skin tissue procedure	CH	T	0012	0.8432	51.83	11.18	10.37
19000	Drainage of breast lesion		T	0004	2.0687	127.16		25.43
19001	Drain breast lesion add-on	CH	T	0002	1.0995	67.58		13.52
19020	Incision of breast lesion		T	0008	17.5086	1,076.22		215.24
19030	Injection for breast x-ray		N					
19100	Bx breast percut w/o image		T	0005	3.9045	240.00	71.59	48.00
19101	Biopsy of breast, open		T	0028	19.2788	1,185.03	303.74	237.01
19102	Bx breast percut w/image		T	0005	3.9045	240.00	71.59	48.00
19103	Bx breast percut w/device		T	0658	6.4387	395.77		79.15
19105	Cryosurg ablate fa, each	NI	T	0029	28.0166	1,722.12	581.52	344.42
19110	Nipple exploration		T	0028	19.2788	1,185.03	303.74	237.01
19112	Excise breast duct fistula		T	0028	19.2788	1,185.03	303.74	237.01
19120	Removal of breast lesion		T	0028	19.2788	1,185.03	303.74	237.01
19125	Excision, breast lesion		T	0028	19.2788	1,185.03	303.74	237.01
19126	Excision, addl breast lesion		T	0028	19.2788	1,185.03	303.74	237.01
19140	Removal of breast tissue	CH	D					
19160	Partial mastectomy	CH	D					
19162	P-mastectomy w/ln removal	CH	D					
19180	Removal of breast	CH	D					
19182	Removal of breast	CH	D					
19200	Removal of breast	CH	D					
19220	Removal of breast	CH	D					
19240	Removal of breast	CH	D					
19260	Removal of chest wall lesion		T	0021	15.1024	928.31	219.48	185.66
19290	Place needle wire, breast		N					
19291	Place needle wire, breast		N					
19295	Place breast clip, percut		S	0657	1.7369	106.76		21.35
19296	Place po breast cath for rad	CH	T	0648	51.2269	3,148.82		629.76
19297	Place breast cath for rad	CH	T	0648	51.2269	3,148.82		629.76
19298	Place breast rad tube/caths		S	1524		3,250.00		650.00
19300	Removal of breast tissue	NI	T	0028	19.2788	1,185.03	303.74	237.01
19301	Partical mastectomy	NI	T	0028	19.2788	1,185.03	303.74	237.01
19302	P-mastectomy w/ln removal	NI	T	0693	36.9988	2,274.24	721.30	454.85
19303	Mast, simple, complete	NI	T	0029	28.0166	1,722.12	581.52	344.42
19304	Mast, subq	NI	T	0029	28.0166	1,722.12	581.52	344.42
19305	Mast, radical	NI	C					
19306	Mast, rad, urban type	NI	C					
19307	Mast, mod rad	NI	T	0030	37.8692	2,327.74	747.07	465.55
19316	Suspension of breast		T	0029	28.0166	1,722.12	581.52	344.42
19318	Reduction of large breast		T	0693	36.9988	2,274.24	721.30	454.85
19324	Enlarge breast		T	0693	36.9988	2,274.24	721.30	454.85
19325	Enlarge breast with implant		T	0648	51.2269	3,148.82		629.76
19328	Removal of breast implant		T	0029	28.0166	1,722.12	581.52	344.42
19330	Removal of implant material		T	0029	28.0166	1,722.12	581.52	344.42
19340	Immediate breast prosthesis		T	0030	37.8692	2,327.74	747.07	465.55
19342	Delayed breast prosthesis		T	0648	51.2269	3,148.82		629.76
19350	Breast reconstruction		T	0028	19.2788	1,185.03	303.74	237.01
19355	Correct inverted nipple(s)		T	0029	28.0166	1,722.12	581.52	344.42
19357	Breast reconstruction		T	0648	51.2269	3,148.82		629.76
19366	Breast reconstruction		T	0029	28.0166	1,722.12	581.52	344.42
19370	Surgery of breast capsule		T	0029	28.0166	1,722.12	581.52	344.42
19371	Removal of breast capsule		T	0029	28.0166	1,722.12	581.52	344.42
19380	Revise breast reconstruction		T	0030	37.8692	2,327.74	747.07	465.55
19396	Design custom breast implant		T	0029	28.0166	1,722.12	581.52	344.42
19499	Breast surgery procedure		T	0028	19.2788	1,185.03	303.74	237.01
20000	Incision of abscess		T	0006	1.4392	88.46		17.69
20005	Incision of deep abscess		T	0049	20.8706	1,282.87		256.57
20100	Explore wound, neck		T	0023	4.2212	259.47		51.89
20101	Explore wound, chest		T	0027	21.4302	1,317.27	329.72	263.45
20102	Explore wound, abdomen		T	0027	21.4302	1,317.27	329.72	263.45
20103	Explore wound, extremity		T	0023	4.2212	259.47		51.89
20150	Excise epiphyseal bar		T	0051	41.0893	2,525.68		505.14
20200	Muscle biopsy		T	0021	15.1024	928.31	219.48	185.66

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
20205	Deep muscle biopsy		T	0021	15.1024	928.31	219.48	185.66
20206	Needle biopsy, muscle		T	0005	3.9045	240.00	71.59	48.00
20220	Bone biopsy, trocar/needle		T	0019	4.0919	251.52	71.87	50.30
20225	Bone biopsy, trocar/needle		T	0020	6.8083	418.49	107.67	83.70
20240	Bone biopsy, excisional		T	0022	20.0656	1,233.39	354.45	246.68
20245	Bone biopsy, excisional		T	0022	20.0656	1,233.39	354.45	246.68
20250	Open bone biopsy		T	0049	20.8706	1,282.87		256.57
20251	Open bone biopsy		T	0049	20.8706	1,282.87		256.57
20500	Injection of sinus tract		T	0251	2.452	150.72		30.14
20501	Inject sinus tract for x-ray		N					
20520	Removal of foreign body		T	0019	4.0919	251.52	71.87	50.30
20525	Removal of foreign body		T	0022	20.0656	1,233.39	354.45	246.68
20526	Ther injection, carp tunnel		T	0204	2.2614	139.00	40.13	27.80
20550	Inj tendon sheath/ligament		T	0204	2.2614	139.00	40.13	27.80
20551	Inj tendon origin/insertion		T	0204	2.2614	139.00	40.13	27.80
20552	Inj trigger point, 1/2 muscl		T	0204	2.2614	139.00	40.13	27.80
20553	Inject trigger points, ≧ 3		T	0204	2.2614	139.00	40.13	27.80
20600	Drain/inject, joint/bursa		T	0204	2.2614	139.00	40.13	27.80
20605	Drain/inject, joint/bursa		T	0204	2.2614	139.00	40.13	27.80
20610	Drain/inject, joint/bursa		T	0204	2.2614	139.00	40.13	27.80
20612	Aspirate/inj ganglion cyst		T	0204	2.2614	139.00	40.13	27.80
20615	Treatment of bone cyst		T	0004	2.0687	127.16		25.43
20650	Insert and remove bone pin		T	0049	20.8706	1,282.87		256.57
20662	Application of pelvis brace		T	0049	20.8706	1,282.87		256.57
20663	Application of thigh brace		T	0049	20.8706	1,282.87		256.57
20665	Removal of fixation device		X	0340	0.6102	37.51		7.50
20670	Removal of support implant		T	0021	15.1024	928.31	219.48	185.66
20680	Removal of support implant		T	0022	20.0656	1,233.39	354.45	246.68
20690	Apply bone fixation device		T	0050	25.1296	1,544.67		308.93
20692	Apply bone fixation device		T	0050	25.1296	1,544.67		308.93
20693	Adjust bone fixation device		T	0049	20.8706	1,282.87		256.57
20694	Remove bone fixation device		T	0049	20.8706	1,282.87		256.57
20822	Replantation digit, complete		T	0054	25.8758	1,590.53		318.11
20900	Removal of bone for graft		T	0050	25.1296	1,544.67		308.93
20902	Removal of bone for graft		T	0050	25.1296	1,544.67		308.93
20910	Remove cartilage for graft		T	0027	21.4302	1,317.27	329.72	263.45
20912	Remove cartilage for graft		T	0027	21.4302	1,317.27	329.72	263.45
20920	Removal of fascia for graft		T	0686	14.0346	862.68		172.54
20922	Removal of fascia for graft		T	0027	21.4302	1,317.27	329.72	263.45
20924	Removal of tendon for graft		T	0050	25.1296	1,544.67		308.93
20926	Removal of tissue for graft		T	0686	14.0346	862.68		172.54
20950	Fluid pressure, muscle		T	0006	1.4392	88.46		17.69
20972	Bone/skin graft, metatarsal		T	0056	40.8559	2,511.33		502.27
20973	Bone/skin graft, great toe		T	0056	40.8559	2,511.33		502.27
20975	Electrical bone stimulation		X	0340	0.6102	37.51		7.50
20979	Us bone stimulation		X	0340	0.6102	37.51		7.50
20982	Ablate, bone tumor(s) perq	CH	T	0051	41.0893	2,525.68		505.14
20999	Musculoskeletal surgery		T	0049	20.8706	1,282.87		256.57
21010	Incision of jaw joint		T	0254	23.3299	1,434.04	321.35	286.81
21015	Resection of facial tumor		T	0253	16.4266	1,009.71	282.29	201.94
21025	Excision of bone, lower jaw		T	0256	38.1991	2,348.02		469.60
21026	Excision of facial bone(s)		T	0256	38.1991	2,348.02		469.60
21029	Contour of face bone lesion		T	0256	38.1991	2,348.02		469.60
21030	Excise max/zygoma b9 tumor		T	0254	23.3299	1,434.04	321.35	286.81
21031	Remove exostosis, mandible		T	0254	23.3299	1,434.04	321.35	286.81
21032	Remove exostosis, maxilla		T	0254	23.3299	1,434.04	321.35	286.81
21034	Excise max/zygoma mlg tumor		T	0256	38.1991	2,348.02		469.60
21040	Excise mandible lesion		T	0254	23.3299	1,434.04	321.35	286.81
21044	Removal of jaw bone lesion		T	0256	38.1991	2,348.02		469.60
21046	Remove mandible cyst complex		T	0256	38.1991	2,348.02		469.60
21047	Excise lwr jaw cyst w/repair		T	0256	38.1991	2,348.02		469.60
21048	Remove maxilla cyst complex		T	0256	38.1991	2,348.02		469.60
21049	Excis uppr jaw cyst w/repair		T	0256	38.1991	2,348.02		469.60
21050	Removal of jaw joint		T	0256	38.1991	2,348.02		469.60
21060	Remove jaw joint cartilage		T	0256	38.1991	2,348.02		469.60
21070	Remove coronoid process		T	0256	38.1991	2,348.02		469.60
21076	Prepare face/oral prosthesis		T	0254	23.3299	1,434.04	321.35	286.81
21077	Prepare face/oral prosthesis		T	0256	38.1991	2,348.02		469.60
21079	Prepare face/oral prosthesis		T	0256	38.1991	2,348.02		469.60
21080	Prepare face/oral prosthesis		T	0256	38.1991	2,348.02		469.60

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21081	Prepare face/oral prosthesis		T	0256	38.1991	2,348.02		469.60
21082	Prepare face/oral prosthesis		T	0256	38.1991	2,348.02		469.60
21083	Prepare face/oral prosthesis		T	0256	38.1991	2,348.02		469.60
21084	Prepare face/oral prosthesis		T	0256	38.1991	2,348.02		469.60
21085	Prepare face/oral prosthesis		T	0253	16.4266	1,009.71	282.29	201.94
21086	Prepare face/oral prosthesis		T	0256	38.1991	2,348.02		469.60
21087	Prepare face/oral prosthesis		T	0256	38.1991	2,348.02		469.60
21088	Prepare face/oral prosthesis		T	0256	38.1991	2,348.02		469.60
21089	Prepare face/oral prosthesis		T	0251	2.452	150.72		30.14
21100	Maxillofacial fixation		T	0256	38.1991	2,348.02		469.60
21110	Interdental fixation		T	0252	7.5511	464.15	109.16	92.83
21116	Injection, jaw joint x-ray		N					
21120	Reconstruction of chin		T	0254	23.3299	1,434.04	321.35	286.81
21121	Reconstruction of chin		T	0254	23.3299	1,434.04	321.35	286.81
21122	Reconstruction of chin		T	0254	23.3299	1,434.04	321.35	286.81
21123	Reconstruction of chin		T	0254	23.3299	1,434.04	321.35	286.81
21125	Augmentation, lower jaw bone		T	0254	23.3299	1,434.04	321.35	286.81
21127	Augmentation, lower jaw bone		T	0256	38.1991	2,348.02		469.60
21137	Reduction of forehead		T	0254	23.3299	1,434.04	321.35	286.81
21138	Reduction of forehead		T	0256	38.1991	2,348.02		469.60
21139	Reduction of forehead		T	0256	38.1991	2,348.02		469.60
21150	Reconstruct midface, lefort		T	0256	38.1991	2,348.02		469.60
21175	Reconstruct orbit/forehead		T	0256	38.1991	2,348.02		469.60
21181	Contour cranial bone lesion		T	0254	23.3299	1,434.04	321.35	286.81
21195	Reconst lwr jaw w/o fixation		T	0256	38.1991	2,348.02		469.60
21198	Reconstr lwr jaw segment		T	0256	38.1991	2,348.02		469.60
21199	Reconstr lwr jaw w/advance		T	0256	38.1991	2,348.02		469.60
21206	Reconstruct upper jaw bone		T	0256	38.1991	2,348.02		469.60
21208	Augmentation of facial bones		T	0256	38.1991	2,348.02		469.60
21209	Reduction of facial bones		T	0256	38.1991	2,348.02		469.60
21210	Face bone graft		T	0256	38.1991	2,348.02		469.60
21215	Lower jaw bone graft		T	0256	38.1991	2,348.02		469.60
21230	Rib cartilage graft		T	0256	38.1991	2,348.02		469.60
21235	Ear cartilage graft		T	0254	23.3299	1,434.04	321.35	286.81
21240	Reconstruction of jaw joint		T	0256	38.1991	2,348.02		469.60
21242	Reconstruction of jaw joint		T	0256	38.1991	2,348.02		469.60
21243	Reconstruction of jaw joint		T	0256	38.1991	2,348.02		469.60
21244	Reconstruction of lower jaw		T	0256	38.1991	2,348.02		469.60
21245	Reconstruction of jaw		T	0256	38.1991	2,348.02		469.60
21246	Reconstruction of jaw		T	0256	38.1991	2,348.02		469.60
21248	Reconstruction of jaw		T	0256	38.1991	2,348.02		469.60
21249	Reconstruction of jaw		T	0256	38.1991	2,348.02		469.60
21260	Revise eye sockets		T	0256	38.1991	2,348.02		469.60
21261	Revise eye sockets		T	0256	38.1991	2,348.02		469.60
21263	Revise eye sockets		T	0256	38.1991	2,348.02		469.60
21267	Revise eye sockets		T	0256	38.1991	2,348.02		469.60
21270	Augmentation, cheek bone		T	0256	38.1991	2,348.02		469.60
21275	Revision, orbitofacial bones		T	0256	38.1991	2,348.02		469.60
21280	Revision of eyelid		T	0256	38.1991	2,348.02		469.60
21282	Revision of eyelid		T	0253	16.4266	1,009.71	282.29	201.94
21295	Revision of jaw muscle/bone		T	0252	7.5511	464.15	109.16	92.83
21296	Revision of jaw muscle/bone		T	0254	23.3299	1,434.04	321.35	286.81
21299	Cranio/maxillofacial surgery		T	0251	2.452	150.72		30.14
21300	Treatment of skull fracture	CH	D					
21310	Treatment of nose fracture		T	0251	2.452	150.72		30.14
21315	Treatment of nose fracture		T	0251	2.452	150.72		30.14
21320	Treatment of nose fracture		T	0252	7.5511	464.15	109.16	92.83
21325	Treatment of nose fracture		T	0254	23.3299	1,434.04	321.35	286.81
21330	Treatment of nose fracture		T	0254	23.3299	1,434.04	321.35	286.81
21335	Treatment of nose fracture		T	0254	23.3299	1,434.04	321.35	286.81
21336	Treat nasal septal fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
21337	Treat nasal septal fracture		T	0253	16.4266	1,009.71	282.29	201.94
21338	Treat nasoethmoid fracture		T	0254	23.3299	1,434.04	321.35	286.81
21339	Treat nasoethmoid fracture		T	0254	23.3299	1,434.04	321.35	286.81
21340	Treatment of nose fracture		T	0256	38.1991	2,348.02		469.60
21345	Treat nose/jaw fracture		T	0254	23.3299	1,434.04	321.35	286.81
21355	Treat cheek bone fracture		T	0256	38.1991	2,348.02		469.60
21356	Treat cheek bone fracture		T	0254	23.3299	1,434.04	321.35	286.81
21390	Treat eye socket fracture		T	0256	38.1991	2,348.02		469.60
21400	Treat eye socket fracture		T	0252	7.5511	464.15	109.16	92.83

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21401	Treat eye socket fracture		T	0253	16.4266	1,009.71	282.29	201.94
21406	Treat eye socket fracture		T	0256	38.1991	2,348.02		469.60
21407	Treat eye socket fracture		T	0256	38.1991	2,348.02		469.60
21408	Treat eye socket fracture		T	0256	38.1991	2,348.02		469.60
21421	Treat mouth roof fracture		T	0254	23.3299	1,434.04	321.35	286.81
21440	Treat dental ridge fracture		T	0254	23.3299	1,434.04	321.35	286.81
21445	Treat dental ridge fracture		T	0254	23.3299	1,434.04	321.35	286.81
21450	Treat lower jaw fracture		T	0251	2.452	150.72		30.14
21451	Treat lower jaw fracture		T	0252	7.5511	464.15	109.16	92.83
21452	Treat lower jaw fracture		T	0253	16.4266	1,009.71	282.29	201.94
21453	Treat lower jaw fracture		T	0256	38.1991	2,348.02		469.60
21454	Treat lower jaw fracture		T	0254	23.3299	1,434.04	321.35	286.81
21461	Treat lower jaw fracture		T	0256	38.1991	2,348.02		469.60
21462	Treat lower jaw fracture		T	0256	38.1991	2,348.02		469.60
21465	Treat lower jaw fracture		T	0256	38.1991	2,348.02		469.60
21470	Treat lower jaw fracture		T	0256	38.1991	2,348.02		469.60
21480	Reset dislocated jaw		T	0251	2.452	150.72		30.14
21485	Reset dislocated jaw		T	0253	16.4266	1,009.71	282.29	201.94
21490	Repair dislocated jaw		T	0256	38.1991	2,348.02		469.60
21495	Treat hyoid bone fracture		T	0253	16.4266	1,009.71	282.29	201.94
21497	Interdental wiring		T	0253	16.4266	1,009.71	282.29	201.94
21499	Head surgery procedure		T	0251	2.452	150.72		30.14
21501	Drain neck/chest lesion		T	0008	17.5086	1,076.22		215.24
21502	Drain chest lesion		T	0049	20.8706	1,282.87		256.57
21550	Biopsy of neck/chest	CH	T	0020	6.8083	418.49	107.67	83.70
21555	Remove lesion, neck/chest		T	0022	20.0656	1,233.39	354.45	246.68
21556	Remove lesion, neck/chest		T	0022	20.0656	1,233.39	354.45	246.68
21557	Remove tumor, neck/chest		T	0022	20.0656	1,233.39	354.45	246.68
21600	Partial removal of rib		T	0050	25.1296	1,544.67		308.93
21610	Partial removal of rib		T	0050	25.1296	1,544.67		308.93
21685	Hyoid myotomy & suspension		T	0252	7.5511	464.15	109.16	92.83
21700	Revision of neck muscle		T	0049	20.8706	1,282.87		256.57
21720	Revision of neck muscle		T	0049	20.8706	1,282.87		256.57
21725	Revision of neck muscle		T	0006	1.4392	88.46		17.69
21742	Repair stern/nuss w/o scope		T	0051	41.0893	2,525.68		505.14
21743	Repair sternum/nuss w/scope		T	0051	41.0893	2,525.68		505.14
21800	Treatment of rib fracture		T	0043	1.6857	103.62		20.72
21805	Treatment of rib fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
21820	Treat sternum fracture		T	0043	1.6857	103.62		20.72
21899	Neck/chest surgery procedure		T	0251	2.452	150.72		30.14
21920	Biopsy soft tissue of back		T	0020	6.8083	418.49	107.67	83.70
21925	Biopsy soft tissue of back		T	0022	20.0656	1,233.39	354.45	246.68
21930	Remove lesion, back or flank		T	0022	20.0656	1,233.39	354.45	246.68
21935	Remove tumor, back		T	0022	20.0656	1,233.39	354.45	246.68
22100	Remove part of neck vertebra		T	0208	44.1489	2,713.74		542.75
22101	Remove part, thorax vertebra		T	0208	44.1489	2,713.74		542.75
22102	Remove part, lumbar vertebra		T	0208	44.1489	2,713.74		542.75
22103	Remove extra spine segment		T	0208	44.1489	2,713.74		542.75
22222	Revision of thorax spine		T	0208	44.1489	2,713.74		542.75
22305	Treat spine process fracture		T	0043	1.6857	103.62		20.72
22310	Treat spine fracture		T	0043	1.6857	103.62		20.72
22315	Treat spine fracture		T	0043	1.6857	103.62		20.72
22505	Manipulation of spine		T	0045	14.5947	897.11	268.47	179.42
22520	Percut vertebroplasty thor		T	0050	25.1296	1,544.67		308.93
22521	Percut vertebroplasty lumb		T	0050	25.1296	1,544.67		308.93
22522	Percut vertebroplasty addÆl		T	0050	25.1296	1,544.67		308.93
22523	Percut kyphoplasty, thor		T	0052	66.58	4,092.54		818.51
22524	Percut kyphoplasty, lumbar		T	0052	66.58	4,092.54		818.51
22525	Percut kyphoplasty, add-on		T	0052	66.58	4,092.54		818.51
22526	Idet, single level	NI	T	0050	25.1296	1,544.67		308.93
22527	Idet, 1 or more levels	NI	T	0050	25.1296	1,544.67		308.93
22612	Lumbar spine fusion		T	0208	44.1489	2,713.74		542.75
22614	Spine fusion, extra segment		T	0208	44.1489	2,713.74		542.75
22851	Apply spine prosth device	CH	T	0049	20.8706	1,282.87		256.57
22857	Lumbar artif diskectomy	NI	C					
22862	Revise lumbar artif disc	NI	C					
22865	Remove lumb artif disc	NI	C					
22899	Spine surgery procedure	CH	T	0049	20.8706	1,282.87		256.57
22900	Remove abdominal wall lesion		T	0022	20.0656	1,233.39	354.45	246.68
22999	Abdomen surgery procedure	CH	T	0049	20.8706	1,282.87		256.57

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23000	Removal of calcium deposits		T	0021	15.1024	928.31	219.48	185.66
23020	Release shoulder joint		T	0051	41.0893	2,525.68		505.14
23030	Drain shoulder lesion		T	0008	17.5086	1,076.22		215.24
23031	Drain shoulder bursa		T	0008	17.5086	1,076.22		215.24
23035	Drain shoulder bone lesion		T	0049	20.8706	1,282.87		256.57
23040	Exploratory shoulder surgery		T	0050	25.1296	1,544.67		308.93
23044	Exploratory shoulder surgery		T	0050	25.1296	1,544.67		308.93
23065	Biopsy shoulder tissues	CH	T	0020	6.8083	418.49	107.67	83.70
23066	Biopsy shoulder tissues		T	0022	20.0656	1,233.39	354.45	246.68
23075	Removal of shoulder lesion		T	0021	15.1024	928.31	219.48	185.66
23076	Removal of shoulder lesion		T	0022	20.0656	1,233.39	354.45	246.68
23077	Remove tumor of shoulder		T	0022	20.0656	1,233.39	354.45	246.68
23100	Biopsy of shoulder joint		T	0049	20.8706	1,282.87		256.57
23101	Shoulder joint surgery		T	0050	25.1296	1,544.67		308.93
23105	Remove shoulder joint lining		T	0050	25.1296	1,544.67		308.93
23106	Incision of collarbone joint		T	0050	25.1296	1,544.67		308.93
23107	Explore treat shoulder joint		T	0050	25.1296	1,544.67		308.93
23120	Partial removal, collar bone		T	0051	41.0893	2,525.68		505.14
23125	Removal of collar bone		T	0051	41.0893	2,525.68		505.14
23130	Remove shoulder bone, part		T	0051	41.0893	2,525.68		505.14
23140	Removal of bone lesion		T	0049	20.8706	1,282.87		256.57
23145	Removal of bone lesion		T	0050	25.1296	1,544.67		308.93
23146	Removal of bone lesion		T	0050	25.1296	1,544.67		308.93
23150	Removal of humerus lesion		T	0050	25.1296	1,544.67		308.93
23155	Removal of humerus lesion		T	0050	25.1296	1,544.67		308.93
23156	Removal of humerus lesion		T	0050	25.1296	1,544.67		308.93
23170	Remove collar bone lesion		T	0050	25.1296	1,544.67		308.93
23172	Remove shoulder blade lesion		T	0050	25.1296	1,544.67		308.93
23174	Remove humerus lesion		T	0050	25.1296	1,544.67		308.93
23180	Remove collar bone lesion		T	0050	25.1296	1,544.67		308.93
23182	Remove shoulder blade lesion		T	0050	25.1296	1,544.67		308.93
23184	Remove humerus lesion		T	0050	25.1296	1,544.67		308.93
23190	Partial removal of scapula		T	0050	25.1296	1,544.67		308.93
23195	Removal of head of humerus		T	0050	25.1296	1,544.67		308.93
23330	Remove shoulder foreign body		T	0020	6.8083	418.49	107.67	83.70
23331	Remove shoulder foreign body		T	0022	20.0656	1,233.39	354.45	246.68
23350	Injection for shoulder x-ray		N					
23395	Muscle transfer,shoulder/arm		T	0051	41.0893	2,525.68		505.14
23397	Muscle transfers		T	0052	66.58	4,092.54		818.51
23400	Fixation of shoulder blade		T	0050	25.1296	1,544.67		308.93
23405	Incision of tendon & muscle		T	0050	25.1296	1,544.67		308.93
23406	Incise tendon(s) & muscle(s)		T	0050	25.1296	1,544.67		308.93
23410	Repair rotator cuff, acute	CH	T	0051	41.0893	2,525.68		505.14
23412	Repair rotator cuff, chronic	CH	T	0051	41.0893	2,525.68		505.14
23415	Release of shoulder ligament		T	0051	41.0893	2,525.68		505.14
23420	Repair of shoulder	CH	T	0051	41.0893	2,525.68		505.14
23430	Repair biceps tendon	CH	T	0051	41.0893	2,525.68		505.14
23440	Remove/transplant tendon	CH	T	0051	41.0893	2,525.68		505.14
23450	Repair shoulder capsule		T	0052	66.58	4,092.54		818.51
23455	Repair shoulder capsule		T	0052	66.58	4,092.54		818.51
23460	Repair shoulder capsule		T	0052	66.58	4,092.54		818.51
23462	Repair shoulder capsule	CH	T	0051	41.0893	2,525.68		505.14
23465	Repair shoulder capsule		T	0052	66.58	4,092.54		818.51
23466	Repair shoulder capsule	CH	T	0051	41.0893	2,525.68		505.14
23470	Reconstruct shoulder joint		T	0425	107.1942	6,589.01	1,378.01	1,317.80
23480	Revision of collar bone		T	0051	41.0893	2,525.68		505.14
23485	Revision of collar bone	CH	T	0052	66.58	4,092.54		818.51
23490	Reinforce clavicle		T	0051	41.0893	2,525.68		505.14
23491	Reinforce shoulder bones	CH	T	0052	66.58	4,092.54		818.51
23500	Treat clavicle fracture		T	0043	1.6857	103.62		20.72
23505	Treat clavicle fracture		T	0043	1.6857	103.62		20.72
23515	Treat clavicle fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
23520	Treat clavicle dislocation		T	0043	1.6857	103.62		20.72
23525	Treat clavicle dislocation		T	0043	1.6857	103.62		20.72
23530	Treat clavicle dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
23532	Treat clavicle dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81
23540	Treat clavicle dislocation		T	0043	1.6857	103.62		20.72
23545	Treat clavicle dislocation		T	0043	1.6857	103.62		20.72
23550	Treat clavicle dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
23552	Treat clavicle dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23570	Treat shoulder blade fx		T	0043	1.6857	103.62		20.72
23575	Treat shoulder blade fx		T	0043	1.6857	103.62		20.72
23585	Treat scapula fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
23600	Treat humerus fracture		T	0043	1.6857	103.62		20.72
23605	Treat humerus fracture		T	0043	1.6857	103.62		20.72
23615	Treat humerus fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
23616	Treat humerus fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
23620	Treat humerus fracture		T	0043	1.6857	103.62		20.72
23625	Treat humerus fracture		T	0043	1.6857	103.62		20.72
23630	Treat humerus fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
23650	Treat shoulder dislocation		T	0043	1.6857	103.62		20.72
23655	Treat shoulder dislocation		T	0045	14.5947	897.11	268.47	179.42
23660	Treat shoulder dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
23665	Treat dislocation/fracture		T	0043	1.6857	103.62		20.72
23670	Treat dislocation/fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
23675	Treat dislocation/fracture		T	0043	1.6857	103.62		20.72
23680	Treat dislocation/fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
23700	Fixation of shoulder		T	0045	14.5947	897.11	268.47	179.42
23800	Fusion of shoulder joint	CH	T	0052	66.58	4,092.54		818.51
23802	Fusion of shoulder joint		T	0051	41.0893	2,525.68		505.14
23921	Amputation follow-up surgery		T	0025	5.2594	323.28	101.85	64.66
23929	Shoulder surgery procedure		T	0043	1.6857	103.62		20.72
23930	Drainage of arm lesion		T	0008	17.5086	1,076.22		215.24
23931	Drainage of arm bursa		T	0008	17.5086	1,076.22		215.24
23935	Drain arm/elbow bone lesion		T	0049	20.8706	1,282.87		256.57
24000	Exploratory elbow surgery		T	0050	25.1296	1,544.67		308.93
24006	Release elbow joint		T	0050	25.1296	1,544.67		308.93
24065	Biopsy arm/elbow soft tissue		T	0021	15.1024	928.31	219.48	185.66
24066	Biopsy arm/elbow soft tissue		T	0021	15.1024	928.31	219.48	185.66
24075	Remove arm/elbow lesion		T	0021	15.1024	928.31	219.48	185.66
24076	Remove arm/elbow lesion		T	0022	20.0656	1,233.39	354.45	246.68
24077	Remove tumor of arm/elbow		T	0022	20.0656	1,233.39	354.45	246.68
24100	Biopsy elbow joint lining		T	0049	20.8706	1,282.87		256.57
24101	Explore/treat elbow joint		T	0050	25.1296	1,544.67		308.93
24102	Remove elbow joint lining		T	0050	25.1296	1,544.67		308.93
24105	Removal of elbow bursa		T	0049	20.8706	1,282.87		256.57
24110	Remove humerus lesion		T	0049	20.8706	1,282.87		256.57
24115	Remove/graft bone lesion		T	0050	25.1296	1,544.67		308.93
24116	Remove/graft bone lesion		T	0050	25.1296	1,544.67		308.93
24120	Remove elbow lesion		T	0049	20.8706	1,282.87		256.57
24125	Remove/graft bone lesion		T	0050	25.1296	1,544.67		308.93
24126	Remove/graft bone lesion		T	0050	25.1296	1,544.67		308.93
24130	Removal of head of radius		T	0050	25.1296	1,544.67		308.93
24134	Removal of arm bone lesion		T	0050	25.1296	1,544.67		308.93
24136	Remove radius bone lesion		T	0050	25.1296	1,544.67		308.93
24138	Remove elbow bone lesion		T	0050	25.1296	1,544.67		308.93
24140	Partial removal of arm bone		T	0050	25.1296	1,544.67		308.93
24145	Partial removal of radius		T	0050	25.1296	1,544.67		308.93
24147	Partial removal of elbow		T	0050	25.1296	1,544.67		308.93
24149	Radical resection of elbow		T	0050	25.1296	1,544.67		308.93
24150	Extensive humerus surgery	CH	T	0051	41.0893	2,525.68		505.14
24151	Extensive humerus surgery		T	0052	66.58	4,092.54		818.51
24152	Extensive radius surgery	CH	T	0051	41.0893	2,525.68		505.14
24153	Extensive radius surgery		T	0052	66.58	4,092.54		818.51
24155	Removal of elbow joint		T	0051	41.0893	2,525.68		505.14
24160	Remove elbow joint implant		T	0050	25.1296	1,544.67		308.93
24164	Remove radius head implant		T	0050	25.1296	1,544.67		308.93
24200	Removal of arm foreign body		T	0019	4.0919	251.52	71.87	50.30
24201	Removal of arm foreign body		T	0021	15.1024	928.31	219.48	185.66
24220	Injection for elbow x-ray		N					
24300	Manipulate elbow w/anesth		T	0045	14.5947	897.11	268.47	179.42
24301	Muscle/tendon transfer		T	0050	25.1296	1,544.67		308.93
24305	Arm tendon lengthening		T	0050	25.1296	1,544.67		308.93
24310	Revision of arm tendon		T	0049	20.8706	1,282.87		256.57
24320	Repair of arm tendon		T	0051	41.0893	2,525.68		505.14
24330	Revision of arm muscles	CH	T	0052	66.58	4,092.54		818.51
24331	Revision of arm muscles		T	0051	41.0893	2,525.68		505.14
24332	Tenolysis, triceps		T	0049	20.8706	1,282.87		256.57
24340	Repair of biceps tendon		T	0051	41.0893	2,525.68		505.14
24341	Repair arm tendon/muscle		T	0051	41.0893	2,525.68		505.14

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24342	Repair of ruptured tendon		T	0051	41.0893	2,525.68		505.14
24343	Repr elbow lat ligmnt w/tiss		T	0050	25.1296	1,544.67		308.93
24344	Reconstruct elbow lat ligmnt	CH	T	0052	66.58	4,092.54		818.51
24345	Repr elbw med ligmnt w/tissu		T	0050	25.1296	1,544.67		308.93
24346	Reconstruct elbow med ligmnt		T	0051	41.0893	2,525.68		505.14
24350	Repair of tennis elbow		T	0050	25.1296	1,544.67		308.93
24351	Repair of tennis elbow		T	0050	25.1296	1,544.67		308.93
24352	Repair of tennis elbow		T	0050	25.1296	1,544.67		308.93
24354	Repair of tennis elbow		T	0050	25.1296	1,544.67		308.93
24356	Revision of tennis elbow		T	0050	25.1296	1,544.67		308.93
24360	Reconstruct elbow joint		T	0047	33.4505	2,056.14	537.03	411.23
24361	Reconstruct elbow joint		T	0425	107.1942	6,589.01	1,378.01	1,317.80
24362	Reconstruct elbow joint		T	0048	47.4378	2,915.91		583.18
24363	Replace elbow joint		T	0425	107.1942	6,589.01	1,378.01	1,317.80
24365	Reconstruct head of radius		T	0047	33.4505	2,056.14	537.03	411.23
24366	Reconstruct head of radius		T	0425	107.1942	6,589.01	1,378.01	1,317.80
24400	Revision of humerus		T	0050	25.1296	1,544.67		308.93
24410	Revision of humerus		T	0050	25.1296	1,544.67		308.93
24420	Revision of humerus		T	0051	41.0893	2,525.68		505.14
24430	Repair of humerus	CH	T	0052	66.58	4,092.54		818.51
24435	Repair humerus with graft	CH	T	0052	66.58	4,092.54		818.51
24470	Revision of elbow joint		T	0051	41.0893	2,525.68		505.14
24495	Decompression of forearm		T	0050	25.1296	1,544.67		308.93
24498	Reinforce humerus	CH	T	0052	66.58	4,092.54		818.51
24500	Treat humerus fracture		T	0043	1.6857	103.62		20.72
24505	Treat humerus fracture		T	0043	1.6857	103.62		20.72
24515	Treat humerus fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
24516	Treat humerus fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
24530	Treat humerus fracture		T	0043	1.6857	103.62		20.72
24535	Treat humerus fracture		T	0043	1.6857	103.62		20.72
24538	Treat humerus fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
24545	Treat humerus fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
24546	Treat humerus fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
24560	Treat humerus fracture		T	0043	1.6857	103.62		20.72
24565	Treat humerus fracture		T	0043	1.6857	103.62		20.72
24566	Treat humerus fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
24575	Treat humerus fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
24576	Treat humerus fracture		T	0043	1.6857	103.62		20.72
24577	Treat humerus fracture		T	0043	1.6857	103.62		20.72
24579	Treat humerus fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
24582	Treat humerus fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
24586	Treat elbow fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
24587	Treat elbow fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
24600	Treat elbow dislocation		T	0043	1.6857	103.62		20.72
24605	Treat elbow dislocation		T	0045	14.5947	897.11	268.47	179.42
24615	Treat elbow dislocation	CH	T	0064	57.2172	3,517.03	835.79	703.41
24620	Treat elbow fracture		T	0043	1.6857	103.62		20.72
24635	Treat elbow fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
24640	Treat elbow dislocation		T	0043	1.6857	103.62		20.72
24650	Treat radius fracture		T	0043	1.6857	103.62		20.72
24655	Treat radius fracture		T	0043	1.6857	103.62		20.72
24665	Treat radius fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
24666	Treat radius fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
24670	Treat ulnar fracture		T	0043	1.6857	103.62		20.72
24675	Treat ulnar fracture		T	0043	1.6857	103.62		20.72
24685	Treat ulnar fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
24800	Fusion of elbow joint		T	0051	41.0893	2,525.68		505.14
24802	Fusion/graft of elbow joint		T	0051	41.0893	2,525.68		505.14
24925	Amputation follow-up surgery		T	0049	20.8706	1,282.87		256.57
24935	Revision of amputation		T	0052	66.58	4,092.54		818.51
24999	Upper arm/elbow surgery		T	0043	1.6857	103.62		20.72
25000	Incision of tendon sheath		T	0049	20.8706	1,282.87		256.57
25001	Incise flexor carpi radialis		T	0049	20.8706	1,282.87		256.57
25020	Decompress forearm 1 space		T	0049	20.8706	1,282.87		256.57
25023	Decompress forearm 1 space		T	0050	25.1296	1,544.67		308.93
25024	Decompress forearm 2 spaces		T	0050	25.1296	1,544.67		308.93
25025	Decompress forearm 2 spaces		T	0050	25.1296	1,544.67		308.93
25028	Drainage of forearm lesion		T	0049	20.8706	1,282.87		256.57
25031	Drainage of forearm bursa		T	0049	20.8706	1,282.87		256.57
25035	Treat forearm bone lesion		T	0049	20.8706	1,282.87		256.57

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25040	Explore/treat wrist joint		T	0050	25.1296	1,544.67		308.93
25065	Biopsy forearm soft tissues	CH	T	0020	6.8083	418.49	107.67	83.70
25066	Biopsy forearm soft tissues		T	0022	20.0656	1,233.39	354.45	246.68
25075	Removal forearm lesion subcu		T	0021	15.1024	928.31	219.48	185.66
25076	Removal forearm lesion deep		T	0022	20.0656	1,233.39	354.45	246.68
25077	Remove tumor, forearm/wrist		T	0022	20.0656	1,233.39	354.45	246.68
25085	Incision of wrist capsule		T	0049	20.8706	1,282.87		256.57
25100	Biopsy of wrist joint		T	0049	20.8706	1,282.87		256.57
25101	Explore/treat wrist joint		T	0050	25.1296	1,544.67		308.93
25105	Remove wrist joint lining		T	0050	25.1296	1,544.67		308.93
25107	Remove wrist joint cartilage		T	0050	25.1296	1,544.67		308.93
25109	Excise tendon forearm/wrist	NI	T	0049	20.8706	1,282.87		256.57
25110	Remove wrist tendon lesion		T	0049	20.8706	1,282.87		256.57
25111	Remove wrist tendon lesion		T	0053	16.154	992.95	253.49	198.59
25112	Reremove wrist tendon lesion		T	0053	16.154	992.95	253.49	198.59
25115	Remove wrist/forearm lesion		T	0049	20.8706	1,282.87		256.57
25116	Remove wrist/forearm lesion		T	0049	20.8706	1,282.87		256.57
25118	Excise wrist tendon sheath		T	0050	25.1296	1,544.67		308.93
25119	Partial removal of ulna		T	0050	25.1296	1,544.67		308.93
25120	Removal of forearm lesion		T	0050	25.1296	1,544.67		308.93
25125	Remove/graft forearm lesion		T	0050	25.1296	1,544.67		308.93
25126	Remove/graft forearm lesion		T	0050	25.1296	1,544.67		308.93
25130	Removal of wrist lesion		T	0050	25.1296	1,544.67		308.93
25135	Remove & graft wrist lesion		T	0050	25.1296	1,544.67		308.93
25136	Remove & graft wrist lesion		T	0050	25.1296	1,544.67		308.93
25145	Remove forearm bone lesion		T	0050	25.1296	1,544.67		308.93
25150	Partial removal of ulna		T	0050	25.1296	1,544.67		308.93
25151	Partial removal of radius		T	0050	25.1296	1,544.67		308.93
25170	Extensive forearm surgery	CH	T	0051	41.0893	2,525.68		505.14
25210	Removal of wrist bone		T	0054	25.8758	1,590.53		318.11
25215	Removal of wrist bones		T	0054	25.8758	1,590.53		318.11
25230	Partial removal of radius		T	0050	25.1296	1,544.67		308.93
25240	Partial removal of ulna		T	0050	25.1296	1,544.67		308.93
25246	Injection for wrist x-ray		N					
25248	Remove forearm foreign body		T	0049	20.8706	1,282.87		256.57
25250	Removal of wrist prosthesis		T	0050	25.1296	1,544.67		308.93
25251	Removal of wrist prosthesis		T	0050	25.1296	1,544.67		308.93
25259	Manipulate wrist w/anesthes		T	0043	1.6857	103.62		20.72
25260	Repair forearm tendon/muscle		T	0050	25.1296	1,544.67		308.93
25263	Repair forearm tendon/muscle		T	0050	25.1296	1,544.67		308.93
25265	Repair forearm tendon/muscle		T	0050	25.1296	1,544.67		308.93
25270	Repair forearm tendon/muscle		T	0050	25.1296	1,544.67		308.93
25272	Repair forearm tendon/muscle		T	0050	25.1296	1,544.67		308.93
25274	Repair forearm tendon/muscle		T	0050	25.1296	1,544.67		308.93
25275	Repair forearm tendon sheath		T	0050	25.1296	1,544.67		308.93
25280	Revise wrist/forearm tendon		T	0050	25.1296	1,544.67		308.93
25290	Incise wrist/forearm tendon		T	0050	25.1296	1,544.67		308.93
25295	Release wrist/forearm tendon		T	0049	20.8706	1,282.87		256.57
25300	Fusion of tendons at wrist		T	0050	25.1296	1,544.67		308.93
25301	Fusion of tendons at wrist		T	0050	25.1296	1,544.67		308.93
25310	Transplant forearm tendon		T	0051	41.0893	2,525.68		505.14
25312	Transplant forearm tendon		T	0051	41.0893	2,525.68		505.14
25315	Revise palsy hand tendon(s)		T	0051	41.0893	2,525.68		505.14
25316	Revise palsy hand tendon(s)	CH	T	0052	66.58	4,092.54		818.51
25320	Repair/revise wrist joint		T	0051	41.0893	2,525.68		505.14
25332	Revise wrist joint		T	0047	33.4505	2,056.14	537.03	411.23
25335	Realignment of hand		T	0051	41.0893	2,525.68		505.14
25337	Reconstruct ulna/radioulnar		T	0051	41.0893	2,525.68		505.14
25350	Revision of radius	CH	T	0052	66.58	4,092.54		818.51
25355	Revision of radius		T	0051	41.0893	2,525.68		505.14
25360	Revision of ulna		T	0050	25.1296	1,544.67		308.93
25365	Revise radius & ulna		T	0050	25.1296	1,544.67		308.93
25370	Revise radius or ulna		T	0051	41.0893	2,525.68		505.14
25375	Revise radius & ulna		T	0051	41.0893	2,525.68		505.14
25390	Shorten radius or ulna		T	0050	25.1296	1,544.67		308.93
25391	Lengthen radius or ulna		T	0051	41.0893	2,525.68		505.14
25392	Shorten radius & ulna		T	0050	25.1296	1,544.67		308.93
25393	Lengthen radius & ulna		T	0051	41.0893	2,525.68		505.14
25394	Repair carpal bone, shorten		T	0053	16.154	992.95	253.49	198.59
25400	Repair radius or ulna		T	0050	25.1296	1,544.67		308.93

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25405	Repair/graft radius or ulna		T	0050	25.1296	1,544.67		308.93
25415	Repair radius & ulna		T	0050	25.1296	1,544.67		308.93
25420	Repair/graft radius & ulna	CH	T	0052	66.58	4,092.54		818.51
25425	Repair/graft radius or ulna		T	0051	41.0893	2,525.68		505.14
25426	Repair/graft radius & ulna		T	0051	41.0893	2,525.68		505.14
25430	Vasc graft into carpal bone		T	0054	25.8758	1,590.53		318.11
25431	Repair nonunion carpal bone		T	0054	25.8758	1,590.53		318.11
25440	Repair/graft wrist bone	CH	T	0052	66.58	4,092.54		818.51
25441	Reconstruct wrist joint		T	0425	107.1942	6,589.01	1,378.01	1,317.80
25442	Reconstruct wrist joint		T	0425	107.1942	6,589.01	1,378.01	1,317.80
25443	Reconstruct wrist joint		T	0048	47.4378	2,915.91		583.18
25444	Reconstruct wrist joint		T	0048	47.4378	2,915.91		583.18
25445	Reconstruct wrist joint		T	0048	47.4378	2,915.91		583.18
25446	Wrist replacement		T	0425	107.1942	6,589.01	1,378.01	1,317.80
25447	Repair wrist joint(s)		T	0047	33.4505	2,056.14	537.03	411.23
25449	Remove wrist joint implant		T	0047	33.4505	2,056.14	537.03	411.23
25450	Revision of wrist joint		T	0051	41.0893	2,525.68		505.14
25455	Revision of wrist joint		T	0051	41.0893	2,525.68		505.14
25490	Reinforce radius		T	0051	41.0893	2,525.68		505.14
25491	Reinforce ulna		T	0051	41.0893	2,525.68		505.14
25492	Reinforce radius and ulna		T	0051	41.0893	2,525.68		505.14
25500	Treat fracture of radius		T	0043	1.6857	103.62		20.72
25505	Treat fracture of radius		T	0043	1.6857	103.62		20.72
25515	Treat fracture of radius	CH	T	0063	37.5382	2,307.40	548.33	461.48
25520	Treat fracture of radius		T	0043	1.6857	103.62		20.72
25525	Treat fracture of radius	CH	T	0063	37.5382	2,307.40	548.33	461.48
25526	Treat fracture of radius	CH	T	0063	37.5382	2,307.40	548.33	461.48
25530	Treat fracture of ulna		T	0043	1.6857	103.62		20.72
25535	Treat fracture of ulna		T	0043	1.6857	103.62		20.72
25545	Treat fracture of ulna	CH	T	0063	37.5382	2,307.40	548.33	461.48
25560	Treat fracture radius & ulna		T	0043	1.6857	103.62		20.72
25565	Treat fracture radius & ulna		T	0043	1.6857	103.62		20.72
25574	Treat fracture radius & ulna	CH	T	0064	57.2172	3,517.03	835.79	703.41
25575	Treat fracture radius/ulna	CH	T	0064	57.2172	3,517.03	835.79	703.41
25600	Treat fracture radius/ulna		T	0043	1.6857	103.62		20.72
25605	Treat fracture radius/ulna		T	0043	1.6857	103.62		20.72
25606	Treat fx distal radial	NI	T	0062	25.5264	1,569.06	372.87	313.81
25607	Treat fx rad extra-articul	NI	T	0064	57.2172	3,517.03	835.79	703.41
25608	Treat fx rad intra-articul	NI	T	0064	57.2172	3,517.03	835.79	703.41
25609	Treat fx radial 3+ frag	NI	T	0064	57.2172	3,517.03	835.79	703.41
25611	Treat fracture radius/ulna	CH	D					
25620	Treat fracture radius/ulna	CH	D					
25622	Treat wrist bone fracture		T	0043	1.6857	103.62		20.72
25624	Treat wrist bone fracture		T	0043	1.6857	103.62		20.72
25628	Treat wrist bone fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
25630	Treat wrist bone fracture		T	0043	1.6857	103.62		20.72
25635	Treat wrist bone fracture		T	0043	1.6857	103.62		20.72
25645	Treat wrist bone fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
25650	Treat wrist bone fracture		T	0043	1.6857	103.62		20.72
25651	Pin ulnar styloid fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
25652	Treat fracture ulnar styloid	CH	T	0063	37.5382	2,307.40	548.33	461.48
25660	Treat wrist dislocation		T	0043	1.6857	103.62		20.72
25670	Treat wrist dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81
25671	Pin radioulnar dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81
25675	Treat wrist dislocation		T	0043	1.6857	103.62		20.72
25676	Treat wrist dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81
25680	Treat wrist fracture		T	0043	1.6857	103.62		20.72
25685	Treat wrist fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
25690	Treat wrist dislocation		T	0043	1.6857	103.62		20.72
25695	Treat wrist dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81
25800	Fusion of wrist joint	CH	T	0052	66.58	4,092.54		818.51
25805	Fusion/graft of wrist joint		T	0051	41.0893	2,525.68		505.14
25810	Fusion/graft of wrist joint	CH	T	0052	66.58	4,092.54		818.51
25820	Fusion of hand bones		T	0053	16.154	992.95	253.49	198.59
25825	Fuse hand bones with graft		T	0054	25.8758	1,590.53		318.11
25830	Fusion, radioulnar jnt/ulna	CH	T	0052	66.58	4,092.54		818.51
25907	Amputation follow-up surgery		T	0049	20.8706	1,282.87		256.57
25922	Amputate hand at wrist		T	0049	20.8706	1,282.87		256.57
25929	Amputation follow-up surgery		T	0686	14.0346	862.68		172.54
25999	Forearm or wrist surgery		T	0043	1.6857	103.62		20.72

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26010	Drainage of finger abscess		T	0006	1.4392	88.46		17.69
26011	Drainage of finger abscess		T	0007	11.1535	685.58		137.12
26020	Drain hand tendon sheath		T	0053	16.154	992.95	253.49	198.59
26025	Drainage of palm bursa		T	0053	16.154	992.95	253.49	198.59
26030	Drainage of palm bursa(s)		T	0053	16.154	992.95	253.49	198.59
26034	Treat hand bone lesion		T	0053	16.154	992.95	253.49	198.59
26035	Decompress fingers/hand		T	0053	16.154	992.95	253.49	198.59
26037	Decompress fingers/hand		T	0053	16.154	992.95	253.49	198.59
26040	Release palm contracture		T	0054	25.8758	1,590.53		318.11
26045	Release palm contracture		T	0054	25.8758	1,590.53		318.11
26055	Incise finger tendon sheath		T	0053	16.154	992.95	253.49	198.59
26060	Incision of finger tendon		T	0053	16.154	992.95	253.49	198.59
26070	Explore/treat hand joint		T	0053	16.154	992.95	253.49	198.59
26075	Explore/treat finger joint		T	0053	16.154	992.95	253.49	198.59
26080	Explore/treat finger joint		T	0053	16.154	992.95	253.49	198.59
26100	Biopsy hand joint lining		T	0053	16.154	992.95	253.49	198.59
26105	Biopsy finger joint lining		T	0053	16.154	992.95	253.49	198.59
26110	Biopsy finger joint lining		T	0053	16.154	992.95	253.49	198.59
26115	Removal hand lesion subcut		T	0022	20.0656	1,233.39	354.45	246.68
26116	Removal hand lesion, deep		T	0022	20.0656	1,233.39	354.45	246.68
26117	Remove tumor, hand/finger		T	0022	20.0656	1,233.39	354.45	246.68
26121	Release palm contracture		T	0054	25.8758	1,590.53		318.11
26123	Release palm contracture		T	0054	25.8758	1,590.53		318.11
26125	Release palm contracture		T	0053	16.154	992.95	253.49	198.59
26130	Remove wrist joint lining		T	0053	16.154	992.95	253.49	198.59
26135	Revise finger joint, each		T	0054	25.8758	1,590.53		318.11
26140	Revise finger joint, each		T	0053	16.154	992.95	253.49	198.59
26145	Tendon excision, palm/finger		T	0053	16.154	992.95	253.49	198.59
26160	Remove tendon sheath lesion		T	0053	16.154	992.95	253.49	198.59
26170	Removal of palm tendon, each		T	0053	16.154	992.95	253.49	198.59
26180	Removal of finger tendon		T	0053	16.154	992.95	253.49	198.59
26185	Remove finger bone		T	0053	16.154	992.95	253.49	198.59
26200	Remove hand bone lesion		T	0053	16.154	992.95	253.49	198.59
26205	Remove/graft bone lesion		T	0054	25.8758	1,590.53		318.11
26210	Removal of finger lesion		T	0053	16.154	992.95	253.49	198.59
26215	Remove/graft finger lesion		T	0053	16.154	992.95	253.49	198.59
26230	Partial removal of hand bone		T	0053	16.154	992.95	253.49	198.59
26235	Partial removal, finger bone		T	0053	16.154	992.95	253.49	198.59
26236	Partial removal, finger bone		T	0053	16.154	992.95	253.49	198.59
26250	Extensive hand surgery		T	0053	16.154	992.95	253.49	198.59
26255	Extensive hand surgery		T	0054	25.8758	1,590.53		318.11
26260	Extensive finger surgery		T	0053	16.154	992.95	253.49	198.59
26261	Extensive finger surgery		T	0053	16.154	992.95	253.49	198.59
26262	Partial removal of finger		T	0053	16.154	992.95	253.49	198.59
26320	Removal of implant from hand		T	0021	15.1024	928.31	219.48	185.66
26340	Manipulate finger w/anesth		T	0043	1.6857	103.62		20.72
26350	Repair finger/hand tendon		T	0054	25.8758	1,590.53		318.11
26352	Repair/graft hand tendon		T	0054	25.8758	1,590.53		318.11
26356	Repair finger/hand tendon		T	0054	25.8758	1,590.53		318.11
26357	Repair finger/hand tendon		T	0054	25.8758	1,590.53		318.11
26358	Repair/graft hand tendon		T	0054	25.8758	1,590.53		318.11
26370	Repair finger/hand tendon		T	0054	25.8758	1,590.53		318.11
26372	Repair/graft hand tendon		T	0054	25.8758	1,590.53		318.11
26373	Repair finger/hand tendon		T	0054	25.8758	1,590.53		318.11
26390	Revise hand/finger tendon		T	0054	25.8758	1,590.53		318.11
26392	Repair/graft hand tendon		T	0054	25.8758	1,590.53		318.11
26410	Repair hand tendon		T	0053	16.154	992.95	253.49	198.59
26412	Repair/graft hand tendon		T	0054	25.8758	1,590.53		318.11
26415	Excision, hand/finger tendon		T	0054	25.8758	1,590.53		318.11
26416	Graft hand or finger tendon		T	0054	25.8758	1,590.53		318.11
26418	Repair finger tendon		T	0053	16.154	992.95	253.49	198.59
26420	Repair/graft finger tendon		T	0054	25.8758	1,590.53		318.11
26426	Repair finger/hand tendon		T	0054	25.8758	1,590.53		318.11
26428	Repair/graft finger tendon		T	0054	25.8758	1,590.53		318.11
26432	Repair finger tendon		T	0053	16.154	992.95	253.49	198.59
26433	Repair finger tendon		T	0053	16.154	992.95	253.49	198.59
26434	Repair/graft finger tendon		T	0054	25.8758	1,590.53		318.11
26437	Realignment of tendons		T	0053	16.154	992.95	253.49	198.59
26440	Release palm/finger tendon		T	0053	16.154	992.95	253.49	198.59
26442	Release palm & finger tendon		T	0054	25.8758	1,590.53		318.11

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26445	Release hand/finger tendon		T	0053	16.154	992.95	253.49	198.59
26449	Release forearm/hand tendon		T	0054	25.8758	1,590.53		318.11
26450	Incision of palm tendon		T	0053	16.154	992.95	253.49	198.59
26455	Incision of finger tendon		T	0053	16.154	992.95	253.49	198.59
26460	Incise hand/finger tendon		T	0053	16.154	992.95	253.49	198.59
26471	Fusion of finger tendons		T	0053	16.154	992.95	253.49	198.59
26474	Fusion of finger tendons		T	0053	16.154	992.95	253.49	198.59
26476	Tendon lengthening		T	0053	16.154	992.95	253.49	198.59
26477	Tendon shortening		T	0053	16.154	992.95	253.49	198.59
26478	Lengthening of hand tendon		T	0053	16.154	992.95	253.49	198.59
26479	Shortening of hand tendon		T	0053	16.154	992.95	253.49	198.59
26480	Transplant hand tendon		T	0054	25.8758	1,590.53		318.11
26483	Transplant/graft hand tendon		T	0054	25.8758	1,590.53		318.11
26485	Transplant palm tendon		T	0054	25.8758	1,590.53		318.11
26489	Transplant/graft palm tendon		T	0054	25.8758	1,590.53		318.11
26490	Revise thumb tendon		T	0054	25.8758	1,590.53		318.11
26492	Tendon transfer with graft		T	0054	25.8758	1,590.53		318.11
26494	Hand tendon/muscle transfer		T	0054	25.8758	1,590.53		318.11
26496	Revise thumb tendon		T	0054	25.8758	1,590.53		318.11
26497	Finger tendon transfer		T	0054	25.8758	1,590.53		318.11
26498	Finger tendon transfer		T	0054	25.8758	1,590.53		318.11
26499	Revision of finger		T	0054	25.8758	1,590.53		318.11
26500	Hand tendon reconstruction		T	0053	16.154	992.95	253.49	198.59
26502	Hand tendon reconstruction		T	0054	25.8758	1,590.53		318.11
26504	Hand tendon reconstruction	CH	D					
26508	Release thumb contracture		T	0053	16.154	992.95	253.49	198.59
26510	Thumb tendon transfer		T	0054	25.8758	1,590.53		318.11
26516	Fusion of knuckle joint		T	0054	25.8758	1,590.53		318.11
26517	Fusion of knuckle joints		T	0054	25.8758	1,590.53		318.11
26518	Fusion of knuckle joints		T	0054	25.8758	1,590.53		318.11
26520	Release knuckle contracture		T	0053	16.154	992.95	253.49	198.59
26525	Release finger contracture		T	0053	16.154	992.95	253.49	198.59
26530	Revise knuckle joint		T	0047	33.4505	2,056.14	537.03	411.23
26531	Revise knuckle with implant		T	0048	47.4378	2,915.91		583.18
26535	Revise finger joint		T	0047	33.4505	2,056.14	537.03	411.23
26536	Revise/implant finger joint		T	0048	47.4378	2,915.91		583.18
26540	Repair hand joint		T	0053	16.154	992.95	253.49	198.59
26541	Repair hand joint with graft		T	0054	25.8758	1,590.53		318.11
26542	Repair hand joint with graft		T	0053	16.154	992.95	253.49	198.59
26545	Reconstruct finger joint		T	0054	25.8758	1,590.53		318.11
26546	Repair nonunion hand		T	0054	25.8758	1,590.53		318.11
26548	Reconstruct finger joint		T	0054	25.8758	1,590.53		318.11
26550	Construct thumb replacement		T	0054	25.8758	1,590.53		318.11
26555	Positional change of finger		T	0054	25.8758	1,590.53		318.11
26560	Repair of web finger		T	0053	16.154	992.95	253.49	198.59
26561	Repair of web finger		T	0054	25.8758	1,590.53		318.11
26562	Repair of web finger		T	0054	25.8758	1,590.53		318.11
26565	Correct metacarpal flaw		T	0054	25.8758	1,590.53		318.11
26567	Correct finger deformity		T	0054	25.8758	1,590.53		318.11
26568	Lengthen metacarpal/finger		T	0054	25.8758	1,590.53		318.11
26580	Repair hand deformity		T	0053	16.154	992.95	253.49	198.59
26587	Reconstruct extra finger		T	0053	16.154	992.95	253.49	198.59
26590	Repair finger deformity		T	0053	16.154	992.95	253.49	198.59
26591	Repair muscles of hand		T	0054	25.8758	1,590.53		318.11
26593	Release muscles of hand		T	0053	16.154	992.95	253.49	198.59
26596	Excision constricting tissue		T	0053	16.154	992.95	253.49	198.59
26600	Treat metacarpal fracture		T	0043	1.6857	103.62		20.72
26605	Treat metacarpal fracture		T	0043	1.6857	103.62		20.72
26607	Treat metacarpal fracture		T	0043	1.6857	103.62		20.72
26608	Treat metacarpal fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
26615	Treat metacarpal fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
26641	Treat thumb dislocation		T	0043	1.6857	103.62		20.72
26645	Treat thumb fracture		T	0043	1.6857	103.62		20.72
26650	Treat thumb fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
26665	Treat thumb fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
26670	Treat hand dislocation		T	0043	1.6857	103.62		20.72
26675	Treat hand dislocation		T	0043	1.6857	103.62		20.72
26676	Pin hand dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81
26685	Treat hand dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
26686	Treat hand dislocation	CH	T	0064	57.2172	3,517.03	835.79	703.41

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26700	Treat knuckle dislocation		T	0043	1.6857	103.62		20.72
26705	Treat knuckle dislocation		T	0043	1.6857	103.62		20.72
26706	Pin knuckle dislocation		T	0043	1.6857	103.62		20.72
26715	Treat knuckle dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
26720	Treat finger fracture, each		T	0043	1.6857	103.62		20.72
26725	Treat finger fracture, each		T	0043	1.6857	103.62		20.72
26727	Treat finger fracture, each	CH	T	0062	25.5264	1,569.06	372.87	313.81
26735	Treat finger fracture, each	CH	T	0063	37.5382	2,307.40	548.33	461.48
26740	Treat finger fracture, each		T	0043	1.6857	103.62		20.72
26742	Treat finger fracture, each		T	0043	1.6857	103.62		20.72
26746	Treat finger fracture, each	CH	T	0063	37.5382	2,307.40	548.33	461.48
26750	Treat finger fracture, each		T	0043	1.6857	103.62		20.72
26755	Treat finger fracture, each		T	0043	1.6857	103.62		20.72
26756	Pin finger fracture, each	CH	T	0062	25.5264	1,569.06	372.87	313.81
26765	Treat finger fracture, each	CH	T	0063	37.5382	2,307.40	548.33	461.48
26770	Treat finger dislocation		T	0043	1.6857	103.62		20.72
26775	Treat finger dislocation		T	0045	14.5947	897.11	268.47	179.42
26776	Pin finger dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81
26785	Treat finger dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81
26820	Thumb fusion with graft		T	0054	25.8758	1,590.53		318.11
26841	Fusion of thumb		T	0054	25.8758	1,590.53		318.11
26842	Thumb fusion with graft		T	0054	25.8758	1,590.53		318.11
26843	Fusion of hand joint		T	0054	25.8758	1,590.53		318.11
26844	Fusion/graft of hand joint		T	0054	25.8758	1,590.53		318.11
26850	Fusion of knuckle		T	0054	25.8758	1,590.53		318.11
26852	Fusion of knuckle with graft		T	0054	25.8758	1,590.53		318.11
26860	Fusion of finger joint		T	0054	25.8758	1,590.53		318.11
26861	Fusion of finger jnt, add-on		T	0054	25.8758	1,590.53		318.11
26862	Fusion/graft of finger joint		T	0054	25.8758	1,590.53		318.11
26863	Fuse/graft added joint		T	0054	25.8758	1,590.53		318.11
26910	Amputate metacarpal bone		T	0054	25.8758	1,590.53		318.11
26951	Amputation of finger/thumb		T	0053	16.154	992.95	253.49	198.59
26952	Amputation of finger/thumb		T	0053	16.154	992.95	253.49	198.59
26989	Hand/finger surgery		T	0043	1.6857	103.62		20.72
26990	Drainage of pelvis lesion		T	0049	20.8706	1,282.87		256.57
26991	Drainage of pelvis bursa		T	0049	20.8706	1,282.87		256.57
27000	Incision of hip tendon		T	0049	20.8706	1,282.87		256.57
27001	Incision of hip tendon		T	0050	25.1296	1,544.67		308.93
27003	Incision of hip tendon		T	0050	25.1296	1,544.67		308.93
27033	Exploration of hip joint		T	0051	41.0893	2,525.68		505.14
27035	Denervation of hip joint	CH	T	0051	41.0893	2,525.68		505.14
27040	Biopsy of soft tissues		T	0020	6.8083	418.49	107.67	83.70
27041	Biopsy of soft tissues		T	0020	6.8083	418.49	107.67	83.70
27047	Remove hip/pelvis lesion		T	0022	20.0656	1,233.39	354.45	246.68
27048	Remove hip/pelvis lesion		T	0022	20.0656	1,233.39	354.45	246.68
27049	Remove tumor, hip/pelvis		T	0022	20.0656	1,233.39	354.45	246.68
27050	Biopsy of sacroiliac joint		T	0049	20.8706	1,282.87		256.57
27052	Biopsy of hip joint		T	0049	20.8706	1,282.87		256.57
27060	Removal of ischial bursa		T	0049	20.8706	1,282.87		256.57
27062	Remove femur lesion/bursa		T	0049	20.8706	1,282.87		256.57
27065	Removal of hip bone lesion		T	0049	20.8706	1,282.87		256.57
27066	Removal of hip bone lesion		T	0050	25.1296	1,544.67		308.93
27067	Remove/graft hip bone lesion		T	0050	25.1296	1,544.67		308.93
27080	Removal of tail bone		T	0050	25.1296	1,544.67		308.93
27086	Remove hip foreign body		T	0020	6.8083	418.49	107.67	83.70
27087	Remove hip foreign body		T	0049	20.8706	1,282.87		256.57
27093	Injection for hip x-ray		N					
27095	Injection for hip x-ray		N					
27097	Revision of hip tendon		T	0050	25.1296	1,544.67		308.93
27098	Transfer tendon to pelvis		T	0050	25.1296	1,544.67		308.93
27100	Transfer of abdominal muscle		T	0051	41.0893	2,525.68		505.14
27105	Transfer of spinal muscle		T	0051	41.0893	2,525.68		505.14
27110	Transfer of iliopsoas muscle		T	0051	41.0893	2,525.68		505.14
27111	Transfer of iliopsoas muscle		T	0051	41.0893	2,525.68		505.14
27193	Treat pelvic ring fracture		T	0043	1.6857	103.62		20.72
27194	Treat pelvic ring fracture		T	0045	14.5947	897.11	268.47	179.42
27200	Treat tail bone fracture		T	0043	1.6857	103.62		20.72
27202	Treat tail bone fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
27216	Treat pelvic ring fracture		T	0050	25.1296	1,544.67		308.93
27220	Treat hip socket fracture		T	0043	1.6857	103.62		20.72

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27230	Treat thigh fracture		T	0043	1.6857	103.62		20.72
27235	Treat thigh fracture		T	0050	25.1296	1,544.67		308.93
27238	Treat thigh fracture		T	0043	1.6857	103.62		20.72
27246	Treat thigh fracture		T	0043	1.6857	103.62		20.72
27250	Treat hip dislocation		T	0043	1.6857	103.62		20.72
27252	Treat hip dislocation		T	0045	14.5947	897.11	268.47	179.42
27256	Treat hip dislocation		T	0043	1.6857	103.62		20.72
27257	Treat hip dislocation		T	0045	14.5947	897.11	268.47	179.42
27265	Treat hip dislocation		T	0043	1.6857	103.62		20.72
27266	Treat hip dislocation		T	0045	14.5947	897.11	268.47	179.42
27275	Manipulation of hip joint		T	0045	14.5947	897.11	268.47	179.42
27299	Pelvis/hip joint surgery		T	0043	1.6857	103.62		20.72
27301	Drain thigh/knee lesion		T	0008	17.5086	1,076.22		215.24
27305	Incise thigh tendon & fascia		T	0049	20.8706	1,282.87		256.57
27306	Incision of thigh tendon		T	0049	20.8706	1,282.87		256.57
27307	Incision of thigh tendons		T	0049	20.8706	1,282.87		256.57
27310	Exploration of knee joint		T	0050	25.1296	1,544.67		308.93
27315	Partial removal, thigh nerve	CH	D					
27320	Partial removal, thigh nerve	CH	D					
27323	Biopsy, thigh soft tissues	CH	T	0020	6.8083	418.49	107.67	83.70
27324	Biopsy, thigh soft tissues		T	0022	20.0656	1,233.39	354.45	246.68
27325	Neurectomy, hamstring	NI	T	0220	17.8499	1,097.20		219.44
27326	Neurectomy, popliteal	NI	T	0220	17.8499	1,097.20		219.44
27327	Removal of thigh lesion		T	0022	20.0656	1,233.39	354.45	246.68
27328	Removal of thigh lesion		T	0022	20.0656	1,233.39	354.45	246.68
27329	Remove tumor, thigh/knee		T	0022	20.0656	1,233.39	354.45	246.68
27330	Biopsy, knee joint lining		T	0050	25.1296	1,544.67		308.93
27331	Explore/treat knee joint		T	0050	25.1296	1,544.67		308.93
27332	Removal of knee cartilage		T	0050	25.1296	1,544.67		308.93
27333	Removal of knee cartilage		T	0050	25.1296	1,544.67		308.93
27334	Remove knee joint lining		T	0050	25.1296	1,544.67		308.93
27335	Remove knee joint lining		T	0050	25.1296	1,544.67		308.93
27340	Removal of kneecap bursa		T	0049	20.8706	1,282.87		256.57
27345	Removal of knee cyst		T	0049	20.8706	1,282.87		256.57
27347	Remove knee cyst		T	0049	20.8706	1,282.87		256.57
27350	Removal of kneecap		T	0050	25.1296	1,544.67		308.93
27355	Remove femur lesion		T	0050	25.1296	1,544.67		308.93
27356	Remove femur lesion/graft		T	0050	25.1296	1,544.67		308.93
27357	Remove femur lesion/graft		T	0050	25.1296	1,544.67		308.93
27358	Remove femur lesion/fixation		T	0050	25.1296	1,544.67		308.93
27360	Partial removal, leg bone(s)		T	0050	25.1296	1,544.67		308.93
27370	Injection for knee x-ray		N					
27372	Removal of foreign body		T	0022	20.0656	1,233.39	354.45	246.68
27380	Repair of kneecap tendon		T	0049	20.8706	1,282.87		256.57
27381	Repair/graft kneecap tendon		T	0049	20.8706	1,282.87		256.57
27385	Repair of thigh muscle		T	0049	20.8706	1,282.87		256.57
27386	Repair/graft of thigh muscle		T	0049	20.8706	1,282.87		256.57
27390	Incision of thigh tendon		T	0049	20.8706	1,282.87		256.57
27391	Incision of thigh tendons		T	0049	20.8706	1,282.87		256.57
27392	Incision of thigh tendons		T	0049	20.8706	1,282.87		256.57
27393	Lengthening of thigh tendon		T	0050	25.1296	1,544.67		308.93
27394	Lengthening of thigh tendons		T	0050	25.1296	1,544.67		308.93
27395	Lengthening of thigh tendons		T	0051	41.0893	2,525.68		505.14
27396	Transplant of thigh tendon		T	0050	25.1296	1,544.67		308.93
27397	Transplants of thigh tendons		T	0051	41.0893	2,525.68		505.14
27400	Revise thigh muscles/tendons		T	0051	41.0893	2,525.68		505.14
27403	Repair of knee cartilage		T	0050	25.1296	1,544.67		308.93
27405	Repair of knee ligament		T	0051	41.0893	2,525.68		505.14
27407	Repair of knee ligament	CH	T	0052	66.58	4,092.54		818.51
27409	Repair of knee ligaments		T	0051	41.0893	2,525.68		505.14
27412	Autochondrocyte implant knee		T	0042	45.5027	2,796.96	804.74	559.39
27415	Osteochondral knee allograft		T	0042	45.5027	2,796.96	804.74	559.39
27418	Repair degenerated kneecap		T	0051	41.0893	2,525.68		505.14
27420	Revision of unstable kneecap		T	0051	41.0893	2,525.68		505.14
27422	Revision of unstable kneecap		T	0051	41.0893	2,525.68		505.14
27424	Revision/removal of kneecap		T	0051	41.0893	2,525.68		505.14
27425	Lat retinacular release open		T	0050	25.1296	1,544.67		308.93
27427	Reconstruction, knee	CH	T	0051	41.0893	2,525.68		505.14
27428	Reconstruction, knee		T	0052	66.58	4,092.54		818.51
27429	Reconstruction, knee		T	0052	66.58	4,092.54		818.51

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27430	Revision of thigh muscles		T	0051	41.0893	2,525.68		505.14
27435	Incision of knee joint		T	0051	41.0893	2,525.68		505.14
27437	Revise kneecap		T	0047	33.4505	2,056.14	537.03	411.23
27438	Revise kneecap with implant		T	0048	47.4378	2,915.91		583.18
27440	Revision of knee joint		T	0047	33.4505	2,056.14	537.03	411.23
27441	Revision of knee joint		T	0047	33.4505	2,056.14	537.03	411.23
27442	Revision of knee joint		T	0047	33.4505	2,056.14	537.03	411.23
27443	Revision of knee joint		T	0047	33.4505	2,056.14	537.03	411.23
27446	Revision of knee joint		T	0681	205.6815	12,642.83		2,528.57
27475	Surgery to stop leg growth		T	0050	25.1296	1,544.67		308.93
27496	Decompression of thigh/knee		T	0049	20.8706	1,282.87		256.57
27497	Decompression of thigh/knee		T	0049	20.8706	1,282.87		256.57
27498	Decompression of thigh/knee		T	0049	20.8706	1,282.87		256.57
27499	Decompression of thigh/knee		T	0049	20.8706	1,282.87		256.57
27500	Treatment of thigh fracture		T	0043	1.6857	103.62		20.72
27501	Treatment of thigh fracture		T	0043	1.6857	103.62		20.72
27502	Treatment of thigh fracture		T	0043	1.6857	103.62		20.72
27503	Treatment of thigh fracture		T	0043	1.6857	103.62		20.72
27508	Treatment of thigh fracture		T	0043	1.6857	103.62		20.72
27509	Treatment of thigh fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
27510	Treatment of thigh fracture		T	0043	1.6857	103.62		20.72
27516	Treat thigh fx growth plate		T	0043	1.6857	103.62		20.72
27517	Treat thigh fx growth plate		T	0043	1.6857	103.62		20.72
27520	Treat kneecap fracture		T	0043	1.6857	103.62		20.72
27524	Treat kneecap fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
27530	Treat knee fracture		T	0043	1.6857	103.62		20.72
27532	Treat knee fracture		T	0043	1.6857	103.62		20.72
27538	Treat knee fracture(s)		T	0043	1.6857	103.62		20.72
27550	Treat knee dislocation		T	0043	1.6857	103.62		20.72
27552	Treat knee dislocation		T	0045	14.5947	897.11	268.47	179.42
27560	Treat kneecap dislocation		T	0043	1.6857	103.62		20.72
27562	Treat kneecap dislocation		T	0045	14.5947	897.11	268.47	179.42
27566	Treat kneecap dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
27570	Fixation of knee joint		T	0045	14.5947	897.11	268.47	179.42
27594	Amputation follow-up surgery		T	0049	20.8706	1,282.87		256.57
27599	Leg surgery procedure		T	0043	1.6857	103.62		20.72
27600	Decompression of lower leg		T	0049	20.8706	1,282.87		256.57
27601	Decompression of lower leg		T	0049	20.8706	1,282.87		256.57
27602	Decompression of lower leg		T	0049	20.8706	1,282.87		256.57
27603	Drain lower leg lesion		T	0008	17.5086	1,076.22		215.24
27604	Drain lower leg bursa		T	0049	20.8706	1,282.87		256.57
27605	Incision of achilles tendon		T	0055	20.4263	1,255.56	355.34	251.11
27606	Incision of achilles tendon		T	0049	20.8706	1,282.87		256.57
27607	Treat lower leg bone lesion		T	0049	20.8706	1,282.87		256.57
27610	Explore/treat ankle joint		T	0050	25.1296	1,544.67		308.93
27612	Exploration of ankle joint		T	0050	25.1296	1,544.67		308.93
27613	Biopsy lower leg soft tissue		T	0020	6.8083	418.49	107.67	83.70
27614	Biopsy lower leg soft tissue		T	0022	20.0656	1,233.39	354.45	246.68
27615	Remove tumor, lower leg	CH	T	0050	25.1296	1,544.67		308.93
27618	Remove lower leg lesion		T	0021	15.1024	928.31	219.48	185.66
27619	Remove lower leg lesion		T	0022	20.0656	1,233.39	354.45	246.68
27620	Explore/treat ankle joint		T	0050	25.1296	1,544.67		308.93
27625	Remove ankle joint lining		T	0050	25.1296	1,544.67		308.93
27626	Remove ankle joint lining		T	0050	25.1296	1,544.67		308.93
27630	Removal of tendon lesion		T	0049	20.8706	1,282.87		256.57
27635	Remove lower leg bone lesion		T	0050	25.1296	1,544.67		308.93
27637	Remove/graft leg bone lesion		T	0050	25.1296	1,544.67		308.93
27638	Remove/graft leg bone lesion		T	0050	25.1296	1,544.67		308.93
27640	Partial removal of tibia		T	0051	41.0893	2,525.68		505.14
27641	Partial removal of fibula		T	0050	25.1296	1,544.67		308.93
27647	Extensive ankle/heel surgery		T	0051	41.0893	2,525.68		505.14
27648	Injection for ankle x-ray		N					
27650	Repair achilles tendon		T	0051	41.0893	2,525.68		505.14
27652	Repair/graft achilles tendon	CH	T	0052	66.58	4,092.54		818.51
27654	Repair of achilles tendon		T	0051	41.0893	2,525.68		505.14
27656	Repair leg fascia defect		T	0049	20.8706	1,282.87		256.57
27658	Repair of leg tendon, each		T	0049	20.8706	1,282.87		256.57
27659	Repair of leg tendon, each		T	0049	20.8706	1,282.87		256.57
27664	Repair of leg tendon, each		T	0049	20.8706	1,282.87		256.57
27665	Repair of leg tendon, each		T	0050	25.1296	1,544.67		308.93

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27675	Repair lower leg tendons		T	0049	20.8706	1,282.87		256.57
27676	Repair lower leg tendons		T	0050	25.1296	1,544.67		308.93
27680	Release of lower leg tendon		T	0050	25.1296	1,544.67		308.93
27681	Release of lower leg tendons		T	0050	25.1296	1,544.67		308.93
27685	Revision of lower leg tendon		T	0050	25.1296	1,544.67		308.93
27686	Revise lower leg tendons		T	0050	25.1296	1,544.67		308.93
27687	Revision of calf tendon		T	0050	25.1296	1,544.67		308.93
27690	Revise lower leg tendon		T	0051	41.0893	2,525.68		505.14
27691	Revise lower leg tendon		T	0051	41.0893	2,525.68		505.14
27692	Revise additional leg tendon		T	0051	41.0893	2,525.68		505.14
27695	Repair of ankle ligament		T	0050	25.1296	1,544.67		308.93
27696	Repair of ankle ligaments		T	0050	25.1296	1,544.67		308.93
27698	Repair of ankle ligament		T	0050	25.1296	1,544.67		308.93
27700	Revision of ankle joint		T	0047	33.4505	2,056.14	537.03	411.23
27704	Removal of ankle implant		T	0049	20.8706	1,282.87		256.57
27705	Incision of tibia		T	0051	41.0893	2,525.68		505.14
27707	Incision of fibula		T	0049	20.8706	1,282.87		256.57
27709	Incision of tibia & fibula		T	0050	25.1296	1,544.67		308.93
27730	Repair of tibia epiphysis		T	0050	25.1296	1,544.67		308.93
27732	Repair of fibula epiphysis		T	0050	25.1296	1,544.67		308.93
27734	Repair lower leg epiphyses		T	0050	25.1296	1,544.67		308.93
27740	Repair of leg epiphyses		T	0050	25.1296	1,544.67		308.93
27742	Repair of leg epiphyses		T	0051	41.0893	2,525.68		505.14
27745	Reinforce tibia	CH	T	0052	66.58	4,092.54		818.51
27750	Treatment of tibia fracture		T	0043	1.6857	103.62		20.72
27752	Treatment of tibia fracture		T	0043	1.6857	103.62		20.72
27756	Treatment of tibia fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
27758	Treatment of tibia fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
27759	Treatment of tibia fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
27760	Treatment of ankle fracture		T	0043	1.6857	103.62		20.72
27762	Treatment of ankle fracture		T	0043	1.6857	103.62		20.72
27766	Treatment of ankle fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
27780	Treatment of fibula fracture		T	0043	1.6857	103.62		20.72
27781	Treatment of fibula fracture		T	0043	1.6857	103.62		20.72
27784	Treatment of fibula fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
27786	Treatment of ankle fracture		T	0043	1.6857	103.62		20.72
27788	Treatment of ankle fracture		T	0043	1.6857	103.62		20.72
27792	Treatment of ankle fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
27808	Treatment of ankle fracture		T	0043	1.6857	103.62		20.72
27810	Treatment of ankle fracture		T	0043	1.6857	103.62		20.72
27814	Treatment of ankle fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
27816	Treatment of ankle fracture		T	0043	1.6857	103.62		20.72
27818	Treatment of ankle fracture		T	0043	1.6857	103.62		20.72
27822	Treatment of ankle fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
27823	Treatment of ankle fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
27824	Treat lower leg fracture		T	0043	1.6857	103.62		20.72
27825	Treat lower leg fracture		T	0043	1.6857	103.62		20.72
27826	Treat lower leg fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
27827	Treat lower leg fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
27828	Treat lower leg fracture	CH	T	0064	57.2172	3,517.03	835.79	703.41
27829	Treat lower leg joint	CH	T	0063	37.5382	2,307.40	548.33	461.48
27830	Treat lower leg dislocation		T	0043	1.6857	103.62		20.72
27831	Treat lower leg dislocation		T	0043	1.6857	103.62		20.72
27832	Treat lower leg dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
27840	Treat ankle dislocation		T	0043	1.6857	103.62		20.72
27842	Treat ankle dislocation		T	0045	14.5947	897.11	268.47	179.42
27846	Treat ankle dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
27848	Treat ankle dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
27860	Fixation of ankle joint		T	0045	14.5947	897.11	268.47	179.42
27870	Fusion of ankle joint, open	CH	T	0052	66.58	4,092.54		818.51
27871	Fusion of tibiofibular joint	CH	T	0052	66.58	4,092.54		818.51
27884	Amputation follow-up surgery		T	0049	20.8706	1,282.87		256.57
27889	Amputation of foot at ankle		T	0050	25.1296	1,544.67		308.93
27892	Decompression of leg		T	0049	20.8706	1,282.87		256.57
27893	Decompression of leg		T	0049	20.8706	1,282.87		256.57
27894	Decompression of leg		T	0049	20.8706	1,282.87		256.57
27899	Leg/ankle surgery procedure		T	0043	1.6857	103.62		20.72
28001	Drainage of bursa of foot		T	0007	11.1535	685.58		137.12
28002	Treatment of foot infection		T	0049	20.8706	1,282.87		256.57
28003	Treatment of foot infection		T	0049	20.8706	1,282.87		256.57

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28005	Treat foot bone lesion		T	0055	20.4263	1,255.56	355.34	251.11
28008	Incision of foot fascia		T	0055	20.4263	1,255.56	355.34	251.11
28010	Incision of toe tendon		T	0055	20.4263	1,255.56	355.34	251.11
28011	Incision of toe tendons		T	0055	20.4263	1,255.56	355.34	251.11
28020	Exploration of foot joint		T	0055	20.4263	1,255.56	355.34	251.11
28022	Exploration of foot joint		T	0055	20.4263	1,255.56	355.34	251.11
28024	Exploration of toe joint		T	0055	20.4263	1,255.56	355.34	251.11
28030	Removal of foot nerve	CH	D					
28035	Decompression of tibia nerve		T	0220	17.8499	1,097.20		219.44
28043	Excision of foot lesion	CH	T	0022	20.0656	1,233.39	354.45	246.68
28045	Excision of foot lesion		T	0055	20.4263	1,255.56	355.34	251.11
28046	Resection of tumor, foot		T	0055	20.4263	1,255.56	355.34	251.11
28050	Biopsy of foot joint lining		T	0055	20.4263	1,255.56	355.34	251.11
28052	Biopsy of foot joint lining		T	0055	20.4263	1,255.56	355.34	251.11
28054	Biopsy of toe joint lining		T	0055	20.4263	1,255.56	355.34	251.11
28055	Neurectomy, foot	NI	T	0220	17.8499	1,097.20		219.44
28060	Partial removal, foot fascia		T	0055	20.4263	1,255.56	355.34	251.11
28062	Removal of foot fascia		T	0055	20.4263	1,255.56	355.34	251.11
28070	Removal of foot joint lining		T	0055	20.4263	1,255.56	355.34	251.11
28072	Removal of foot joint lining		T	0055	20.4263	1,255.56	355.34	251.11
28080	Removal of foot lesion		T	0055	20.4263	1,255.56	355.34	251.11
28086	Excise foot tendon sheath		T	0055	20.4263	1,255.56	355.34	251.11
28088	Excise foot tendon sheath		T	0055	20.4263	1,255.56	355.34	251.11
28090	Removal of foot lesion		T	0055	20.4263	1,255.56	355.34	251.11
28092	Removal of toe lesions		T	0055	20.4263	1,255.56	355.34	251.11
28100	Removal of ankle/heel lesion		T	0055	20.4263	1,255.56	355.34	251.11
28102	Remove/graft foot lesion		T	0056	40.8559	2,511.33		502.27
28103	Remove/graft foot lesion		T	0056	40.8559	2,511.33		502.27
28104	Removal of foot lesion		T	0055	20.4263	1,255.56	355.34	251.11
28106	Remove/graft foot lesion		T	0056	40.8559	2,511.33		502.27
28107	Remove/graft foot lesion		T	0056	40.8559	2,511.33		502.27
28108	Removal of toe lesions		T	0055	20.4263	1,255.56	355.34	251.11
28110	Part removal of metatarsal		T	0055	20.4263	1,255.56	355.34	251.11
28111	Part removal of metatarsal		T	0055	20.4263	1,255.56	355.34	251.11
28112	Part removal of metatarsal		T	0055	20.4263	1,255.56	355.34	251.11
28113	Part removal of metatarsal		T	0055	20.4263	1,255.56	355.34	251.11
28114	Removal of metatarsal heads		T	0055	20.4263	1,255.56	355.34	251.11
28116	Revision of foot		T	0055	20.4263	1,255.56	355.34	251.11
28118	Removal of heel bone		T	0055	20.4263	1,255.56	355.34	251.11
28119	Removal of heel spur		T	0055	20.4263	1,255.56	355.34	251.11
28120	Part removal of ankle/heel		T	0055	20.4263	1,255.56	355.34	251.11
28122	Partial removal of foot bone		T	0055	20.4263	1,255.56	355.34	251.11
28124	Partial removal of toe		T	0055	20.4263	1,255.56	355.34	251.11
28126	Partial removal of toe		T	0055	20.4263	1,255.56	355.34	251.11
28130	Removal of ankle bone		T	0055	20.4263	1,255.56	355.34	251.11
28140	Removal of metatarsal		T	0055	20.4263	1,255.56	355.34	251.11
28150	Removal of toe		T	0055	20.4263	1,255.56	355.34	251.11
28153	Partial removal of toe		T	0055	20.4263	1,255.56	355.34	251.11
28160	Partial removal of toe		T	0055	20.4263	1,255.56	355.34	251.11
28171	Extensive foot surgery		T	0055	20.4263	1,255.56	355.34	251.11
28173	Extensive foot surgery		T	0055	20.4263	1,255.56	355.34	251.11
28175	Extensive foot surgery		T	0055	20.4263	1,255.56	355.34	251.11
28190	Removal of foot foreign body		T	0019	4.0919	251.52	71.87	50.30
28192	Removal of foot foreign body		T	0021	15.1024	928.31	219.48	185.66
28193	Removal of foot foreign body		T	0020	6.8083	418.49	107.67	83.70
28200	Repair of foot tendon		T	0055	20.4263	1,255.56	355.34	251.11
28202	Repair/graft of foot tendon		T	0055	20.4263	1,255.56	355.34	251.11
28208	Repair of foot tendon		T	0055	20.4263	1,255.56	355.34	251.11
28210	Repair/graft of foot tendon		T	0056	40.8559	2,511.33		502.27
28220	Release of foot tendon		T	0055	20.4263	1,255.56	355.34	251.11
28222	Release of foot tendons		T	0055	20.4263	1,255.56	355.34	251.11
28225	Release of foot tendon		T	0055	20.4263	1,255.56	355.34	251.11
28226	Release of foot tendons		T	0055	20.4263	1,255.56	355.34	251.11
28230	Incision of foot tendon(s)		T	0055	20.4263	1,255.56	355.34	251.11
28232	Incision of toe tendon		T	0055	20.4263	1,255.56	355.34	251.11
28234	Incision of foot tendon		T	0055	20.4263	1,255.56	355.34	251.11
28238	Revision of foot tendon		T	0056	40.8559	2,511.33		502.27
28240	Release of big toe		T	0055	20.4263	1,255.56	355.34	251.11
28250	Revision of foot fascia		T	0055	20.4263	1,255.56	355.34	251.11
28260	Release of midfoot joint		T	0055	20.4263	1,255.56	355.34	251.11

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28261	Revision of foot tendon		T	0055	20.4263	1,255.56	355.34	251.11
28262	Revision of foot and ankle		T	0055	20.4263	1,255.56	355.34	251.11
28264	Release of midfoot joint		T	0056	40.8559	2,511.33		502.27
28270	Release of foot contracture		T	0055	20.4263	1,255.56	355.34	251.11
28272	Release of toe joint, each		T	0055	20.4263	1,255.56	355.34	251.11
28280	Fusion of toes		T	0055	20.4263	1,255.56	355.34	251.11
28285	Repair of hammertoe		T	0055	20.4263	1,255.56	355.34	251.11
28286	Repair of hammertoe		T	0055	20.4263	1,255.56	355.34	251.11
28288	Partial removal of foot bone		T	0055	20.4263	1,255.56	355.34	251.11
28289	Repair hallux rigidus		T	0055	20.4263	1,255.56	355.34	251.11
28290	Correction of bunion		T	0057	28.2349	1,735.54	475.91	347.11
28292	Correction of bunion		T	0057	28.2349	1,735.54	475.91	347.11
28293	Correction of bunion		T	0057	28.2349	1,735.54	475.91	347.11
28294	Correction of bunion		T	0057	28.2349	1,735.54	475.91	347.11
28296	Correction of bunion		T	0057	28.2349	1,735.54	475.91	347.11
28297	Correction of bunion		T	0057	28.2349	1,735.54	475.91	347.11
28298	Correction of bunion		T	0057	28.2349	1,735.54	475.91	347.11
28299	Correction of bunion		T	0057	28.2349	1,735.54	475.91	347.11
28300	Incision of heel bone		T	0056	40.8559	2,511.33		502.27
28302	Incision of ankle bone		T	0055	20.4263	1,255.56	355.34	251.11
28304	Incision of midfoot bones		T	0056	40.8559	2,511.33		502.27
28305	Incise/graft midfoot bones		T	0056	40.8559	2,511.33		502.27
28306	Incision of metatarsal		T	0055	20.4263	1,255.56	355.34	251.11
28307	Incision of metatarsal		T	0055	20.4263	1,255.56	355.34	251.11
28308	Incision of metatarsal		T	0055	20.4263	1,255.56	355.34	251.11
28309	Incision of metatarsals		T	0056	40.8559	2,511.33		502.27
28310	Revision of big toe		T	0055	20.4263	1,255.56	355.34	251.11
28312	Revision of toe		T	0055	20.4263	1,255.56	355.34	251.11
28313	Repair deformity of toe		T	0055	20.4263	1,255.56	355.34	251.11
28315	Removal of sesamoid bone		T	0055	20.4263	1,255.56	355.34	251.11
28320	Repair of foot bones		T	0056	40.8559	2,511.33		502.27
28322	Repair of metatarsals		T	0056	40.8559	2,511.33		502.27
28340	Resect enlarged toe tissue		T	0055	20.4263	1,255.56	355.34	251.11
28341	Resect enlarged toe		T	0055	20.4263	1,255.56	355.34	251.11
28344	Repair extra toe(s)		T	0055	20.4263	1,255.56	355.34	251.11
28345	Repair webbed toe(s)		T	0055	20.4263	1,255.56	355.34	251.11
28360	Reconstruct cleft foot		T	0056	40.8559	2,511.33		502.27
28400	Treatment of heel fracture		T	0043	1.6857	103.62		20.72
28405	Treatment of heel fracture		T	0043	1.6857	103.62		20.72
28406	Treatment of heel fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
28415	Treat heel fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
28420	Treat/graft heel fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
28430	Treatment of ankle fracture		T	0043	1.6857	103.62		20.72
28435	Treatment of ankle fracture		T	0043	1.6857	103.62		20.72
28436	Treatment of ankle fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
28445	Treat ankle fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
28450	Treat midfoot fracture, each		T	0043	1.6857	103.62		20.72
28455	Treat midfoot fracture, each		T	0043	1.6857	103.62		20.72
28456	Treat midfoot fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
28465	Treat midfoot fracture, each	CH	T	0063	37.5382	2,307.40	548.33	461.48
28470	Treat metatarsal fracture		T	0043	1.6857	103.62		20.72
28475	Treat metatarsal fracture		T	0043	1.6857	103.62		20.72
28476	Treat metatarsal fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
28485	Treat metatarsal fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
28490	Treat big toe fracture		T	0043	1.6857	103.62		20.72
28495	Treat big toe fracture		T	0043	1.6857	103.62		20.72
28496	Treat big toe fracture	CH	T	0062	25.5264	1,569.06	372.87	313.81
28505	Treat big toe fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
28510	Treatment of toe fracture		T	0043	1.6857	103.62		20.72
28515	Treatment of toe fracture		T	0043	1.6857	103.62		20.72
28525	Treat toe fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
28530	Treat sesamoid bone fracture		T	0043	1.6857	103.62		20.72
28531	Treat sesamoid bone fracture	CH	T	0063	37.5382	2,307.40	548.33	461.48
28540	Treat foot dislocation		T	0043	1.6857	103.62		20.72
28545	Treat foot dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81
28546	Treat foot dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81
28555	Repair foot dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
28570	Treat foot dislocation		T	0043	1.6857	103.62		20.72
28575	Treat foot dislocation		T	0043	1.6857	103.62		20.72
28576	Treat foot dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28585	Repair foot dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
28600	Treat foot dislocation		T	0043	1.6857	103.62		20.72
28605	Treat foot dislocation		T	0043	1.6857	103.62		20.72
28606	Treat foot dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81
28615	Repair foot dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
28630	Treat toe dislocation		T	0043	1.6857	103.62		20.72
28635	Treat toe dislocation		T	0045	14.5947	897.11	268.47	179.42
28636	Treat toe dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81
28645	Repair toe dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
28660	Treat toe dislocation		T	0043	1.6857	103.62		20.72
28665	Treat toe dislocation		T	0045	14.5947	897.11	268.47	179.42
28666	Treat toe dislocation	CH	T	0062	25.5264	1,569.06	372.87	313.81
28675	Repair of toe dislocation	CH	T	0063	37.5382	2,307.40	548.33	461.48
28705	Fusion of foot bones		T	0056	40.8559	2,511.33		502.27
28715	Fusion of foot bones		T	0056	40.8559	2,511.33		502.27
28725	Fusion of foot bones		T	0056	40.8559	2,511.33		502.27
28730	Fusion of foot bones		T	0056	40.8559	2,511.33		502.27
28735	Fusion of foot bones		T	0056	40.8559	2,511.33		502.27
28737	Revision of foot bones		T	0056	40.8559	2,511.33		502.27
28740	Fusion of foot bones		T	0056	40.8559	2,511.33		502.27
28750	Fusion of big toe joint		T	0056	40.8559	2,511.33		502.27
28755	Fusion of big toe joint		T	0055	20.4263	1,255.56	355.34	251.11
28760	Fusion of big toe joint		T	0056	40.8559	2,511.33		502.27
28810	Amputation toe & metatarsal		T	0055	20.4263	1,255.56	355.34	251.11
28820	Amputation of toe		T	0055	20.4263	1,255.56	355.34	251.11
28825	Partial amputation of toe		T	0055	20.4263	1,255.56	355.34	251.11
28890	High energy eswt, plantar f	CH	T	0050	25.1296	1,544.67		308.93
28899	Foot/toes surgery procedure		T	0043	1.6857	103.62		20.72
29000	Application of body cast		S	0058	1.0607	65.20		13.04
29010	Application of body cast		S	0426	2.2777	140.01		28.00
29015	Application of body cast		S	0426	2.2777	140.01		28.00
29020	Application of body cast		S	0058	1.0607	65.20		13.04
29025	Application of body cast		S	0058	1.0607	65.20		13.04
29035	Application of body cast		S	0426	2.2777	140.01		28.00
29040	Application of body cast		S	0058	1.0607	65.20		13.04
29044	Application of body cast		S	0426	2.2777	140.01		28.00
29046	Application of body cast		S	0426	2.2777	140.01		28.00
29049	Application of figure eight		S	0058	1.0607	65.20		13.04
29055	Application of shoulder cast		S	0426	2.2777	140.01		28.00
29058	Application of shoulder cast		S	0058	1.0607	65.20		13.04
29065	Application of long arm cast		S	0426	2.2777	140.01		28.00
29075	Application of forearm cast		S	0426	2.2777	140.01		28.00
29085	Apply hand/wrist cast		S	0058	1.0607	65.20		13.04
29086	Apply finger cast		S	0058	1.0607	65.20		13.04
29105	Apply long arm splint		S	0058	1.0607	65.20		13.04
29125	Apply forearm splint		S	0058	1.0607	65.20		13.04
29126	Apply forearm splint		S	0058	1.0607	65.20		13.04
29130	Application of finger splint		S	0058	1.0607	65.20		13.04
29131	Application of finger splint		S	0058	1.0607	65.20		13.04
29200	Strapping of chest		S	0058	1.0607	65.20		13.04
29220	Strapping of low back		S	0058	1.0607	65.20		13.04
29240	Strapping of shoulder		S	0058	1.0607	65.20		13.04
29260	Strapping of elbow or wrist		S	0058	1.0607	65.20		13.04
29280	Strapping of hand or finger		S	0058	1.0607	65.20		13.04
29305	Application of hip cast		S	0426	2.2777	140.01		28.00
29325	Application of hip casts		S	0426	2.2777	140.01		28.00
29345	Application of long leg cast		S	0426	2.2777	140.01		28.00
29355	Application of long leg cast		S	0426	2.2777	140.01		28.00
29358	Apply long leg cast brace		S	0426	2.2777	140.01		28.00
29365	Application of long leg cast		S	0426	2.2777	140.01		28.00
29405	Apply short leg cast		S	0426	2.2777	140.01		28.00
29425	Apply short leg cast		S	0426	2.2777	140.01		28.00
29435	Apply short leg cast		S	0426	2.2777	140.01		28.00
29440	Addition of walker to cast		S	0058	1.0607	65.20		13.04
29445	Apply rigid leg cast		S	0426	2.2777	140.01		28.00
29450	Application of leg cast		S	0058	1.0607	65.20		13.04
29505	Application, long leg splint		S	0058	1.0607	65.20		13.04
29515	Application lower leg splint		S	0058	1.0607	65.20		13.04
29520	Strapping of hip		S	0058	1.0607	65.20		13.04
29530	Strapping of knee		S	0058	1.0607	65.20		13.04

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29540	Strapping of ankle and/or ft		S	0058	1.0607	65.20		13.04
29550	Strapping of toes		S	0058	1.0607	65.20		13.04
29580	Application of paste boot		S	0058	1.0607	65.20		13.04
29590	Application of foot splint		S	0058	1.0607	65.20		13.04
29700	Removal/revision of cast		S	0058	1.0607	65.20		13.04
29705	Removal/revision of cast		S	0058	1.0607	65.20		13.04
29710	Removal/revision of cast		S	0426	2.2777	140.01		28.00
29715	Removal/revision of cast		S	0058	1.0607	65.20		13.04
29720	Repair of body cast		S	0058	1.0607	65.20		13.04
29730	Windowing of cast		S	0058	1.0607	65.20		13.04
29740	Wedging of cast		S	0058	1.0607	65.20		13.04
29750	Wedging of clubfoot cast		S	0058	1.0607	65.20		13.04
29799	Casting/strapping procedure		S	0058	1.0607	65.20		13.04
29800	Jaw arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29804	Jaw arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29805	Shoulder arthroscopy, dx		T	0041	28.6245	1,759.49		351.90
29806	Shoulder arthroscopy/surgery		T	0042	45.5027	2,796.96	804.74	559.39
29807	Shoulder arthroscopy/surgery		T	0042	45.5027	2,796.96	804.74	559.39
29819	Shoulder arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29820	Shoulder arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29821	Shoulder arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29822	Shoulder arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29823	Shoulder arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29824	Shoulder arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29825	Shoulder arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29826	Shoulder arthroscopy/surgery		T	0042	45.5027	2,796.96	804.74	559.39
29827	Arthroscop rotator cuff repr		T	0042	45.5027	2,796.96	804.74	559.39
29830	Elbow arthroscopy		T	0041	28.6245	1,759.49		351.90
29834	Elbow arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29835	Elbow arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29836	Elbow arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29837	Elbow arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29838	Elbow arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29840	Wrist arthroscopy		T	0041	28.6245	1,759.49		351.90
29843	Wrist arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29844	Wrist arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29845	Wrist arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29846	Wrist arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29847	Wrist arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29848	Wrist endoscopy/surgery		T	0041	28.6245	1,759.49		351.90
29850	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29851	Knee arthroscopy/surgery		T	0042	45.5027	2,796.96	804.74	559.39
29855	Tibial arthroscopy/surgery		T	0042	45.5027	2,796.96	804.74	559.39
29856	Tibial arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29860	Hip arthroscopy, dx		T	0041	28.6245	1,759.49		351.90
29861	Hip arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29862	Hip arthroscopy/surgery		T	0042	45.5027	2,796.96	804.74	559.39
29863	Hip arthroscopy/surgery		T	0042	45.5027	2,796.96	804.74	559.39
29866	Autgrft implnt, knee w/scope		T	0042	45.5027	2,796.96	804.74	559.39
29867	Allgrft implnt, knee w/scope		T	0042	45.5027	2,796.96	804.74	559.39
29868	Meniscal trnspl, knee w/scpe		T	0042	45.5027	2,796.96	804.74	559.39
29870	Knee arthroscopy, dx		T	0041	28.6245	1,759.49		351.90
29871	Knee arthroscopy/drainage		T	0041	28.6245	1,759.49		351.90
29873	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29874	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29875	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29876	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29877	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29879	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29880	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29881	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29882	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29883	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29884	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29885	Knee arthroscopy/surgery		T	0042	45.5027	2,796.96	804.74	559.39
29886	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29887	Knee arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29888	Knee arthroscopy/surgery		T	0042	45.5027	2,796.96	804.74	559.39
29889	Knee arthroscopy/surgery		T	0042	45.5027	2,796.96	804.74	559.39
29891	Ankle arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29892	Ankle arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29893	Scope, plantar fasciotomy		T	0055	20.4263	1,255.56	355.34	251.11
29894	Ankle arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29895	Ankle arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29897	Ankle arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29898	Ankle arthroscopy/surgery		T	0041	28.6245	1,759.49		351.90
29899	Ankle arthroscopy/surgery		T	0042	45.5027	2,796.96	804.74	559.39
29900	Mcp joint arthroscopy, dx		T	0053	16.154	992.95	253.49	198.59
29901	Mcp joint arthroscopy, surg		T	0053	16.154	992.95	253.49	198.59
29902	Mcp joint arthroscopy, surg		T	0053	16.154	992.95	253.49	198.59
29999	Arthroscopy of joint		T	0041	28.6245	1,759.49		351.90
30000	Drainage of nose lesion		T	0251	2.452	150.72		30.14
30020	Drainage of nose lesion		T	0251	2.452	150.72		30.14
30100	Intranasal biopsy		T	0252	7.5511	464.15	109.16	92.83
30110	Removal of nose polyp(s)		T	0253	16.4266	1,009.71	282.29	201.94
30115	Removal of nose polyp(s)		T	0253	16.4266	1,009.71	282.29	201.94
30117	Removal of intranasal lesion		T	0253	16.4266	1,009.71	282.29	201.94
30118	Removal of intranasal lesion		T	0254	23.3299	1,434.04	321.35	286.81
30120	Revision of nose		T	0253	16.4266	1,009.71	282.29	201.94
30124	Removal of nose lesion		T	0252	7.5511	464.15	109.16	92.83
30125	Removal of nose lesion		T	0256	38.1991	2,348.02		469.60
30130	Excise inferior turbinate		T	0253	16.4266	1,009.71	282.29	201.94
30140	Resect inferior turbinate		T	0254	23.3299	1,434.04	321.35	286.81
30150	Partial removal of nose		T	0256	38.1991	2,348.02		469.60
30160	Removal of nose		T	0256	38.1991	2,348.02		469.60
30200	Injection treatment of nose		T	0252	7.5511	464.15	109.16	92.83
30210	Nasal sinus therapy		T	0252	7.5511	464.15	109.16	92.83
30220	Insert nasal septal button		T	0252	7.5511	464.15	109.16	92.83
30300	Remove nasal foreign body		X	0340	0.6102	37.51		7.50
30310	Remove nasal foreign body		T	0253	16.4266	1,009.71	282.29	201.94
30320	Remove nasal foreign body		T	0253	16.4266	1,009.71	282.29	201.94
30400	Reconstruction of nose		T	0256	38.1991	2,348.02		469.60
30410	Reconstruction of nose		T	0256	38.1991	2,348.02		469.60
30420	Reconstruction of nose		T	0256	38.1991	2,348.02		469.60
30430	Revision of nose		T	0254	23.3299	1,434.04	321.35	286.81
30435	Revision of nose		T	0256	38.1991	2,348.02		469.60
30450	Revision of nose		T	0256	38.1991	2,348.02		469.60
30460	Revision of nose		T	0256	38.1991	2,348.02		469.60
30462	Revision of nose		T	0256	38.1991	2,348.02		469.60
30465	Repair nasal stenosis		T	0256	38.1991	2,348.02		469.60
30520	Repair of nasal septum		T	0254	23.3299	1,434.04	321.35	286.81
30540	Repair nasal defect		T	0256	38.1991	2,348.02		469.60
30545	Repair nasal defect		T	0256	38.1991	2,348.02		469.60
30560	Release of nasal adhesions		T	0251	2.452	150.72		30.14
30580	Repair upper jaw fistula		T	0256	38.1991	2,348.02		469.60
30600	Repair mouth/nose fistula		T	0256	38.1991	2,348.02		469.60
30620	Intranasal reconstruction		T	0256	38.1991	2,348.02		469.60
30630	Repair nasal septum defect		T	0254	23.3299	1,434.04	321.35	286.81
30801	Ablate inf turbinate, superf		T	0252	7.5511	464.15	109.16	92.83
30802	Cauterization, inner nose		T	0252	7.5511	464.15	109.16	92.83
30901	Control of nosebleed		T	0250	1.1791	72.48	25.39	14.50
30903	Control of nosebleed		T	0250	1.1791	72.48	25.39	14.50
30905	Control of nosebleed		T	0250	1.1791	72.48	25.39	14.50
30906	Repeat control of nosebleed		T	0250	1.1791	72.48	25.39	14.50
30915	Ligation, nasal sinus artery	CH	T	0092	24.8809	1,529.38	309.87	305.88
30920	Ligation, upper jaw artery		T	0092	24.8809	1,529.38	309.87	305.88
30930	Ther fx, nasal inf turbinate		T	0253	16.4266	1,009.71	282.29	201.94
30999	Nasal surgery procedure		T	0251	2.452	150.72		30.14
31000	Irrigation, maxillary sinus		T	0251	2.452	150.72		30.14
31002	Irrigation, sphenoid sinus		T	0252	7.5511	464.15	109.16	92.83
31020	Exploration, maxillary sinus		T	0254	23.3299	1,434.04	321.35	286.81
31030	Exploration, maxillary sinus		T	0256	38.1991	2,348.02		469.60
31032	Explore sinus, remove polyps		T	0256	38.1991	2,348.02		469.60
31040	Exploration behind upper jaw		T	0254	23.3299	1,434.04	321.35	286.81
31050	Exploration, sphenoid sinus		T	0256	38.1991	2,348.02		469.60
31051	Sphenoid sinus surgery		T	0256	38.1991	2,348.02		469.60
31070	Exploration of frontal sinus		T	0254	23.3299	1,434.04	321.35	286.81
31075	Exploration of frontal sinus		T	0256	38.1991	2,348.02		469.60
31080	Removal of frontal sinus		T	0256	38.1991	2,348.02		469.60
31081	Removal of frontal sinus		T	0256	38.1991	2,348.02		469.60

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31084	Removal of frontal sinus		T	0256	38.1991	2,348.02		469.60
31085	Removal of frontal sinus		T	0256	38.1991	2,348.02		469.60
31086	Removal of frontal sinus		T	0256	38.1991	2,348.02		469.60
31087	Removal of frontal sinus		T	0256	38.1991	2,348.02		469.60
31090	Exploration of sinuses		T	0256	38.1991	2,348.02		469.60
31200	Removal of ethmoid sinus		T	0256	38.1991	2,348.02		469.60
31201	Removal of ethmoid sinus		T	0256	38.1991	2,348.02		469.60
31205	Removal of ethmoid sinus		T	0256	38.1991	2,348.02		469.60
31231	Nasal endoscopy, dx		T	0072	1.4054	86.39	21.27	17.28
31233	Nasal/sinus endoscopy, dx		T	0072	1.4054	86.39	21.27	17.28
31235	Nasal/sinus endoscopy, dx		T	0074	14.7928	909.28	292.25	181.86
31237	Nasal/sinus endoscopy, surg	CH	T	0074	14.7928	909.28	292.25	181.86
31238	Nasal/sinus endoscopy, surg		T	0074	14.7928	909.28	292.25	181.86
31239	Nasal/sinus endoscopy, surg		T	0075	21.9512	1,349.30	445.92	269.86
31240	Nasal/sinus endoscopy, surg		T	0074	14.7928	909.28	292.25	181.86
31254	Revision of ethmoid sinus		T	0075	21.9512	1,349.30	445.92	269.86
31255	Removal of ethmoid sinus		T	0075	21.9512	1,349.30	445.92	269.86
31256	Exploration maxillary sinus		T	0075	21.9512	1,349.30	445.92	269.86
31267	Endoscopy, maxillary sinus		T	0075	21.9512	1,349.30	445.92	269.86
31276	Sinus endoscopy, surgical		T	0075	21.9512	1,349.30	445.92	269.86
31287	Nasal/sinus endoscopy, surg		T	0075	21.9512	1,349.30	445.92	269.86
31288	Nasal/sinus endoscopy, surg		T	0075	21.9512	1,349.30	445.92	269.86
31292	Nasal/sinus endoscopy, surg		T	0075	21.9512	1,349.30	445.92	269.86
31293	Nasal/sinus endoscopy, surg		T	0075	21.9512	1,349.30	445.92	269.86
31294	Nasal/sinus endoscopy, surg		T	0075	21.9512	1,349.30	445.92	269.86
31299	Sinus surgery procedure		T	0251	2.452	150.72		30.14
31300	Removal of larynx lesion		T	0254	23.3299	1,434.04	321.35	286.81
31320	Diagnostic incision, larynx		T	0256	38.1991	2,348.02		469.60
31400	Revision of larynx		T	0256	38.1991	2,348.02		469.60
31420	Removal of epiglottis		T	0256	38.1991	2,348.02		469.60
31500	Insert emergency airway		S	0094	2.4233	148.96	46.29	29.79
31502	Change of windpipe airway		T	0121	2.3587	144.98	43.80	29.00
31505	Diagnostic laryngoscopy		T	0071	0.7698	47.32	11.20	9.46
31510	Laryngoscopy with biopsy		T	0074	14.7928	909.28	292.25	181.86
31511	Remove foreign body, larynx		T	0072	1.4054	86.39	21.27	17.28
31512	Removal of larynx lesion		T	0074	14.7928	909.28	292.25	181.86
31513	Injection into vocal cord		T	0072	1.4054	86.39	21.27	17.28
31515	Laryngoscopy for aspiration		T	0074	14.7928	909.28	292.25	181.86
31520	Dx laryngoscopy, newborn		T	0072	1.4054	86.39	21.27	17.28
31525	Dx laryngoscopy excl nb		T	0074	14.7928	909.28	292.25	181.86
31526	Dx laryngoscopy w/oper scope		T	0075	21.9512	1,349.30	445.92	269.86
31527	Laryngoscopy for treatment		T	0075	21.9512	1,349.30	445.92	269.86
31528	Laryngoscopy and dilation		T	0074	14.7928	909.28	292.25	181.86
31529	Laryngoscopy and dilation		T	0074	14.7928	909.28	292.25	181.86
31530	Laryngoscopy w/fb removal		T	0075	21.9512	1,349.30	445.92	269.86
31531	Laryngoscopy w/fb & op scope		T	0075	21.9512	1,349.30	445.92	269.86
31535	Laryngoscopy w/biopsy		T	0075	21.9512	1,349.30	445.92	269.86
31536	Laryngoscopy w/bx & op scope		T	0075	21.9512	1,349.30	445.92	269.86
31540	Laryngoscopy w/exc of tumor		T	0075	21.9512	1,349.30	445.92	269.86
31541	Larynscop w/tumr exc + scope		T	0075	21.9512	1,349.30	445.92	269.86
31545	Remove vc lesion w/scope		T	0075	21.9512	1,349.30	445.92	269.86
31546	Remove vc lesion scope/graft		T	0075	21.9512	1,349.30	445.92	269.86
31560	Laryngoscop w/arytenoidectom		T	0075	21.9512	1,349.30	445.92	269.86
31561	Larynscop, remve cart + scop		T	0075	21.9512	1,349.30	445.92	269.86
31570	Laryngoscope w/vc inj		T	0074	14.7928	909.28	292.25	181.86
31571	Laryngoscop w/vc inj + scope		T	0075	21.9512	1,349.30	445.92	269.86
31575	Diagnostic laryngoscopy		T	0072	1.4054	86.39	21.27	17.28
31576	Laryngoscopy with biopsy		T	0075	21.9512	1,349.30	445.92	269.86
31577	Remove foreign body, larynx		T	0073	3.8463	236.42	69.15	47.28
31578	Removal of larynx lesion		T	0075	21.9512	1,349.30	445.92	269.86
31579	Diagnostic laryngoscopy		T	0073	3.8463	236.42	69.15	47.28
31580	Revision of larynx		T	0256	38.1991	2,348.02		469.60
31582	Revision of larynx		T	0256	38.1991	2,348.02		469.60
31588	Revision of larynx		T	0256	38.1991	2,348.02		469.60
31590	Reinnervate larynx		T	0256	38.1991	2,348.02		469.60
31595	Larynx nerve surgery		T	0256	38.1991	2,348.02		469.60
31599	Larynx surgery procedure		T	0251	2.452	150.72		30.14
31600	Incision of windpipe		T	0254	23.3299	1,434.04	321.35	286.81
31601	Incision of windpipe		T	0254	23.3299	1,434.04	321.35	286.81
31603	Incision of windpipe		T	0252	7.5511	464.15	109.16	92.83

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31605	Incision of windpipe		T	0252	7.5511	464.15	109.16	92.83
31610	Incision of windpipe		T	0254	23.3299	1,434.04	321.35	286.81
31611	Surgery/speech prosthesis		T	0254	23.3299	1,434.04	321.35	286.81
31612	Puncture/clear windpipe		T	0254	23.3299	1,434.04	321.35	286.81
31613	Repair windpipe opening		T	0254	23.3299	1,434.04	321.35	286.81
31614	Repair windpipe opening		T	0256	38.1991	2,348.02		469.60
31615	Visualization of windpipe		T	0076	9.5228	585.35	189.82	117.07
31620	Endobronchial us add-on		S	0670	32.2854	1,984.52	536.10	396.90
31622	Dx bronchoscope/wash		T	0076	9.5228	585.35	189.82	117.07
31623	Dx bronchoscope/brush		T	0076	9.5228	585.35	189.82	117.07
31624	Dx bronchoscope/lavage		T	0076	9.5228	585.35	189.82	117.07
31625	Bronchoscopy w/biopsy(s)		T	0076	9.5228	585.35	189.82	117.07
31628	Bronchoscopy/lung bx, each		T	0076	9.5228	585.35	189.82	117.07
31629	Bronchoscopy/needle bx, each		T	0076	9.5228	585.35	189.82	117.07
31630	Bronchoscopy dilate/fx repr		T	0415	22.0099	1,352.90	459.92	270.58
31631	Bronchoscopy, dilate w/stent		T	0415	22.0099	1,352.90	459.92	270.58
31632	Bronchoscopy/lung bx, add'l		T	0076	9.5228	585.35	189.82	117.07
31633	Bronchoscopy/needle bx add'l		T	0076	9.5228	585.35	189.82	117.07
31635	Bronchoscopy w/fb removal		T	0076	9.5228	585.35	189.82	117.07
31636	Bronchoscopy, bronch stents		T	0415	22.0099	1,352.90	459.92	270.58
31637	Bronchoscopy, stent add-on		T	0076	9.5228	585.35	189.82	117.07
31638	Bronchoscopy, revise stent		T	0415	22.0099	1,352.90	459.92	270.58
31640	Bronchoscopy w/tumor excise		T	0415	22.0099	1,352.90	459.92	270.58
31641	Bronchoscopy, treat blockage		T	0415	22.0099	1,352.90	459.92	270.58
31643	Diag bronchoscope/catheter		T	0076	9.5228	585.35	189.82	117.07
31645	Bronchoscopy, clear airways		T	0076	9.5228	585.35	189.82	117.07
31646	Bronchoscopy, reclear airway		T	0076	9.5228	585.35	189.82	117.07
31656	Bronchoscopy, inj for x-ray		T	0076	9.5228	585.35	189.82	117.07
31700	Insertion of airway catheter	CH	D					
31708	Instill airway contrast dye	CH	D					
31710	Insertion of airway catheter	CH	D					
31715	Injection for bronchus x-ray		N					
31717	Bronchial brush biopsy		T	0073	3.8463	236.42	69.15	47.28
31720	Clearance of airways		T	0071	0.7698	47.32	11.20	9.46
31730	Intro, windpipe wire/tube		T	0073	3.8463	236.42	69.15	47.28
31750	Repair of windpipe		T	0256	38.1991	2,348.02		469.60
31755	Repair of windpipe		T	0256	38.1991	2,348.02		469.60
31785	Remove windpipe lesion		T	0254	23.3299	1,434.04	321.35	286.81
31820	Closure of windpipe lesion		T	0253	16.4266	1,009.71	282.29	201.94
31825	Repair of windpipe defect		T	0254	23.3299	1,434.04	321.35	286.81
31830	Revise windpipe scar		T	0254	23.3299	1,434.04	321.35	286.81
31899	Airways surgical procedure		T	0076	9.5228	585.35	189.82	117.07
32000	Drainage of chest		T	0070	3.6244	222.78		44.56
32002	Treatment of collapsed lung		T	0070	3.6244	222.78		44.56
32005	Treat lung lining chemically		T	0070	3.6244	222.78		44.56
32019	Insert pleural catheter	CH	T	0652	29.5416	1,815.86		363.17
32020	Insertion of chest tube		T	0070	3.6244	222.78		44.56
32201	Drain, percut, lung lesion		T	0070	3.6244	222.78		44.56
32400	Needle biopsy chest lining		T	0685	6.1384	377.32	115.47	75.46
32405	Biopsy, lung or mediastinum		T	0685	6.1384	377.32	115.47	75.46
32420	Puncture/clear lung		T	0070	3.6244	222.78		44.56
32601	Thoracoscopy, diagnostic		T	0069	31.9442	1,963.55	591.64	392.71
32602	Thoracoscopy, diagnostic		T	0069	31.9442	1,963.55	591.64	392.71
32603	Thoracoscopy, diagnostic		T	0069	31.9442	1,963.55	591.64	392.71
32604	Thoracoscopy, diagnostic		T	0069	31.9442	1,963.55	591.64	392.71
32605	Thoracoscopy, diagnostic		T	0069	31.9442	1,963.55	591.64	392.71
32606	Thoracoscopy, diagnostic		T	0069	31.9442	1,963.55	591.64	392.71
32960	Therapeutic pneumothorax		T	0070	3.6244	222.78		44.56
32998	Perq rf ablate tx, pul tumor	NI	T	0423	37.3604	2,296.47		459.29
32999	Chest surgery procedure		T	0070	3.6244	222.78		44.56
33010	Drainage of heart sac		T	0070	3.6244	222.78		44.56
33011	Repeat drainage of heart sac		T	0070	3.6244	222.78		44.56
33200	Insertion of heart pacemaker	CH	D					
33201	Insertion of heart pacemaker	CH	D					
33202	Insert epicard eltrd, open	NI	C					
33203	Insert epicard eltrd, endo	NI	C					
33206	Insertion of heart pacemaker		T	0089	123.6693	7,601.70	1,682.28	1,520.34
33207	Insertion of heart pacemaker		T	0089	123.6693	7,601.70	1,682.28	1,520.34
33208	Insertion of heart pacemaker		T	0655	152.6392	9,382.43		1,876.49
33210	Insertion of heart electrode		T	0106	58.8594	3,617.97		723.59

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33211	Insertion of heart electrode		T	0106	58.8594	3,617.97		723.59
33212	Insertion of pulse generator		T	0090	98.3023	6,042.45	1,612.80	1,208.49
33213	Insertion of pulse generator		T	0654	112.7719	6,931.86		1,386.37
33214	Upgrade of pacemaker system		T	0655	152.6392	9,382.43		1,876.49
33215	Reposition pacing-defib lead		T	0105	25.6142	1,574.45	370.40	314.89
33216	Insert lead pace-defib, one		T	0106	58.8594	3,617.97		723.59
33217	Insert lead pace-defib, dual		T	0106	58.8594	3,617.97		723.59
33218	Repair lead pace-defib, one	CH	T	0105	25.6142	1,574.45	370.40	314.89
33220	Repair lead pace-defib, dual	CH	T	0105	25.6142	1,574.45	370.40	314.89
33222	Revise pocket, pacemaker		T	0027	21.4302	1,317.27	329.72	263.45
33223	Revise pocket, pacing-defib		T	0027	21.4302	1,317.27	329.72	263.45
33224	Insert pacing lead & connect		T	0418	307.2828	18,888.06		3,777.61
33225	Lventric pacing lead add-on		T	0418	307.2828	18,888.06		3,777.61
33226	Reposition l ventric lead		T	0105	25.6142	1,574.45	370.40	314.89
33233	Removal of pacemaker system		T	0105	25.6142	1,574.45	370.40	314.89
33234	Removal of pacemaker system		T	0105	25.6142	1,574.45	370.40	314.89
33235	Removal pacemaker electrode		T	0105	25.6142	1,574.45	370.40	314.89
33241	Remove pulse generator		T	0105	25.6142	1,574.45	370.40	314.89
33244	Remove eltrd, transven		T	0105	25.6142	1,574.45	370.40	314.89
33245	Insert epic eltrd pace-defib	CH	D					
33246	Insert epic eltrd/generator	CH	D					
33253	Reconstruct atria	CH	D					
33254	Ablate atria, lmtd	NI	C					
33255	Ablate atria w/o bypass, ext	NI	C					
33256	Ablate atria w/bypass, exten	NI	C					
33265	Ablate atria w/bypass, endo	NI	C					
33266	Ablate atria w/o bypass endo	NI	C					
33282	Implant pat-active ht record		S	0680	72.6022	4,462.71		892.54
33284	Remove pat-active ht record		T	0109	10.9918	675.64		135.13
33508	Endoscopic vein harvest		N					
33675	Close mult vsd	NI	C					
33676	Close mult vsd w/resection	NI	C					
33677	Cl mult vsd w/rem pul band	NI	C					
33724	Repair venous anomaly	NI	C					
33726	Repair pul venous stenosis	NI	C					
33999	Cardiac surgery procedure		T	0070	3.6244	222.78		44.56
34101	Removal of artery clot		T	0088	37.7391	2,319.75	655.22	463.95
34111	Removal of arm artery clot		T	0088	37.7391	2,319.75	655.22	463.95
34201	Removal of artery clot		T	0088	37.7391	2,319.75	655.22	463.95
34203	Removal of leg artery clot		T	0088	37.7391	2,319.75	655.22	463.95
34421	Removal of vein clot		T	0088	37.7391	2,319.75	655.22	463.95
34471	Removal of vein clot		T	0088	37.7391	2,319.75	655.22	463.95
34490	Removal of vein clot		T	0088	37.7391	2,319.75	655.22	463.95
34501	Repair valve, femoral vein		T	0088	37.7391	2,319.75	655.22	463.95
34510	Transposition of vein valve		T	0088	37.7391	2,319.75	655.22	463.95
34520	Cross-over vein graft		T	0088	37.7391	2,319.75	655.22	463.95
34530	Leg vein fusion		T	0088	37.7391	2,319.75	655.22	463.95
35011	Repair defect of artery		T	0653	32.3818	1,990.44		398.09
35180	Repair blood vessel lesion		T	0093	22.8653	1,405.48		281.10
35184	Repair blood vessel lesion		T	0093	22.8653	1,405.48		281.10
35188	Repair blood vessel lesion		T	0088	37.7391	2,319.75	655.22	463.95
35190	Repair blood vessel lesion		T	0093	22.8653	1,405.48		281.10
35201	Repair blood vessel lesion		T	0093	22.8653	1,405.48		281.10
35206	Repair blood vessel lesion		T	0093	22.8653	1,405.48		281.10
35207	Repair blood vessel lesion		T	0088	37.7391	2,319.75	655.22	463.95
35226	Repair blood vessel lesion		T	0093	22.8653	1,405.48		281.10
35231	Repair blood vessel lesion		T	0093	22.8653	1,405.48		281.10
35236	Repair blood vessel lesion		T	0093	22.8653	1,405.48		281.10
35256	Repair blood vessel lesion		T	0093	22.8653	1,405.48		281.10
35261	Repair blood vessel lesion		T	0653	32.3818	1,990.44		398.09
35266	Repair blood vessel lesion		T	0653	32.3818	1,990.44		398.09
35286	Repair blood vessel lesion		T	0653	32.3818	1,990.44		398.09
35302	Rechanneling of artery	NI	C					
35303	Rechanneling of artery	NI	C					
35304	Rechanneling of artery	NI	C					
35305	Rechanneling of artery	NI	C					
35306	Rechanneling of artery	NI	C					
35321	Rechanneling of artery		T	0093	22.8653	1,405.48		281.10
35381	Rechanneling of artery	CH	D					
35458	Repair arterial blockage		T	0081	42.936	2,639.19		527.84

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35459	Repair arterial blockage		T	0081	42.936	2,639.19		527.84
35460	Repair venous blockage		T	0081	42.936	2,639.19		527.84
35470	Repair arterial blockage		T	0081	42.936	2,639.19		527.84
35471	Repair arterial blockage		T	0081	42.936	2,639.19		527.84
35472	Repair arterial blockage		T	0081	42.936	2,639.19		527.84
35473	Repair arterial blockage		T	0081	42.936	2,639.19		527.84
35474	Repair arterial blockage		T	0081	42.936	2,639.19		527.84
35475	Repair arterial blockage		T	0081	42.936	2,639.19		527.84
35476	Repair venous blockage		T	0081	42.936	2,639.19		527.84
35484	Atherectomy, open		T	0081	42.936	2,639.19		527.84
35485	Atherectomy, open		T	0081	42.936	2,639.19		527.84
35490	Atherectomy, percutaneous		T	0081	42.936	2,639.19		527.84
35491	Atherectomy, percutaneous		T	0081	42.936	2,639.19		527.84
35492	Atherectomy, percutaneous		T	0081	42.936	2,639.19		527.84
35493	Atherectomy, percutaneous		T	0081	42.936	2,639.19		527.84
35494	Atherectomy, percutaneous		T	0081	42.936	2,639.19		527.84
35495	Atherectomy, percutaneous		T	0081	42.936	2,639.19		527.84
35500	Harvest vein for bypass		T	0081	42.936	2,639.19		527.84
35507	Artery bypass graft	CH	D					
35537	Artery bypass graft	NI	C					
35538	Artery bypass graft	NI	C					
35539	Artery bypass graft	NI	C					
35540	Artery bypass graft	NI	C					
35541	Artery bypass graft	CH	D					
35546	Artery bypass graft	CH	D					
35572	Harvest femoropopliteal vein		N					
35637	Artery bypass graft	NI	C					
35638	Artery bypass graft	NI	C					
35641	Artery bypass graft	CH	D					
35685	Bypass graft patency/patch		T	0093	22.8653	1,405.48		281.10
35686	Bypass graft/av fist patency		T	0093	22.8653	1,405.48		281.10
35761	Exploration of artery/vein		T	0115	29.2133	1,795.68	374.81	359.14
35860	Explore limb vessels		T	0093	22.8653	1,405.48		281.10
35875	Removal of clot in graft		T	0088	37.7391	2,319.75	655.22	463.95
35876	Removal of clot in graft		T	0088	37.7391	2,319.75	655.22	463.95
35879	Revise graft w/vein		T	0088	37.7391	2,319.75	655.22	463.95
35881	Revise graft w/vein		T	0088	37.7391	2,319.75	655.22	463.95
35883	Revise graft w/nonauto graft	NI	T	0088	37.7391	2,319.75	655.22	463.95
35884	Revise graft w/vein	NI	T	0088	37.7391	2,319.75	655.22	463.95
35903	Excision, graft, extremity		T	0115	29.2133	1,795.68	374.81	359.14
36000	Place needle in vein		N					
36002	Pseudoaneurysm injection trt		S	0267	2.4606	151.25	60.50	30.25
36005	Injection ext venography		N					
36010	Place catheter in vein		N					
36011	Place catheter in vein		N					
36012	Place catheter in vein		N					
36013	Place catheter in artery		N					
36014	Place catheter in artery		N					
36015	Place catheter in artery		N					
36100	Establish access to artery		N					
36120	Establish access to artery		N					
36140	Establish access to artery		N					
36145	Artery to vein shunt		N					
36160	Establish access to aorta		N					
36200	Place catheter in aorta		N					
36215	Place catheter in artery		N					
36216	Place catheter in artery		N					
36217	Place catheter in artery		N					
36218	Place catheter in artery		N					
36245	Place catheter in artery		N					
36246	Place catheter in artery		N					
36247	Place catheter in artery		N					
36248	Place catheter in artery		N					
36260	Insertion of infusion pump		T	0623	28.5032	1,752.03		350.41
36261	Revision of infusion pump		T	0623	28.5032	1,752.03		350.41
36262	Removal of infusion pump		T	0622	22.6665	1,393.26		278.65
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36410	Non-routine bl draw > 3 yrs		N					
36416	Capillary blood draw		N					
36420	Vein access cutdown < 1 yr		T	0035	0.1999	12.29		2.46
36425	Vein access cutdown > 1 yr		T	0035	0.1999	12.29		2.46
36430	Blood transfusion service		S	0110	3.4584	212.58		42.52
36440	Bl push transfuse, 2 yr or <		S	0110	3.4584	212.58		42.52
36450	Bl exchange/transfuse, nb		S	0110	3.4584	212.58		42.52
36455	Bl exchange/transfuse non-nb		S	0110	3.4584	212.58		42.52
36460	Transfusion service, fetal		S	0110	3.4584	212.58		42.52
36468	Injection(s), spider veins		T	0098	1.0798	66.37		13.27
36469	Injection(s), spider veins		T	0098	1.0798	66.37		13.27
36470	Injection therapy of vein		T	0098	1.0798	66.37		13.27
36471	Injection therapy of veins		T	0098	1.0798	66.37		13.27
36475	Endovenous rf, 1st vein		T	0091	34.7288	2,134.71		426.94
36476	Endovenous rf, vein add-on		T	0091	34.7288	2,134.71		426.94
36478	Endovenous laser, 1st vein	CH	T	0092	24.8809	1,529.38	309.87	305.88
36479	Endovenous laser vein addon	CH	T	0092	24.8809	1,529.38	309.87	305.88
36481	Insertion of catheter, vein		N					
36500	Insertion of catheter, vein		N					
36510	Insertion of catheter, vein		N					
36511	Apheresis wbc		S	0111	11.7134	720.00	198.40	144.00
36512	Apheresis rbc		S	0111	11.7134	720.00	198.40	144.00
36513	Apheresis platelets		S	0111	11.7134	720.00	198.40	144.00
36514	Apheresis plasma		S	0111	11.7134	720.00	198.40	144.00
36515	Apheresis, adsorp/reinfuse		S	0112	30.2231	1,857.75	433.29	371.55
36516	Apheresis, selective		S	0112	30.2231	1,857.75	433.29	371.55
36522	Photopheresis		S	0112	30.2231	1,857.75	433.29	371.55
36540	Collect blood venous device	CH	Q	0624	0.5145	31.63	12.65	6.33
36550	Declot vascular device		T	0676	2.0726	127.40		25.48
36555	Insert non-tunnel cv cath		T	0621	8.7846	539.97		107.99
36556	Insert non-tunnel cv cath		T	0621	8.7846	539.97		107.99
36557	Insert tunneled cv cath		T	0622	22.6665	1,393.26		278.65
36558	Insert tunneled cv cath		T	0622	22.6665	1,393.26		278.65
36560	Insert tunneled cv cath		T	0623	28.5032	1,752.03		350.41
36561	Insert tunneled cv cath		T	0623	28.5032	1,752.03		350.41
36563	Insert tunneled cv cath		T	0623	28.5032	1,752.03		350.41
36565	Insert tunneled cv cath		T	0623	28.5032	1,752.03		350.41
36566	Insert tunneled cv cath	CH	T	0625	83.4609	5,130.17		1,026.03
36568	Insert picc cath		T	0621	8.7846	539.97		107.99
36569	Insert picc cath		T	0621	8.7846	539.97		107.99
36570	Insert picvad cath		T	0622	22.6665	1,393.26		278.65
36571	Insert picvad cath		T	0622	22.6665	1,393.26		278.65
36575	Repair tunneled cv cath		T	0621	8.7846	539.97		107.99
36576	Repair tunneled cv cath		T	0621	8.7846	539.97		107.99
36578	Replace tunneled cv cath		T	0622	22.6665	1,393.26		278.65
36580	Replace cvad cath		T	0621	8.7846	539.97		107.99
36581	Replace tunneled cv cath		T	0622	22.6665	1,393.26		278.65
36582	Replace tunneled cv cath		T	0623	28.5032	1,752.03		350.41
36583	Replace tunneled cv cath		T	0623	28.5032	1,752.03		350.41
36584	Replace picc cath		T	0621	8.7846	539.97		107.99
36585	Replace picvad cath		T	0622	22.6665	1,393.26		278.65
36589	Removal tunneled cv cath		T	0621	8.7846	539.97		107.99
36590	Removal tunneled cv cath		T	0621	8.7846	539.97		107.99
36595	Mech remov tunneled cv cath		T	0622	22.6665	1,393.26		278.65
36596	Mech remov tunneled cv cath		T	0621	8.7846	539.97		107.99
36597	Reposition venous catheter		T	0621	8.7846	539.97		107.99
36598	Inj w/fluor, eval cv device		X	0340	0.6102	37.51		7.50
36600	Withdrawal of arterial blood	CH	Q	0035	0.1999	12.29		2.46
36620	Insertion catheter, artery		N					
36625	Insertion catheter, artery		N					
36640	Insertion catheter, artery		T	0623	28.5032	1,752.03		350.41
36680	Insert needle, bone cavity		T	0002	1.0995	67.58		13.52
36800	Insertion of cannula		T	0115	29.2133	1,795.68	374.81	359.14
36810	Insertion of cannula		T	0115	29.2133	1,795.68	374.81	359.14
36815	Insertion of cannula		T	0115	29.2133	1,795.68	374.81	359.14
36818	Av fuse, uppr arm, cephalic		T	0088	37.7391	2,319.75	655.22	463.95
36819	Av fuse, uppr arm, basilic		T	0088	37.7391	2,319.75	655.22	463.95
36820	Av fusion/forearm vein		T	0088	37.7391	2,319.75	655.22	463.95
36821	Av fusion direct any site		T	0088	37.7391	2,319.75	655.22	463.95
36825	Artery-vein autograft		T	0088	37.7391	2,319.75	655.22	463.95

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36830	Artery-vein nonautograft		T	0088	37.7391	2,319.75	655.22	463.95
36831	Open thrombect av fistula		T	0088	37.7391	2,319.75	655.22	463.95
36832	Av fistula revision, open		T	0088	37.7391	2,319.75	655.22	463.95
36833	Av fistula revision		T	0088	37.7391	2,319.75	655.22	463.95
36834	Repair A–V aneurysm		T	0088	37.7391	2,319.75	655.22	463.95
36835	Artery to vein shunt		T	0115	29.2133	1,795.68	374.81	359.14
36838	Dist revas ligation, hemo		T	0088	37.7391	2,319.75	655.22	463.95
36860	External cannula declotting		T	0676	2.0726	127.40		25.48
36861	Cannula declotting		T	0115	29.2133	1,795.68	374.81	359.14
36870	Percut thrombect av fistula		T	0653	32.3818	1,990.44		398.09
37183	Remove hepatic shunt (tips)		T	0229	68.4697	4,208.70		841.74
37184	Prim art mech thrombectomy	CH	T	0088	37.7391	2,319.75	655.22	463.95
37185	Prim art m-thrombect add-on	CH	T	0088	37.7391	2,319.75	655.22	463.95
37186	Sec art m-thrombect add-on	CH	T	0088	37.7391	2,319.75	655.22	463.95
37187	Venous mech thrombectomy	CH	T	0088	37.7391	2,319.75	655.22	463.95
37188	Venous m-thrombectomy add-on	CH	T	0088	37.7391	2,319.75	655.22	463.95
37195	Thrombolytic therapy, stroke		T	0676	2.0726	127.40		25.48
37200	Transcatheter biopsy		T	0685	6.1384	377.32	115.47	75.46
37201	Transcatheter therapy infuse		T	0676	2.0726	127.40		25.48
37202	Transcatheter therapy infuse		T	0676	2.0726	127.40		25.48
37203	Transcatheter retrieval		T	0103	16.2375	998.09	223.63	199.62
37204	Transcatheter occlusion		T	0115	29.2133	1,795.68	374.81	359.14
37205	Transcath iv stent, percut		T	0229	68.4697	4,208.70		841.74
37206	Transcath iv stent/perc addl		T	0229	68.4697	4,208.70		841.74
37207	Transcath iv stent, open		T	0229	68.4697	4,208.70		841.74
37208	Transcath iv stent/open addl		T	0229	68.4697	4,208.70		841.74
37209	Change iv cath at thromb tx		T	0103	16.2375	998.09	223.63	199.62
37210	Embolization uterine fibroid	NI	T	0202	42.9896	2,642.48	981.50	528.50
37250	Iv us first vessel add-on		S	0416	32.5472	2,000.61		400.12
37251	Iv us each add vessel add-on		S	0416	32.5472	2,000.61		400.12
37500	Endoscopy ligate perf veins	CH	T	0091	34.7288	2,134.71		426.94
37501	Vascular endoscopy procedure		T	0092	24.8809	1,529.38	309.87	305.88
37565	Ligation of neck vein		T	0093	22.8653	1,405.48		281.10
37600	Ligation of neck artery		T	0093	22.8653	1,405.48		281.10
37605	Ligation of neck artery		T	0091	34.7288	2,134.71		426.94
37606	Ligation of neck artery	CH	T	0092	24.8809	1,529.38	309.87	305.88
37607	Ligation of a-v fistula		T	0092	24.8809	1,529.38	309.87	305.88
37609	Temporal artery procedure		T	0021	15.1024	928.31	219.48	185.66
37615	Ligation of neck artery	CH	T	0092	24.8809	1,529.38	309.87	305.88
37620	Revision of major vein		T	0091	34.7288	2,134.71		426.94
37650	Revision of major vein	CH	T	0092	24.8809	1,529.38	309.87	305.88
37700	Revise leg vein		T	0091	34.7288	2,134.71		426.94
37718	Ligate/strip short leg vein	CH	T	0091	34.7288	2,134.71		426.94
37722	Ligate/strip long leg vein	CH	T	0091	34.7288	2,134.71		426.94
37735	Removal of leg veins/lesion	CH	T	0091	34.7288	2,134.71		426.94
37760	Ligation, leg veins, open	CH	T	0092	24.8809	1,529.38	309.87	305.88
37765	Phleb veins—extrem—to 20	CH	T	0092	24.8809	1,529.38	309.87	305.88
37766	Phleb veins—extrem 20+	CH	T	0092	24.8809	1,529.38	309.87	305.88
37780	Revision of leg vein	CH	T	0092	24.8809	1,529.38	309.87	305.88
37785	Ligate/divide/excise vein	CH	T	0092	24.8809	1,529.38	309.87	305.88
37790	Penile venous occlusion		T	0181	32.9873	2,027.66	621.82	405.53
37799	Vascular surgery procedure		T	0103	16.2375	998.09	223.63	199.62
38120	Laparoscopy, splenectomy		T	0131	43.5488	2,676.86	1,001.89	535.37
38129	Laparoscope proc, spleen		T	0130	32.1241	1,974.60	659.53	394.92
38200	Injection for spleen x-ray		N					
38204	Bl donor search management		N					
38205	Harvest allogenic stem cells		S	0111	11.7134	720.00	198.40	144.00
38206	Harvest auto stem cells		S	0111	11.7134	720.00	198.40	144.00
38220	Bone marrow aspiration		T	0003	2.4011	147.59		29.52
38221	Bone marrow biopsy		T	0003	2.4011	147.59		29.52
38230	Bone marrow collection		S	0123	20.3582	1,251.38		250.28
38240	Bone marrow/stem transplant		S	0123	20.3582	1,251.38		250.28
38241	Bone marrow/stem transplant		S	0123	20.3582	1,251.38		250.28
38242	Lymphocyte infuse transplant		S	0111	11.7134	720.00	198.40	144.00
38300	Drainage, lymph node lesion		T	0007	11.1535	685.58		137.12
38305	Drainage, lymph node lesion		T	0008	17.5086	1,076.22		215.24
38308	Incision of lymph channels		T	0113	21.2621	1,306.94		261.39
38500	Biopsy/removal, lymph nodes		T	0113	21.2621	1,306.94		261.39
38505	Needle biopsy, lymph nodes		T	0005	3.9045	240.00	71.59	48.00
38510	Biopsy/removal, lymph nodes		T	0113	21.2621	1,306.94		261.39

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
38520	Biopsy/removal, lymph nodes		T	0113	21.2621	1,306.94		261.39
38525	Biopsy/removal, lymph nodes		T	0113	21.2621	1,306.94		261.39
38530	Biopsy/removal, lymph nodes		T	0113	21.2621	1,306.94		261.39
38542	Explore deep node(s), neck		T	0114	37.7224	2,318.72	467.95	463.74
38550	Removal, neck/armpit lesion		T	0113	21.2621	1,306.94		261.39
38555	Removal, neck/armpit lesion		T	0113	21.2621	1,306.94		261.39
38570	Laparoscopy, lymph node biop		T	0131	43.5488	2,676.86	1,001.89	535.37
38571	Laparoscopy, lymphadenectomy		T	0132	70.5066	4,333.90	1,239.22	866.78
38572	Laparoscopy, lymphadenectomy		T	0131	43.5488	2,676.86	1,001.89	535.37
38589	Laparoscope proc, lymphatic		T	0130	32.1241	1,974.60	659.53	394.92
38700	Removal of lymph nodes, neck		T	0113	21.2621	1,306.94		261.39
38720	Removal of lymph nodes, neck		T	0113	21.2621	1,306.94		261.39
38740	Remove armpit lymph nodes		T	0114	37.7224	2,318.72	467.95	463.74
38745	Remove armpit lymph nodes		T	0114	37.7224	2,318.72	467.95	463.74
38760	Remove groin lymph nodes		T	0113	21.2621	1,306.94		261.39
38790	Inject for lymphatic x-ray		N					
38792	Identify sentinel node	CH	Q	0389	1.3754	84.54	33.81	16.91
38794	Access thoracic lymph duct		N					
38999	Blood/lymph system procedure		S	0110	3.4584	212.58		42.52
39400	Visualization of chest		T	0069	31.9442	1,963.55	591.64	392.71
40490	Biopsy of lip		T	0251	2.452	150.72		30.14
40500	Partial excision of lip		T	0253	16.4266	1,009.71	282.29	201.94
40510	Partial excision of lip		T	0254	23.3299	1,434.04	321.35	286.81
40520	Partial excision of lip		T	0253	16.4266	1,009.71	282.29	201.94
40525	Reconstruct lip with flap		T	0254	23.3299	1,434.04	321.35	286.81
40527	Reconstruct lip with flap		T	0254	23.3299	1,434.04	321.35	286.81
40530	Partial removal of lip		T	0254	23.3299	1,434.04	321.35	286.81
40650	Repair lip		T	0252	7.5511	464.15	109.16	92.83
40652	Repair lip		T	0252	7.5511	464.15	109.16	92.83
40654	Repair lip		T	0252	7.5511	464.15	109.16	92.83
40700	Repair cleft lip/nasal		T	0256	38.1991	2,348.02		469.60
40701	Repair cleft lip/nasal		T	0256	38.1991	2,348.02		469.60
40702	Repair cleft lip/nasal		T	0256	38.1991	2,348.02		469.60
40720	Repair cleft lip/nasal		T	0256	38.1991	2,348.02		469.60
40761	Repair cleft lip/nasal		T	0256	38.1991	2,348.02		469.60
40799	Lip surgery procedure		T	0251	2.452	150.72		30.14
40800	Drainage of mouth lesion	CH	T	0006	1.4392	88.46		17.69
40801	Drainage of mouth lesion		T	0252	7.5511	464.15	109.16	92.83
40804	Removal, foreign body, mouth		X	0340	0.6102	37.51		7.50
40805	Removal, foreign body, mouth		T	0252	7.5511	464.15	109.16	92.83
40806	Incision of lip fold		T	0251	2.452	150.72		30.14
40808	Biopsy of mouth lesion		T	0251	2.452	150.72		30.14
40810	Excision of mouth lesion		T	0253	16.4266	1,009.71	282.29	201.94
40812	Excise/repair mouth lesion		T	0253	16.4266	1,009.71	282.29	201.94
40814	Excise/repair mouth lesion		T	0253	16.4266	1,009.71	282.29	201.94
40816	Excision of mouth lesion		T	0254	23.3299	1,434.04	321.35	286.81
40818	Excise oral mucosa for graft		T	0251	2.452	150.72		30.14
40819	Excise lip or cheek fold		T	0252	7.5511	464.15	109.16	92.83
40820	Treatment of mouth lesion		T	0253	16.4266	1,009.71	282.29	201.94
40830	Repair mouth laceration		T	0251	2.452	150.72		30.14
40831	Repair mouth laceration		T	0252	7.5511	464.15	109.16	92.83
40840	Reconstruction of mouth		T	0254	23.3299	1,434.04	321.35	286.81
40842	Reconstruction of mouth		T	0254	23.3299	1,434.04	321.35	286.81
40843	Reconstruction of mouth		T	0254	23.3299	1,434.04	321.35	286.81
40844	Reconstruction of mouth		T	0256	38.1991	2,348.02		469.60
40845	Reconstruction of mouth		T	0256	38.1991	2,348.02		469.60
40899	Mouth surgery procedure		T	0251	2.452	150.72		30.14
41000	Drainage of mouth lesion		T	0253	16.4266	1,009.71	282.29	201.94
41005	Drainage of mouth lesion		T	0251	2.452	150.72		30.14
41006	Drainage of mouth lesion		T	0254	23.3299	1,434.04	321.35	286.81
41007	Drainage of mouth lesion		T	0253	16.4266	1,009.71	282.29	201.94
41008	Drainage of mouth lesion		T	0253	16.4266	1,009.71	282.29	201.94
41009	Drainage of mouth lesion		T	0251	2.452	150.72		30.14
41010	Incision of tongue fold		T	0252	7.5511	464.15	109.16	92.83
41015	Drainage of mouth lesion		T	0251	2.452	150.72		30.14
41016	Drainage of mouth lesion		T	0252	7.5511	464.15	109.16	92.83
41017	Drainage of mouth lesion		T	0252	7.5511	464.15	109.16	92.83
41018	Drainage of mouth lesion		T	0252	7.5511	464.15	109.16	92.83
41100	Biopsy of tongue		T	0252	7.5511	464.15	109.16	92.83
41105	Biopsy of tongue		T	0253	16.4266	1,009.71	282.29	201.94

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
41108	Biopsy of floor of mouth		T	0252	7.5511	464.15	109.16	92.83
41110	Excision of tongue lesion		T	0253	16.4266	1,009.71	282.29	201.94
41112	Excision of tongue lesion		T	0253	16.4266	1,009.71	282.29	201.94
41113	Excision of tongue lesion		T	0253	16.4266	1,009.71	282.29	201.94
41114	Excision of tongue lesion		T	0254	23.3299	1,434.04	321.35	286.81
41115	Excision of tongue fold		T	0252	7.5511	464.15	109.16	92.83
41116	Excision of mouth lesion		T	0253	16.4266	1,009.71	282.29	201.94
41120	Partial removal of tongue		T	0254	23.3299	1,434.04	321.35	286.81
41250	Repair tongue laceration		T	0251	2.452	150.72		30.14
41251	Repair tongue laceration		T	0251	2.452	150.72		30.14
41252	Repair tongue laceration		T	0252	7.5511	464.15	109.16	92.83
41500	Fixation of tongue		T	0254	23.3299	1,434.04	321.35	286.81
41510	Tongue to lip surgery		T	0253	16.4266	1,009.71	282.29	201.94
41520	Reconstruction, tongue fold		T	0252	7.5511	464.15	109.16	92.83
41599	Tongue and mouth surgery		T	0251	2.452	150.72		30.14
41800	Drainage of gum lesion	CH	T	0006	1.4392	88.46		17.69
41805	Removal foreign body, gum		T	0254	23.3299	1,434.04	321.35	286.81
41806	Removal foreign body,jawbone		T	0253	16.4266	1,009.71	282.29	201.94
41820	Excision, gum, each quadrant		T	0252	7.5511	464.15	109.16	92.83
41821	Excision of gum flap		T	0252	7.5511	464.15	109.16	92.83
41822	Excision of gum lesion		T	0253	16.4266	1,009.71	282.29	201.94
41823	Excision of gum lesion		T	0254	23.3299	1,434.04	321.35	286.81
41825	Excision of gum lesion		T	0253	16.4266	1,009.71	282.29	201.94
41826	Excision of gum lesion		T	0253	16.4266	1,009.71	282.29	201.94
41827	Excision of gum lesion		T	0254	23.3299	1,434.04	321.35	286.81
41828	Excision of gum lesion		T	0253	16.4266	1,009.71	282.29	201.94
41830	Removal of gum tissue		T	0253	16.4266	1,009.71	282.29	201.94
41850	Treatment of gum lesion		T	0253	16.4266	1,009.71	282.29	201.94
41870	Gum graft		T	0254	23.3299	1,434.04	321.35	286.81
41872	Repair gum		T	0253	16.4266	1,009.71	282.29	201.94
41874	Repair tooth socket		T	0254	23.3299	1,434.04	321.35	286.81
41899	Dental surgery procedure		T	0251	2.452	150.72		30.14
42000	Drainage mouth roof lesion		T	0251	2.452	150.72		30.14
42100	Biopsy roof of mouth		T	0252	7.5511	464.15	109.16	92.83
42104	Excision lesion, mouth roof		T	0253	16.4266	1,009.71	282.29	201.94
42106	Excision lesion, mouth roof		T	0253	16.4266	1,009.71	282.29	201.94
42107	Excision lesion, mouth roof		T	0254	23.3299	1,434.04	321.35	286.81
42120	Remove palate/lesion		T	0256	38.1991	2,348.02		469.60
42140	Excision of uvula		T	0252	7.5511	464.15	109.16	92.83
42145	Repair palate, pharynx/uvula		T	0254	23.3299	1,434.04	321.35	286.81
42160	Treatment mouth roof lesion		T	0253	16.4266	1,009.71	282.29	201.94
42180	Repair palate		T	0251	2.452	150.72		30.14
42182	Repair palate		T	0256	38.1991	2,348.02		469.60
42200	Reconstruct cleft palate		T	0256	38.1991	2,348.02		469.60
42205	Reconstruct cleft palate		T	0256	38.1991	2,348.02		469.60
42210	Reconstruct cleft palate		T	0256	38.1991	2,348.02		469.60
42215	Reconstruct cleft palate		T	0256	38.1991	2,348.02		469.60
42220	Reconstruct cleft palate		T	0256	38.1991	2,348.02		469.60
42225	Reconstruct cleft palate		T	0256	38.1991	2,348.02		469.60
42226	Lengthening of palate		T	0256	38.1991	2,348.02		469.60
42227	Lengthening of palate		T	0256	38.1991	2,348.02		469.60
42235	Repair palate		T	0253	16.4266	1,009.71	282.29	201.94
42260	Repair nose to lip fistula		T	0254	23.3299	1,434.04	321.35	286.81
42280	Preparation, palate mold		T	0251	2.452	150.72		30.14
42281	Insertion, palate prosthesis		T	0253	16.4266	1,009.71	282.29	201.94
42299	Palate/uvula surgery		T	0251	2.452	150.72		30.14
42300	Drainage of salivary gland		T	0253	16.4266	1,009.71	282.29	201.94
42305	Drainage of salivary gland		T	0253	16.4266	1,009.71	282.29	201.94
42310	Drainage of salivary gland		T	0251	2.452	150.72		30.14
42320	Drainage of salivary gland		T	0251	2.452	150.72		30.14
42330	Removal of salivary stone		T	0253	16.4266	1,009.71	282.29	201.94
42335	Removal of salivary stone		T	0253	16.4266	1,009.71	282.29	201.94
42340	Removal of salivary stone		T	0253	16.4266	1,009.71	282.29	201.94
42400	Biopsy of salivary gland		T	0005	3.9045	240.00	71.59	48.00
42405	Biopsy of salivary gland		T	0253	16.4266	1,009.71	282.29	201.94
42408	Excision of salivary cyst		T	0253	16.4266	1,009.71	282.29	201.94
42409	Drainage of salivary cyst		T	0253	16.4266	1,009.71	282.29	201.94
42410	Excise parotid gland/lesion		T	0256	38.1991	2,348.02		469.60
42415	Excise parotid gland/lesion		T	0256	38.1991	2,348.02		469.60
42420	Excise parotid gland/lesion		T	0256	38.1991	2,348.02		469.60

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42425	Excise parotid gland/lesion		T	0256	38.1991	2,348.02		469.60
42440	Excise submaxillary gland		T	0256	38.1991	2,348.02		469.60
42450	Excise sublingual gland		T	0254	23.3299	1,434.04	321.35	286.81
42500	Repair salivary duct		T	0254	23.3299	1,434.04	321.35	286.81
42505	Repair salivary duct		T	0256	38.1991	2,348.02		469.60
42507	Parotid duct diversion		T	0256	38.1991	2,348.02		469.60
42508	Parotid duct diversion		T	0256	38.1991	2,348.02		469.60
42509	Parotid duct diversion		T	0256	38.1991	2,348.02		469.60
42510	Parotid duct diversion		T	0256	38.1991	2,348.02		469.60
42550	Injection for salivary x-ray		N					
42600	Closure of salivary fistula		T	0253	16.4266	1,009.71	282.29	201.94
42650	Dilation of salivary duct		T	0252	7.5511	464.15	109.16	92.83
42660	Dilation of salivary duct		T	0251	2.452	150.72		30.14
42665	Ligation of salivary duct		T	0254	23.3299	1,434.04	321.35	286.81
42699	Salivary surgery procedure		T	0251	2.452	150.72		30.14
42700	Drainage of tonsil abscess		T	0251	2.452	150.72		30.14
42720	Drainage of throat abscess		T	0253	16.4266	1,009.71	282.29	201.94
42725	Drainage of throat abscess		T	0256	38.1991	2,348.02		469.60
42800	Biopsy of throat	CH	T	0252	7.5511	464.15	109.16	92.83
42802	Biopsy of throat		T	0253	16.4266	1,009.71	282.29	201.94
42804	Biopsy of upper nose/throat		T	0253	16.4266	1,009.71	282.29	201.94
42806	Biopsy of upper nose/throat		T	0254	23.3299	1,434.04	321.35	286.81
42808	Excise pharynx lesion		T	0253	16.4266	1,009.71	282.29	201.94
42809	Remove pharynx foreign body		X	0340	0.6102	37.51		7.50
42810	Excision of neck cyst		T	0254	23.3299	1,434.04	321.35	286.81
42815	Excision of neck cyst		T	0256	38.1991	2,348.02		469.60
42820	Remove tonsils and adenoids		T	0258	22.1165	1,359.46	437.25	271.89
42821	Remove tonsils and adenoids		T	0258	22.1165	1,359.46	437.25	271.89
42825	Removal of tonsils		T	0258	22.1165	1,359.46	437.25	271.89
42826	Removal of tonsils		T	0258	22.1165	1,359.46	437.25	271.89
42830	Removal of adenoids		T	0258	22.1165	1,359.46	437.25	271.89
42831	Removal of adenoids		T	0258	22.1165	1,359.46	437.25	271.89
42835	Removal of adenoids		T	0258	22.1165	1,359.46	437.25	271.89
42836	Removal of adenoids		T	0258	22.1165	1,359.46	437.25	271.89
42842	Extensive surgery of throat		T	0254	23.3299	1,434.04	321.35	286.81
42844	Extensive surgery of throat		T	0256	38.1991	2,348.02		469.60
42860	Excision of tonsil tags		T	0258	22.1165	1,359.46	437.25	271.89
42870	Excision of lingual tonsil		T	0258	22.1165	1,359.46	437.25	271.89
42890	Partial removal of pharynx		T	0256	38.1991	2,348.02		469.60
42892	Revision of pharyngeal walls		T	0256	38.1991	2,348.02		469.60
42900	Repair throat wound		T	0252	7.5511	464.15	109.16	92.83
42950	Reconstruction of throat		T	0254	23.3299	1,434.04	321.35	286.81
42955	Surgical opening of throat		T	0254	23.3299	1,434.04	321.35	286.81
42960	Control throat bleeding		T	0250	1.1791	72.48	25.39	14.50
42962	Control throat bleeding		T	0256	38.1991	2,348.02		469.60
42970	Control nose/throat bleeding		T	0250	1.1791	72.48	25.39	14.50
42972	Control nose/throat bleeding		T	0253	16.4266	1,009.71	282.29	201.94
42999	Throat surgery procedure		T	0251	2.452	150.72		30.14
43020	Incision of esophagus		T	0252	7.5511	464.15	109.16	92.83
43030	Throat muscle surgery		T	0253	16.4266	1,009.71	282.29	201.94
43130	Removal of esophagus pouch	CH	T	0256	38.1991	2,348.02		469.60
43200	Esophagus endoscopy		T	0141	8.3175	511.26	143.38	102.25
43201	Esoph scope w/submucous inj		T	0141	8.3175	511.26	143.38	102.25
43202	Esophagus endoscopy, biopsy		T	0141	8.3175	511.26	143.38	102.25
43204	Esoph scope w/sclerosis inj		T	0141	8.3175	511.26	143.38	102.25
43205	Esophagus endoscopy/ligation		T	0141	8.3175	511.26	143.38	102.25
43215	Esophagus endoscopy		T	0141	8.3175	511.26	143.38	102.25
43216	Esophagus endoscopy/lesion		T	0141	8.3175	511.26	143.38	102.25
43217	Esophagus endoscopy		T	0141	8.3175	511.26	143.38	102.25
43219	Esophagus endoscopy		T	0384	22.9475	1,410.54	295.41	282.11
43220	Esoph endoscopy, dilation		T	0141	8.3175	511.26	143.38	102.25
43226	Esoph endoscopy, dilation		T	0141	8.3175	511.26	143.38	102.25
43227	Esoph endoscopy, repair		T	0141	8.3175	511.26	143.38	102.25
43228	Esoph endoscopy, ablation		T	0422	25.7552	1,583.12	448.81	316.62
43231	Esoph endoscopy w/us exam		T	0141	8.3175	511.26	143.38	102.25
43232	Esoph endoscopy w/us fn bx		T	0141	8.3175	511.26	143.38	102.25
43234	Upper GI endoscopy, exam		T	0141	8.3175	511.26	143.38	102.25
43235	Uppr gi endoscopy, diagnosis		T	0141	8.3175	511.26	143.38	102.25
43236	Uppr gi scope w/submuc inj		T	0141	8.3175	511.26	143.38	102.25
43237	Endoscopic us exam, esoph		T	0141	8.3175	511.26	143.38	102.25

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43238	Uppr gi endoscopy w/us fn bx		T	0141	8.3175	511.26	143.38	102.25
43239	Upper GI endoscopy, biopsy		T	0141	8.3175	511.26	143.38	102.25
43240	Esoph endoscope w/drain cyst		T	0141	8.3175	511.26	143.38	102.25
43241	Upper GI endoscopy with tube		T	0141	8.3175	511.26	143.38	102.25
43242	Uppr gi endoscopy w/us fn bx		T	0141	8.3175	511.26	143.38	102.25
43243	Upper gi endoscopy & inject		T	0141	8.3175	511.26	143.38	102.25
43244	Upper GI endoscopy/ligation		T	0141	8.3175	511.26	143.38	102.25
43245	Uppr gi scope dilate strictr		T	0141	8.3175	511.26	143.38	102.25
43246	Place gastrostomy tube		T	0141	8.3175	511.26	143.38	102.25
43247	Operative upper GI endoscopy		T	0141	8.3175	511.26	143.38	102.25
43248	Uppr gi endoscopy/guide wire		T	0141	8.3175	511.26	143.38	102.25
43249	Esoph endoscopy, dilation		T	0141	8.3175	511.26	143.38	102.25
43250	Upper GI endoscopy/tumor		T	0141	8.3175	511.26	143.38	102.25
43251	Operative upper GI endoscopy		T	0141	8.3175	511.26	143.38	102.25
43255	Operative upper GI endoscopy		T	0141	8.3175	511.26	143.38	102.25
43256	Uppr gi endoscopy w/stent		T	0384	22.9475	1,410.54	295.41	282.11
43257	Uppr gi scope w/thrml txmnt		T	0422	25.7552	1,583.12	448.81	316.62
43258	Operative upper GI endoscopy		T	0141	8.3175	511.26	143.38	102.25
43259	Endoscopic ultrasound exam		T	0141	8.3175	511.26	143.38	102.25
43260	Endo cholangiopancreatograph		T	0151	19.8381	1,219.41	245.46	243.88
43261	Endo cholangiopancreatograph		T	0151	19.8381	1,219.41	245.46	243.88
43262	Endo cholangiopancreatograph		T	0151	19.8381	1,219.41	245.46	243.88
43263	Endo cholangiopancreatograph		T	0151	19.8381	1,219.41	245.46	243.88
43264	Endo cholangiopancreatograph		T	0151	19.8381	1,219.41	245.46	243.88
43265	Endo cholangiopancreatograph		T	0151	19.8381	1,219.41	245.46	243.88
43267	Endo cholangiopancreatograph		T	0151	19.8381	1,219.41	245.46	243.88
43268	Endo cholangiopancreatograph		T	0384	22.9475	1,410.54	295.41	282.11
43269	Endo cholangiopancreatograph		T	0384	22.9475	1,410.54	295.41	282.11
43271	Endo cholangiopancreatograph		T	0151	19.8381	1,219.41	245.46	243.88
43272	Endo cholangiopancreatograph		T	0151	19.8381	1,219.41	245.46	243.88
43280	Laparoscopy, fundoplasty		T	0132	70.5066	4,333.90	1,239.22	866.78
43289	Laparoscope proc, esoph		T	0130	32.1241	1,974.60	659.53	394.92
43450	Dilate esophagus		T	0140	5.4566	335.41	91.40	67.08
43453	Dilate esophagus		T	0140	5.4566	335.41	91.40	67.08
43456	Dilate esophagus		T	0140	5.4566	335.41	91.40	67.08
43458	Dilate esophagus		T	0140	5.4566	335.41	91.40	67.08
43499	Esophagus surgery procedure		T	0141	8.3175	511.26	143.38	102.25
43510	Surgical opening of stomach		T	0141	8.3175	511.26	143.38	102.25
43600	Biopsy of stomach		T	0141	8.3175	511.26	143.38	102.25
43647	Lap impl electrode, antrum	NI	T	0130	32.1241	1,974.60	659.53	394.92
43648	Lap revise/remv eltrd antrum	NI	T	0130	32.1241	1,974.60	659.53	394.92
43651	Laparoscopy, vagus nerve		T	0132	70.5066	4,333.90	1,239.22	866.78
43652	Laparoscopy, vagus nerve		T	0132	70.5066	4,333.90	1,239.22	866.78
43653	Laparoscopy, gastrostomy		T	0131	43.5488	2,676.86	1,001.89	535.37
43659	Laparoscope proc, stom		T	0130	32.1241	1,974.60	659.53	394.92
43750	Place gastrostomy tube		T	0141	8.3175	511.26	143.38	102.25
43752	Nasal/orogastric w/stent		X	0272	1.2908	79.34	31.64	15.87
43760	Change gastrostomy tube		T	0121	2.3587	144.98	43.80	29.00
43761	Reposition gastrostomy tube		T	0122	7.48	459.78		91.96
43830	Place gastrostomy tube		T	0422	25.7552	1,583.12	448.81	316.62
43831	Place gastrostomy tube		T	0141	8.3175	511.26	143.38	102.25
43870	Repair stomach opening		T	0141	8.3175	511.26	143.38	102.25
43881	Impl/redo electrd, antrum	NI	C					
43882	Revise/remove electrd antrum	NI	C					
43886	Revise gastric port, open		T	0025	5.2594	323.28	101.85	64.66
43887	Remove gastric port, open		T	0025	5.2594	323.28	101.85	64.66
43888	Change gastric port, open		T	0686	14.0346	862.68		172.54
43999	Stomach surgery procedure		T	0141	8.3175	511.26	143.38	102.25
44100	Biopsy of bowel		T	0141	8.3175	511.26	143.38	102.25
44152	Removal of colon/ileostomy	CH	D					
44153	Removal of colon/ileostomy	CH	D					
44157	Colectomy w/ileoanal anast	NI	C					
44158	Colectomy w/neo-rectum pouch	NI	C					
44180	Lap, enterolysis		T	0131	43.5488	2,676.86	1,001.89	535.37
44186	Lap, jejunostomy		T	0131	43.5488	2,676.86	1,001.89	535.37
44206	Lap part colectomy w/stoma		T	0132	70.5066	4,333.90	1,239.22	866.78
44207	Lcolectomy/coloproctostomy		T	0132	70.5066	4,333.90	1,239.22	866.78
44208	Lcolectomy/coloproctostomy		T	0132	70.5066	4,333.90	1,239.22	866.78
44213	Lap, mobil splenic fl add-on		T	0130	32.1241	1,974.60	659.53	394.92
44238	Laparoscope proc, intestine		T	0130	32.1241	1,974.60	659.53	394.92

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44312	Revision of ileostomy		T	0027	21.4302	1,317.27	329.72	263.45
44340	Revision of colostomy		T	0027	21.4302	1,317.27	329.72	263.45
44360	Small bowel endoscopy		T	0142	9.4946	583.61	152.78	116.72
44361	Small bowel endoscopy/biopsy		T	0142	9.4946	583.61	152.78	116.72
44363	Small bowel endoscopy		T	0142	9.4946	583.61	152.78	116.72
44364	Small bowel endoscopy		T	0142	9.4946	583.61	152.78	116.72
44365	Small bowel endoscopy		T	0142	9.4946	583.61	152.78	116.72
44366	Small bowel endoscopy		T	0142	9.4946	583.61	152.78	116.72
44369	Small bowel endoscopy		T	0142	9.4946	583.61	152.78	116.72
44370	Small bowel endoscopy/stent		T	0384	22.9475	1,410.54	295.41	282.11
44372	Small bowel endoscopy		T	0142	9.4946	583.61	152.78	116.72
44373	Small bowel endoscopy		T	0142	9.4946	583.61	152.78	116.72
44376	Small bowel endoscopy		T	0142	9.4946	583.61	152.78	116.72
44377	Small bowel endoscopy/biopsy		T	0142	9.4946	583.61	152.78	116.72
44378	Small bowel endoscopy		T	0142	9.4946	583.61	152.78	116.72
44379	Sbowel endoscope w/stent		T	0384	22.9475	1,410.54	295.41	282.11
44380	Small bowel endoscopy		T	0142	9.4946	583.61	152.78	116.72
44382	Small bowel endoscopy		T	0142	9.4946	583.61	152.78	116.72
44383	Ileoscopy w/stent		T	0384	22.9475	1,410.54	295.41	282.11
44385	Endoscopy of bowel pouch		T	0143	8.7686	538.99	186.06	107.80
44386	Endoscopy, bowel pouch/biop		T	0143	8.7686	538.99	186.06	107.80
44388	Colonoscopy		T	0143	8.7686	538.99	186.06	107.80
44389	Colonoscopy with biopsy		T	0143	8.7686	538.99	186.06	107.80
44390	Colonoscopy for foreign body		T	0143	8.7686	538.99	186.06	107.80
44391	Colonoscopy for bleeding		T	0143	8.7686	538.99	186.06	107.80
44392	Colonoscopy & polypectomy		T	0143	8.7686	538.99	186.06	107.80
44393	Colonoscopy, lesion removal		T	0143	8.7686	538.99	186.06	107.80
44394	Colonoscopy w/snare		T	0143	8.7686	538.99	186.06	107.80
44397	Colonoscopy w/stent		T	0384	22.9475	1,410.54	295.41	282.11
44500	Intro, gastrointestinal tube		T	0121	2.3587	144.98	43.80	29.00
44701	Intraop colon lavage add-on		N					
44799	Unlisted procedure intestine	CH	T	0153	22.0832	1,357.41	397.95	271.48
44901	Drain app abscess, percut		T	0037	10.2655	631.00	228.76	126.20
44970	Laparoscopy, appendectomy		T	0131	43.5488	2,676.86	1,001.89	535.37
44979	Laparoscope proc, app		T	0130	32.1241	1,974.60	659.53	394.92
45000	Drainage of pelvic abscess		T	0148	5.077	312.07		62.41
45005	Drainage of rectal abscess		T	0155	12.7389	783.03		156.61
45020	Drainage of rectal abscess		T	0155	12.7389	783.03		156.61
45100	Biopsy of rectum		T	0149	22.2682	1,368.78	293.06	273.76
45108	Removal of anorectal lesion	CH	T	0149	22.2682	1,368.78	293.06	273.76
45150	Excision of rectal stricture		T	0149	22.2682	1,368.78	293.06	273.76
45160	Excision of rectal lesion	CH	T	0149	22.2682	1,368.78	293.06	273.76
45170	Excision of rectal lesion	CH	T	0149	22.2682	1,368.78	293.06	273.76
45190	Destruction, rectal tumor	CH	T	0149	22.2682	1,368.78	293.06	273.76
45300	Proctosigmoidoscopy dx		T	0146	4.8683	299.24	64.40	59.85
45303	Proctosigmoidoscopy dilate		T	0147	8.5477	525.41		105.08
45305	Proctosigmoidoscopy w/bx		T	0147	8.5477	525.41		105.08
45307	Proctosigmoidoscopy fb		T	0428	20.6375	1,268.55		253.71
45308	Proctosigmoidoscopy removal		T	0147	8.5477	525.41		105.08
45309	Proctosigmoidoscopy removal		T	0147	8.5477	525.41		105.08
45315	Proctosigmoidoscopy removal		T	0147	8.5477	525.41		105.08
45317	Proctosigmoidoscopy bleed		T	0147	8.5477	525.41		105.08
45320	Proctosigmoidoscopy ablate		T	0428	20.6375	1,268.55		253.71
45321	Proctosigmoidoscopy volvul		T	0428	20.6375	1,268.55		253.71
45327	Proctosigmoidoscopy w/stent		T	0384	22.9475	1,410.54	295.41	282.11
45330	Diagnostic sigmoidoscopy		T	0146	4.8683	299.24	64.40	59.85
45331	Sigmoidoscopy and biopsy		T	0146	4.8683	299.24	64.40	59.85
45332	Sigmoidoscopy w/fb removal		T	0146	4.8683	299.24	64.40	59.85
45333	Sigmoidoscopy & polypectomy		T	0147	8.5477	525.41		105.08
45334	Sigmoidoscopy for bleeding		T	0147	8.5477	525.41		105.08
45335	Sigmoidoscopy w/submuc inj		T	0146	4.8683	299.24	64.40	59.85
45337	Sigmoidoscopy & decompress		T	0146	4.8683	299.24	64.40	59.85
45338	Sigmoidoscopy w/tumr remove		T	0147	8.5477	525.41		105.08
45339	Sigmoidoscopy w/ablate tumr		T	0147	8.5477	525.41		105.08
45340	Sig w/balloon dilation		T	0147	8.5477	525.41		105.08
45341	Sigmoidoscopy w/ultrasound		T	0147	8.5477	525.41		105.08
45342	Sigmoidoscopy w/us guide bx		T	0147	8.5477	525.41		105.08
45345	Sigmoidoscopy w/stent		T	0384	22.9475	1,410.54	295.41	282.11
45355	Surgical colonoscopy		T	0143	8.7686	538.99	186.06	107.80
45378	Diagnostic colonoscopy		T	0143	8.7686	538.99	186.06	107.80

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45379	Colonoscopy w/fb removal		T	0143	8.7686	538.99	186.06	107.80
45380	Colonoscopy and biopsy		T	0143	8.7686	538.99	186.06	107.80
45381	Colonoscopy, submucous inj		T	0143	8.7686	538.99	186.06	107.80
45382	Colonoscopy/control bleeding		T	0143	8.7686	538.99	186.06	107.80
45383	Lesion removal colonoscopy		T	0143	8.7686	538.99	186.06	107.80
45384	Lesion remove colonoscopy		T	0143	8.7686	538.99	186.06	107.80
45385	Lesion removal colonoscopy		T	0143	8.7686	538.99	186.06	107.80
45386	Colonoscopy dilate stricture		T	0143	8.7686	538.99	186.06	107.80
45387	Colonoscopy w/stent		T	0384	22.9475	1,410.54	295.41	282.11
45391	Colonoscopy w/endoscope us		T	0143	8.7686	538.99	186.06	107.80
45392	Colonoscopy w/endoscopic fnb		T	0143	8.7686	538.99	186.06	107.80
45499	Laparoscope proc, rectum		T	0130	32.1241	1,974.60	659.53	394.92
45500	Repair of rectum		T	0149	22.2682	1,368.78	293.06	273.76
45505	Repair of rectum		T	0150	29.6189	1,820.61	437.12	364.12
45520	Treatment of rectal prolapse		T	0098	1.0798	66.37		13.27
45541	Correct rectal prolapse		T	0150	29.6189	1,820.61	437.12	364.12
45560	Repair of rectocele		T	0150	29.6189	1,820.61	437.12	364.12
45900	Reduction of rectal prolapse		T	0148	5.077	312.07		62.41
45905	Dilation of anal sphincter		T	0149	22.2682	1,368.78	293.06	273.76
45910	Dilation of rectal narrowing		T	0149	22.2682	1,368.78	293.06	273.76
45915	Remove rectal obstruction		T	0148	5.077	312.07		62.41
45990	Surg dx exam, anorectal		T	0148	5.077	312.07		62.41
45999	Rectum surgery procedure		T	0148	5.077	312.07		62.41
46020	Placement of seton	CH	T	0149	22.2682	1,368.78	293.06	273.76
46030	Removal of rectal marker		T	0148	5.077	312.07		62.41
46040	Incision of rectal abscess		T	0149	22.2682	1,368.78	293.06	273.76
46045	Incision of rectal abscess	CH	T	0149	22.2682	1,368.78	293.06	273.76
46050	Incision of anal abscess		T	0148	5.077	312.07		62.41
46060	Incision of rectal abscess	CH	T	0149	22.2682	1,368.78	293.06	273.76
46070	Incision of anal septum		T	0155	12.7389	783.03		156.61
46080	Incision of anal sphincter		T	0149	22.2682	1,368.78	293.06	273.76
46083	Incise external hemorrhoid	CH	T	0164	2.1393	131.50		26.30
46200	Removal of anal fissure	CH	T	0149	22.2682	1,368.78	293.06	273.76
46210	Removal of anal crypt		T	0149	22.2682	1,368.78	293.06	273.76
46211	Removal of anal crypts	CH	T	0149	22.2682	1,368.78	293.06	273.76
46220	Removal of anal tag		T	0149	22.2682	1,368.78	293.06	273.76
46221	Ligation of hemorrhoid(s)		T	0148	5.077	312.07		62.41
46230	Removal of anal tags		T	0149	22.2682	1,368.78	293.06	273.76
46250	Hemorrhoidectomy	CH	T	0149	22.2682	1,368.78	293.06	273.76
46255	Hemorrhoidectomy	CH	T	0149	22.2682	1,368.78	293.06	273.76
46257	Remove hemorrhoids & fissure	CH	T	0149	22.2682	1,368.78	293.06	273.76
46258	Remove hemorrhoids & fistula	CH	T	0149	22.2682	1,368.78	293.06	273.76
46260	Hemorrhoidectomy	CH	T	0149	22.2682	1,368.78	293.06	273.76
46261	Remove hemorrhoids & fissure	CH	T	0149	22.2682	1,368.78	293.06	273.76
46262	Remove hemorrhoids & fistula	CH	T	0149	22.2682	1,368.78	293.06	273.76
46270	Removal of anal fistula	CH	T	0149	22.2682	1,368.78	293.06	273.76
46275	Removal of anal fistula	CH	T	0149	22.2682	1,368.78	293.06	273.76
46280	Removal of anal fistula	CH	T	0149	22.2682	1,368.78	293.06	273.76
46285	Removal of anal fistula	CH	T	0149	22.2682	1,368.78	293.06	273.76
46288	Repair anal fistula	CH	T	0149	22.2682	1,368.78	293.06	273.76
46320	Removal of hemorrhoid clot	CH	T	0155	12.7389	783.03		156.61
46500	Injection into hemorrhoid(s)		T	0155	12.7389	783.03		156.61
46505	Chemodenervation anal musc		T	0148	5.077	312.07		62.41
46600	Diagnostic anoscopy		X	0340	0.6102	37.51		7.50
46604	Anoscopy and dilation		T	0147	8.5477	525.41		105.08
46606	Anoscopy and biopsy		T	0146	4.8683	299.24	64.40	59.85
46608	Anoscopy, remove for body		T	0147	8.5477	525.41		105.08
46610	Anoscopy, remove lesion		T	0428	20.6375	1,268.55		253.71
46611	Anoscopy		T	0147	8.5477	525.41		105.08
46612	Anoscopy, remove lesions		T	0428	20.6375	1,268.55		253.71
46614	Anoscopy, control bleeding		T	0146	4.8683	299.24	64.40	59.85
46615	Anoscopy		T	0428	20.6375	1,268.55		253.71
46700	Repair of anal stricture	CH	T	0149	22.2682	1,368.78	293.06	273.76
46706	Repr of anal fistula w/glue		T	0150	29.6189	1,820.61	437.12	364.12
46750	Repair of anal sphincter	CH	T	0171	37.8991	2,329.58	716.76	465.92
46753	Reconstruction of anus	CH	T	0149	22.2682	1,368.78	293.06	273.76
46754	Removal of suture from anus		T	0149	22.2682	1,368.78	293.06	273.76
46760	Repair of anal sphincter	CH	T	0171	37.8991	2,329.58	716.76	465.92
46761	Repair of anal sphincter	CH	T	0171	37.8991	2,329.58	716.76	465.92
46762	Implant artificial sphincter	CH	T	0171	37.8991	2,329.58	716.76	465.92

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46900	Destruction, anal lesion(s)		T	0016	2.6749	164.42		32.88
46910	Destruction, anal lesion(s)		T	0017	17.4423	1,072.14	227.84	214.43
46916	Cryosurgery, anal lesion(s)		T	0013	1.0918	67.11		13.42
46917	Laser surgery, anal lesions		T	0695	20.4276	1,255.64	266.59	251.13
46922	Excision of anal lesion(s)		T	0695	20.4276	1,255.64	266.59	251.13
46924	Destruction, anal lesion(s)		T	0695	20.4276	1,255.64	266.59	251.13
46934	Destruction of hemorrhoids		T	0155	12.7389	783.03		156.61
46935	Destruction of hemorrhoids		T	0155	12.7389	783.03		156.61
46936	Destruction of hemorrhoids		T	0149	22.2682	1,368.78	293.06	273.76
46937	Cryotherapy of rectal lesion		T	0149	22.2682	1,368.78	293.06	273.76
46938	Cryotherapy of rectal lesion		T	0150	29.6189	1,820.61	437.12	364.12
46940	Treatment of anal fissure		T	0149	22.2682	1,368.78	293.06	273.76
46942	Treatment of anal fissure		T	0148	5.077	312.07		62.41
46945	Ligation of hemorrhoids		T	0155	12.7389	783.03		156.61
46946	Ligation of hemorrhoids		T	0155	12.7389	783.03		156.61
46947	Hemorrhoidopexy by stapling		T	0150	29.6189	1,820.61	437.12	364.12
46999	Anus surgery procedure		T	0148	5.077	312.07		62.41
47000	Needle biopsy of liver		T	0685	6.1384	377.32	115.47	75.46
47001	Needle biopsy, liver add-on		N					
47011	Percut drain, liver lesion		T	0037	10.2655	631.00	228.76	126.20
47370	Laparo ablate liver tumor rf		T	0132	70.5066	4,333.90	1,239.22	866.78
47371	Laparo ablate liver cryosurg		T	0131	43.5488	2,676.86	1,001.89	535.37
47379	Laparoscope procedure, liver		T	0130	32.1241	1,974.60	659.53	394.92
47382	Percut ablate liver rf		T	0423	37.3604	2,296.47		459.29
47399	Liver surgery procedure	CH	T	0004	2.0687	127.16		25.43
47490	Incision of gallbladder		T	0152	20.2682	1,245.85		249.17
47500	Injection for liver x-rays		N					
47505	Injection for liver x-rays		N					
47510	Insert catheter, bile duct		T	0152	20.2682	1,245.85		249.17
47511	Insert bile duct drain		T	0152	20.2682	1,245.85		249.17
47525	Change bile duct catheter		T	0427	11.6575	716.56		143.31
47530	Revise/reinsert bile tube		T	0427	11.6575	716.56		143.31
47552	Biliary endoscopy thru skin		T	0152	20.2682	1,245.85		249.17
47553	Biliary endoscopy thru skin		T	0152	20.2682	1,245.85		249.17
47554	Biliary endoscopy thru skin		T	0152	20.2682	1,245.85		249.17
47555	Biliary endoscopy thru skin		T	0152	20.2682	1,245.85		249.17
47556	Biliary endoscopy thru skin		T	0152	20.2682	1,245.85		249.17
47560	Laparoscopy w/cholangio		T	0130	32.1241	1,974.60	659.53	394.92
47561	Laparo w/cholangio/biopsy		T	0130	32.1241	1,974.60	659.53	394.92
47562	Laparoscopic cholecystectomy		T	0131	43.5488	2,676.86	1,001.89	535.37
47563	Laparo cholecystectomy/graph		T	0131	43.5488	2,676.86	1,001.89	535.37
47564	Laparo cholecystectomy/explr		T	0131	43.5488	2,676.86	1,001.89	535.37
47579	Laparoscope proc, biliary		T	0130	32.1241	1,974.60	659.53	394.92
47630	Remove bile duct stone		T	0152	20.2682	1,245.85		249.17
47716	Fusion of bile duct cyst	CH	D					
47719	Fusion of bile duct cyst	NI	C					
47999	Bile tract surgery procedure		T	0152	20.2682	1,245.85		249.17
48005	Resect/debride pancreas	CH	D					
48102	Needle biopsy, pancreas		T	0685	6.1384	377.32	115.47	75.46
48105	Resect/debride pancreas	NI	C					
48180	Fuse pancreas and bowel	CH	D					
48511	Drain pancreatic pseudocyst		T	0037	10.2655	631.00	228.76	126.20
48548	Fuse pancreas and bowel	NI	C					
48999	Pancreas surgery procedure		T	0004	2.0687	127.16		25.43
49021	Drain abdominal abscess		T	0037	10.2655	631.00	228.76	126.20
49041	Drain, percut, abdom abscess		T	0037	10.2655	631.00	228.76	126.20
49061	Drain, percut, retroper absc		T	0037	10.2655	631.00	228.76	126.20
49080	Puncture, peritoneal cavity		T	0070	3.6244	222.78		44.56
49081	Removal of abdominal fluid		T	0070	3.6244	222.78		44.56
49085	Remove abdomen foreign body	CH	D					
49180	Biopsy, abdominal mass		T	0685	6.1384	377.32	115.47	75.46
49200	Removal of abdominal lesion		T	0130	32.1241	1,974.60	659.53	394.92
49250	Excision of umbilicus		T	0153	22.0832	1,357.41	397.95	271.48
49320	Diag laparo separate proc		T	0130	32.1241	1,974.60	659.53	394.92
49321	Laparoscopy, biopsy		T	0130	32.1241	1,974.60	659.53	394.92
49322	Laparoscopy, aspiration		T	0130	32.1241	1,974.60	659.53	394.92
49323	Laparo drain lymphocele		T	0130	32.1241	1,974.60	659.53	394.92
49324	Lap insertion perm ip cath	NI	T	0130	32.1241	1,974.60	659.53	394.92
49325	Lap revision perm ip cath	NI	T	0130	32.1241	1,974.60	659.53	394.92
49326	Lap w/omentopexy add-on	NI	T	0130	32.1241	1,974.60	659.53	394.92

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
49329	Laparo proc, abdm/per/oment		T	0130	32.1241	1,974.60	659.53	394.92
49400	Air injection into abdomen		N					
49402	Remove foreign body, adbomen	NI	T	0153	22.0832	1,357.41	397.95	271.48
49419	Insrt abdom cath for chemotx		T	0115	29.2133	1,795.68	374.81	359.14
49420	Insert abdom drain, temp		T	0652	29.5416	1,815.86		363.17
49421	Insert abdom drain, perm		T	0652	29.5416	1,815.86		363.17
49422	Remove perm cannula/catheter		T	0105	25.6142	1,574.45	370.40	314.89
49423	Exchange drainage catheter		T	0427	11.6575	716.56		143.31
49424	Assess cyst, contrast inject		N					
49426	Revise abdomen-venous shunt		T	0153	22.0832	1,357.41	397.95	271.48
49427	Injection, abdominal shunt		N					
49429	Removal of shunt		T	0105	25.6142	1,574.45	370.40	314.89
49435	Insert subq exten to ip cath	NI	T	0427	11.6575	716.56		143.31
49436	Embedded ip cath exit-site	NI	T	0427	11.6575	716.56		143.31
49491	Rpr hern preemie reduc		T	0154	29.2182	1,795.98	464.85	359.20
49492	Rpr ing hern premie, blocked		T	0154	29.2182	1,795.98	464.85	359.20
49495	Rpr ing hernia baby, reduc		T	0154	29.2182	1,795.98	464.85	359.20
49496	Rpr ing hernia baby, blocked		T	0154	29.2182	1,795.98	464.85	359.20
49500	Rpr ing hernia, init, reduce		T	0154	29.2182	1,795.98	464.85	359.20
49501	Rpr ing hernia, init blocked		T	0154	29.2182	1,795.98	464.85	359.20
49505	Prp i/hern init reduc >5 yr		T	0154	29.2182	1,795.98	464.85	359.20
49507	Prp i/hern init block >5 yr		T	0154	29.2182	1,795.98	464.85	359.20
49520	Rerepair ing hernia, reduce		T	0154	29.2182	1,795.98	464.85	359.20
49521	Rerepair ing hernia, blocked		T	0154	29.2182	1,795.98	464.85	359.20
49525	Repair ing hernia, sliding		T	0154	29.2182	1,795.98	464.85	359.20
49540	Repair lumbar hernia		T	0154	29.2182	1,795.98	464.85	359.20
49550	Rpr rem hernia, init, reduce		T	0154	29.2182	1,795.98	464.85	359.20
49553	Rpr fem hernia, init blocked		T	0154	29.2182	1,795.98	464.85	359.20
49555	Rerepair fem hernia, reduce		T	0154	29.2182	1,795.98	464.85	359.20
49557	Rerepair fem hernia, blocked		T	0154	29.2182	1,795.98	464.85	359.20
49560	Rpr ventral hern init, reduc		T	0154	29.2182	1,795.98	464.85	359.20
49561	Rpr ventral hern init, block		T	0154	29.2182	1,795.98	464.85	359.20
49565	Rerepair ventrl hern, reduce		T	0154	29.2182	1,795.98	464.85	359.20
49566	Rerepair ventrl hern, block		T	0154	29.2182	1,795.98	464.85	359.20
49568	Hernia repair w/mesh		T	0154	29.2182	1,795.98	464.85	359.20
49570	Rpr epigastric hern, reduce		T	0154	29.2182	1,795.98	464.85	359.20
49572	Rpr epigastric hern, blocked		T	0154	29.2182	1,795.98	464.85	359.20
49580	Rpr umbil hern, reduc < 5 yr		T	0154	29.2182	1,795.98	464.85	359.20
49582	Rpr umbil hern, block < 5 yr		T	0154	29.2182	1,795.98	464.85	359.20
49585	Rpr umbil hern, reduc > 5 yr		T	0154	29.2182	1,795.98	464.85	359.20
49587	Rpr umbil hern, block > 5 yr		T	0154	29.2182	1,795.98	464.85	359.20
49590	Repair spigelian hernia		T	0154	29.2182	1,795.98	464.85	359.20
49600	Repair umbilical lesion		T	0154	29.2182	1,795.98	464.85	359.20
49650	Laparo hernia repair initial		T	0131	43.5488	2,676.86	1,001.89	535.37
49651	Laparo hernia repair recur		T	0131	43.5488	2,676.86	1,001.89	535.37
49659	Laparo proc, hernia repair		T	0130	32.1241	1,974.60	659.53	394.92
49999	Abdomen surgery procedure		T	0153	22.0832	1,357.41	397.95	271.48
50020	Renal abscess, open drain		T	0162	23.87	1,467.24		293.45
50021	Renal abscess, percut drain		T	0037	10.2655	631.00	228.76	126.20
50080	Removal of kidney stone		T	0429	43.1004	2,649.30		529.86
50081	Removal of kidney stone		T	0429	43.1004	2,649.30		529.86
50200	Biopsy of kidney		T	0685	6.1384	377.32	115.47	75.46
50382	Change ureter stent, percut		T	0161	19.2251	1,181.73	249.36	236.35
50384	Remove ureter stent, percut		T	0161	19.2251	1,181.73	249.36	236.35
50387	Change ext/int ureter stent		T	0122	7.48	459.78		91.96
50389	Remove renal tube w/fluoro		T	0156	3.4079	209.48		41.90
50390	Drainage of kidney lesion		T	0685	6.1384	377.32	115.47	75.46
50391	Instll rx agnt into rnal tub	CH	T	0126	1.0887	66.92	16.45	13.38
50392	Insert kidney drain		T	0161	19.2251	1,181.73	249.36	236.35
50393	Insert ureteral tube		T	0161	19.2251	1,181.73	249.36	236.35
50394	Injection for kidney x-ray		N					
50395	Create passage to kidney		T	0161	19.2251	1,181.73	249.36	236.35
50396	Measure kidney pressure		T	0164	2.1393	131.50		26.30
50398	Change kidney tube		T	0122	7.48	459.78		91.96
50541	Laparo ablate renal cyst		T	0130	32.1241	1,974.60	659.53	394.92
50542	Laparo ablate renal mass		T	0132	70.5066	4,333.90	1,239.22	866.78
50543	Laparo partial nephrectomy		T	0131	43.5488	2,676.86	1,001.89	535.37
50544	Laparoscopy, pyeloplasty		T	0130	32.1241	1,974.60	659.53	394.92
50549	Laparoscope proc, renal		T	0130	32.1241	1,974.60	659.53	394.92
50551	Kidney endoscopy		T	0160	6.4951	399.24	101.58	79.85

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50553	Kidney endoscopy		T	0161	19.2251	1,181.73	249.36	236.35
50555	Kidney endoscopy & biopsy		T	0160	6.4951	399.24	101.58	79.85
50557	Kidney endoscopy & treatment		T	0162	23.87	1,467.24		293.45
50561	Kidney endoscopy & treatment		T	0161	19.2251	1,181.73	249.36	236.35
50562	Renal scope w/tumor resect		T	0160	6.4951	399.24	101.58	79.85
50570	Kidney endoscopy		T	0160	6.4951	399.24	101.58	79.85
50572	Kidney endoscopy		T	0160	6.4951	399.24	101.58	79.85
50574	Kidney endoscopy & biopsy		T	0160	6.4951	399.24	101.58	79.85
50575	Kidney endoscopy		T	0163	34.9261	2,146.84		429.37
50576	Kidney endoscopy & treatment		T	0161	19.2251	1,181.73	249.36	236.35
50590	Fragmenting of kidney stone		T	0169	43.5398	2,676.30	1,009.47	535.26
50592	Perc rf ablate renal tumor		T	0423	37.3604	2,296.47		459.29
50684	Injection for ureter x-ray		N					
50686	Measure ureter pressure	CH	T	0126	1.0887	66.92	16.45	13.38
50688	Change of ureter tube/stent		T	0122	7.48	459.78		91.96
50690	Injection for ureter x-ray		N					
50945	Laparoscopy ureterolithotomy		T	0131	43.5488	2,676.86	1,001.89	535.37
50947	Laparo new ureter/bladder		T	0131	43.5488	2,676.86	1,001.89	535.37
50948	Laparo new ureter/bladder		T	0131	43.5488	2,676.86	1,001.89	535.37
50949	Laparoscope proc, ureter		T	0130	32.1241	1,974.60	659.53	394.92
50951	Endoscopy of ureter		T	0160	6.4951	399.24	101.58	79.85
50953	Endoscopy of ureter		T	0160	6.4951	399.24	101.58	79.85
50955	Ureter endoscopy & biopsy		T	0161	19.2251	1,181.73	249.36	236.35
50957	Ureter endoscopy & treatment		T	0161	19.2251	1,181.73	249.36	236.35
50961	Ureter endoscopy & treatment		T	0161	19.2251	1,181.73	249.36	236.35
50970	Ureter endoscopy		T	0160	6.4951	399.24	101.58	79.85
50972	Ureter endoscopy & catheter		T	0160	6.4951	399.24	101.58	79.85
50974	Ureter endoscopy & biopsy		T	0161	19.2251	1,181.73	249.36	236.35
50976	Ureter endoscopy & treatment		T	0161	19.2251	1,181.73	249.36	236.35
50980	Ureter endoscopy & treatment		T	0161	19.2251	1,181.73	249.36	236.35
51000	Drainage of bladder		T	0164	2.1393	131.50		26.30
51005	Drainage of bladder	CH	T	0126	1.0887	66.92	16.45	13.38
51010	Drainage of bladder		T	0165	18.1679	1,116.74		223.35
51020	Incise & treat bladder		T	0162	23.87	1,467.24		293.45
51030	Incise & treat bladder		T	0162	23.87	1,467.24		293.45
51040	Incise & drain bladder		T	0162	23.87	1,467.24		293.45
51045	Incise bladder/drain ureter		T	0160	6.4951	399.24	101.58	79.85
51050	Removal of bladder stone		T	0162	23.87	1,467.24		293.45
51065	Remove ureter calculus		T	0162	23.87	1,467.24		293.45
51080	Drainage of bladder abscess		T	0008	17.5086	1,076.22		215.24
51500	Removal of bladder cyst		T	0154	29.2182	1,795.98	464.85	359.20
51520	Removal of bladder lesion		T	0162	23.87	1,467.24		293.45
51600	Injection for bladder x-ray		N					
51605	Preparation for bladder xray		N					
51610	Injection for bladder x-ray		N					
51700	Irrigation of bladder		T	0164	2.1393	131.50		26.30
51701	Insert bladder catheter		X	0340	0.6102	37.51		7.50
51702	Insert temp bladder cath		X	0340	0.6102	37.51		7.50
51703	Insert bladder cath, complex	CH	T	0126	1.0887	66.92	16.45	13.38
51705	Change of bladder tube		T	0121	2.3587	144.98	43.80	29.00
51710	Change of bladder tube		T	0122	7.48	459.78		91.96
51715	Endoscopic injection/implant		T	0168	29.0253	1,784.13	388.16	356.83
51720	Treatment of bladder lesion	CH	T	0164	2.1393	131.50		26.30
51725	Simple cystometrogram	CH	T	0164	2.1393	131.50		26.30
51726	Complex cystometrogram		T	0156	3.4079	209.48		41.90
51736	Urine flow measurement	CH	T	0126	1.0887	66.92	16.45	13.38
51741	Electro-uroflowmetry, first	CH	T	0126	1.0887	66.92	16.45	13.38
51772	Urethra pressure profile	CH	T	0164	2.1393	131.50		26.30
51784	Anal/urinary muscle study	CH	T	0126	1.0887	66.92	16.45	13.38
51785	Anal/urinary muscle study	CH	T	0126	1.0887	66.92	16.45	13.38
51792	Urinary reflex study	CH	T	0126	1.0887	66.92	16.45	13.38
51795	Urine voiding pressure study		T	0164	2.1393	131.50		26.30
51797	Intraabdominal pressure test		T	0164	2.1393	131.50		26.30
51798	Us urine capacity measure		X	0340	0.6102	37.51		7.50
51880	Repair of bladder opening		T	0162	23.87	1,467.24		293.45
51990	Laparo urethral suspension		T	0131	43.5488	2,676.86	1,001.89	535.37
51992	Laparo sling operation	CH	T	0131	43.5488	2,676.86	1,001.89	535.37
51999	Laparoscope proc, bladder		T	0130	32.1241	1,974.60	659.53	394.92
52000	Cystoscopy		T	0160	6.4951	399.24	101.58	79.85
52001	Cystoscopy, removal of clots		T	0160	6.4951	399.24	101.58	79.85

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52005	Cystoscopy & ureter catheter		T	0161	19.2251	1,181.73	249.36	236.35
52007	Cystoscopy and biopsy		T	0161	19.2251	1,181.73	249.36	236.35
52010	Cystoscopy & duct catheter		T	0160	6.4951	399.24	101.58	79.85
52204	Cystoscopy w/biopsy(s)		T	0161	19.2251	1,181.73	249.36	236.35
52214	Cystoscopy and treatment		T	0162	23.87	1,467.24		293.45
52224	Cystoscopy and treatment		T	0162	23.87	1,467.24		293.45
52234	Cystoscopy and treatment		T	0162	23.87	1,467.24		293.45
52235	Cystoscopy and treatment		T	0162	23.87	1,467.24		293.45
52240	Cystoscopy and treatment		T	0162	23.87	1,467.24		293.45
52250	Cystoscopy and radiotracer		T	0162	23.87	1,467.24		293.45
52260	Cystoscopy and treatment		T	0161	19.2251	1,181.73	249.36	236.35
52265	Cystoscopy and treatment		T	0160	6.4951	399.24	101.58	79.85
52270	Cystoscopy & revise urethra		T	0161	19.2251	1,181.73	249.36	236.35
52275	Cystoscopy & revise urethra		T	0161	19.2251	1,181.73	249.36	236.35
52276	Cystoscopy and treatment		T	0161	19.2251	1,181.73	249.36	236.35
52277	Cystoscopy and treatment		T	0162	23.87	1,467.24		293.45
52281	Cystoscopy and treatment		T	0161	19.2251	1,181.73	249.36	236.35
52282	Cystoscopy, implant stent		T	0163	34.9261	2,146.84		429.37
52283	Cystoscopy and treatment		T	0161	19.2251	1,181.73	249.36	236.35
52285	Cystoscopy and treatment		T	0161	19.2251	1,181.73	249.36	236.35
52290	Cystoscopy and treatment		T	0161	19.2251	1,181.73	249.36	236.35
52300	Cystoscopy and treatment		T	0161	19.2251	1,181.73	249.36	236.35
52301	Cystoscopy and treatment		T	0161	19.2251	1,181.73	249.36	236.35
52305	Cystoscopy and treatment		T	0161	19.2251	1,181.73	249.36	236.35
52310	Cystoscopy and treatment		T	0160	6.4951	399.24	101.58	79.85
52315	Cystoscopy and treatment		T	0161	19.2251	1,181.73	249.36	236.35
52317	Remove bladder stone		T	0162	23.87	1,467.24		293.45
52318	Remove bladder stone		T	0162	23.87	1,467.24		293.45
52320	Cystoscopy and treatment		T	0162	23.87	1,467.24		293.45
52325	Cystoscopy, stone removal		T	0162	23.87	1,467.24		293.45
52327	Cystoscopy, inject material		T	0162	23.87	1,467.24		293.45
52330	Cystoscopy and treatment		T	0162	23.87	1,467.24		293.45
52332	Cystoscopy and treatment		T	0162	23.87	1,467.24		293.45
52334	Create passage to kidney		T	0162	23.87	1,467.24		293.45
52341	Cysto w/ureter stricture tx		T	0162	23.87	1,467.24		293.45
52342	Cysto w/up stricture tx		T	0162	23.87	1,467.24		293.45
52343	Cysto w/renal stricture tx		T	0162	23.87	1,467.24		293.45
52344	Cysto/uretero, stricture tx		T	0162	23.87	1,467.24		293.45
52345	Cysto/uretero w/up stricture		T	0162	23.87	1,467.24		293.45
52346	Cystouretero w/renal strict		T	0162	23.87	1,467.24		293.45
52351	Cystouretero & or pyeloscope		T	0161	19.2251	1,181.73	249.36	236.35
52352	Cystouretero w/stone remove		T	0162	23.87	1,467.24		293.45
52353	Cystouretero w/lithotripsy		T	0163	34.9261	2,146.84		429.37
52354	Cystouretero w/biopsy		T	0162	23.87	1,467.24		293.45
52355	Cystouretero w/excise tumor		T	0162	23.87	1,467.24		293.45
52400	Cystouretero w/congen repr		T	0162	23.87	1,467.24		293.45
52402	Cystourethro cut ejacul duct		T	0162	23.87	1,467.24		293.45
52450	Incision of prostate		T	0162	23.87	1,467.24		293.45
52500	Revision of bladder neck		T	0162	23.87	1,467.24		293.45
52510	Dilation prostatic urethra		T	0161	19.2251	1,181.73	249.36	236.35
52601	Prostatectomy (TURP)		T	0163	34.9261	2,146.84		429.37
52606	Control postop bleeding		T	0162	23.87	1,467.24		293.45
52612	Prostatectomy, first stage		T	0163	34.9261	2,146.84		429.37
52614	Prostatectomy, second stage		T	0163	34.9261	2,146.84		429.37
52620	Remove residual prostate		T	0163	34.9261	2,146.84		429.37
52630	Remove prostate regrowth		T	0163	34.9261	2,146.84		429.37
52640	Relieve bladder contracture		T	0162	23.87	1,467.24		293.45
52647	Laser surgery of prostate		T	0429	43.1004	2,649.30		529.86
52648	Laser surgery of prostate		T	0429	43.1004	2,649.30		529.86
52700	Drainage of prostate abscess		T	0162	23.87	1,467.24		293.45
53000	Incision of urethra		T	0166	18.396	1,130.77		226.15
53010	Incision of urethra		T	0166	18.396	1,130.77		226.15
53020	Incision of urethra		T	0166	18.396	1,130.77		226.15
53025	Incision of urethra		T	0166	18.396	1,130.77		226.15
53040	Drainage of urethra abscess		T	0166	18.396	1,130.77		226.15
53060	Drainage of urethra abscess		T	0166	18.396	1,130.77		226.15
53080	Drainage of urinary leakage		T	0166	18.396	1,130.77		226.15
53085	Drainage of urinary leakage		T	0166	18.396	1,130.77		226.15
53200	Biopsy of urethra		T	0166	18.396	1,130.77		226.15
53210	Removal of urethra		T	0168	29.0253	1,784.13	388.16	356.83

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
53215	Removal of urethra		T	0166	18.396	1,130.77		226.15
53220	Treatment of urethra lesion		T	0168	29.0253	1,784.13	388.16	356.83
53230	Removal of urethra lesion		T	0168	29.0253	1,784.13	388.16	356.83
53235	Removal of urethra lesion		T	0166	18.396	1,130.77		226.15
53240	Surgery for urethra pouch		T	0168	29.0253	1,784.13	388.16	356.83
53250	Removal of urethra gland		T	0166	18.396	1,130.77		226.15
53260	Treatment of urethra lesion		T	0166	18.396	1,130.77		226.15
53265	Treatment of urethra lesion		T	0166	18.396	1,130.77		226.15
53270	Removal of urethra gland		T	0166	18.396	1,130.77		226.15
53275	Repair of urethra defect		T	0166	18.396	1,130.77		226.15
53400	Revise urethra, stage 1		T	0168	29.0253	1,784.13	388.16	356.83
53405	Revise urethra, stage 2		T	0168	29.0253	1,784.13	388.16	356.83
53410	Reconstruction of urethra		T	0168	29.0253	1,784.13	388.16	356.83
53420	Reconstruct urethra, stage 1		T	0168	29.0253	1,784.13	388.16	356.83
53425	Reconstruct urethra, stage 2		T	0168	29.0253	1,784.13	388.16	356.83
53430	Reconstruction of urethra		T	0168	29.0253	1,784.13	388.16	356.83
53431	Reconstruct urethra/bladder		T	0168	29.0253	1,784.13	388.16	356.83
53440	Male sling procedure		S	0385	79.2092	4,868.83		973.77
53442	Remove/revise male sling		T	0168	29.0253	1,784.13	388.16	356.83
53444	Insert tandem cuff		S	0385	79.2092	4,868.83		973.77
53445	Insert uro/ves nck sphincter		S	0386	137.3897	8,445.07		1,689.01
53446	Remove uro sphincter		T	0168	29.0253	1,784.13	388.16	356.83
53447	Remove/replace ur sphincter		S	0386	137.3897	8,445.07		1,689.01
53449	Repair uro sphincter		T	0168	29.0253	1,784.13	388.16	356.83
53450	Revision of urethra		T	0168	29.0253	1,784.13	388.16	356.83
53460	Revision of urethra		T	0166	18.396	1,130.77		226.15
53500	Urethrlys, transvag w/ scope		T	0168	29.0253	1,784.13	388.16	356.83
53502	Repair of urethra injury		T	0166	18.396	1,130.77		226.15
53505	Repair of urethra injury		T	0168	29.0253	1,784.13	388.16	356.83
53510	Repair of urethra injury		T	0166	18.396	1,130.77		226.15
53515	Repair of urethra injury		T	0168	29.0253	1,784.13	388.16	356.83
53520	Repair of urethra defect		T	0168	29.0253	1,784.13	388.16	356.83
53600	Dilate urethra stricture		T	0156	3.4079	209.48		41.90
53601	Dilate urethra stricture	CH	T	0126	1.0887	66.92	16.45	13.38
53605	Dilate urethra stricture		T	0161	19.2251	1,181.73	249.36	236.35
53620	Dilate urethra stricture		T	0165	18.1679	1,116.74		223.35
53621	Dilate urethra stricture		T	0164	2.1393	131.50		26.30
53660	Dilation of urethra	CH	T	0126	1.0887	66.92	16.45	13.38
53661	Dilation of urethra	CH	T	0126	1.0887	66.92	16.45	13.38
53665	Dilation of urethra		T	0166	18.396	1,130.77		226.15
53850	Prostatic microwave thermotx		T	0675	41.1375	2,528.64		505.73
53852	Prostatic rf thermotx		T	0675	41.1375	2,528.64		505.73
53853	Prostatic water thermother		T	0162	23.87	1,467.24		293.45
53899	Urology surgery procedure	CH	T	0126	1.0887	66.92	16.45	13.38
54000	Slitting of prepuce		T	0166	18.396	1,130.77		226.15
54001	Slitting of prepuce		T	0166	18.396	1,130.77		226.15
54015	Drain penis lesion		T	0008	17.5086	1,076.22		215.24
54050	Destruction, penis lesion(s)		T	0013	1.0918	67.11		13.42
54055	Destruction, penis lesion(s)		T	0017	17.4423	1,072.14	227.84	214.43
54056	Cryosurgery, penis lesion(s)		T	0012	0.8432	51.83	11.18	10.37
54057	Laser surg, penis lesion(s)		T	0017	17.4423	1,072.14	227.84	214.43
54060	Excision of penis lesion(s)		T	0017	17.4423	1,072.14	227.84	214.43
54065	Destruction, penis lesion(s)		T	0695	20.4276	1,255.64	266.59	251.13
54100	Biopsy of penis		T	0021	15.1024	928.31	219.48	185.66
54105	Biopsy of penis		T	0022	20.0656	1,233.39	354.45	246.68
54110	Treatment of penis lesion		T	0181	32.9873	2,027.66	621.82	405.53
54111	Treat penis lesion, graft		T	0181	32.9873	2,027.66	621.82	405.53
54112	Treat penis lesion, graft		T	0181	32.9873	2,027.66	621.82	405.53
54115	Treatment of penis lesion		T	0008	17.5086	1,076.22		215.24
54120	Partial removal of penis		T	0181	32.9873	2,027.66	621.82	405.53
54150	Circumcision w/regionl block		T	0180	20.5513	1,263.25	304.87	252.65
54152	Circumcision		T	0180	20.5513	1,263.25	304.87	252.65
54160	Circumcision, neonate		T	0180	20.5513	1,263.25	304.87	252.65
54161	Circum 28 days or older		T	0180	20.5513	1,263.25	304.87	252.65
54162	Lysis penil circumic lesion		T	0180	20.5513	1,263.25	304.87	252.65
54163	Repair of circumcision		T	0180	20.5513	1,263.25	304.87	252.65
54164	Frenulotomy of penis		T	0180	20.5513	1,263.25	304.87	252.65
54200	Treatment of penis lesion	CH	T	0164	2.1393	131.50		26.30
54205	Treatment of penis lesion		T	0181	32.9873	2,027.66	621.82	405.53
54220	Treatment of penis lesion	CH	T	0164	2.1393	131.50		26.30

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54230	Prepare penis study		N					
54231	Dynamic cavernosometry		T	0165	18.1679	1,116.74		223.35
54235	Penile injection		T	0164	2.1393	131.50		26.30
54240	Penis study	CH	T	0126	1.0887	66.92	16.45	13.38
54250	Penis study		T	0164	2.1393	131.50		26.30
54300	Revision of penis		T	0181	32.9873	2,027.66	621.82	405.53
54304	Revision of penis		T	0181	32.9873	2,027.66	621.82	405.53
54308	Reconstruction of urethra		T	0181	32.9873	2,027.66	621.82	405.53
54312	Reconstruction of urethra		T	0181	32.9873	2,027.66	621.82	405.53
54316	Reconstruction of urethra		T	0181	32.9873	2,027.66	621.82	405.53
54318	Reconstruction of urethra		T	0181	32.9873	2,027.66	621.82	405.53
54322	Reconstruction of urethra		T	0181	32.9873	2,027.66	621.82	405.53
54324	Reconstruction of urethra		T	0181	32.9873	2,027.66	621.82	405.53
54326	Reconstruction of urethra		T	0181	32.9873	2,027.66	621.82	405.53
54328	Revise penis/urethra		T	0181	32.9873	2,027.66	621.82	405.53
54340	Secondary urethral surgery		T	0181	32.9873	2,027.66	621.82	405.53
54344	Secondary urethral surgery		T	0181	32.9873	2,027.66	621.82	405.53
54348	Secondary urethral surgery		T	0181	32.9873	2,027.66	621.82	405.53
54352	Reconstruct urethra/penis		T	0181	32.9873	2,027.66	621.82	405.53
54360	Penis plastic surgery		T	0181	32.9873	2,027.66	621.82	405.53
54380	Repair penis		T	0181	32.9873	2,027.66	621.82	405.53
54385	Repair penis		T	0181	32.9873	2,027.66	621.82	405.53
54400	Insert semi-rigid prosthesis		S	0385	79.2092	4,868.83		973.77
54401	Insert self-contd prosthesis		S	0386	137.3897	8,445.07		1,689.01
54405	Insert multi-comp penis pros		S	0386	137.3897	8,445.07		1,689.01
54406	Remove muti-comp penis pros		T	0181	32.9873	2,027.66	621.82	405.53
54408	Repair multi-comp penis pros		T	0181	32.9873	2,027.66	621.82	405.53
54410	Remove/replace penis prosth		S	0386	137.3897	8,445.07		1,689.01
54415	Remove self-contd penis pros		T	0181	32.9873	2,027.66	621.82	405.53
54416	Remv/repl penis contain pros		S	0386	137.3897	8,445.07		1,689.01
54420	Revision of penis		T	0181	32.9873	2,027.66	621.82	405.53
54435	Revision of penis		T	0181	32.9873	2,027.66	621.82	405.53
54440	Repair of penis		T	0181	32.9873	2,027.66	621.82	405.53
54450	Preputial stretching		T	0156	3.4079	209.48		41.90
54500	Biopsy of testis		T	0037	10.2655	631.00	228.76	126.20
54505	Biopsy of testis		T	0183	23.531	1,446.40		289.28
54512	Excise lesion testis		T	0183	23.531	1,446.40		289.28
54520	Removal of testis		T	0183	23.531	1,446.40		289.28
54522	Orchiectomy, partial		T	0183	23.531	1,446.40		289.28
54530	Removal of testis		T	0154	29.2182	1,795.98	464.85	359.20
54550	Exploration for testis		T	0154	29.2182	1,795.98	464.85	359.20
54560	Exploration for testis		T	0183	23.531	1,446.40		289.28
54600	Reduce testis torsion		T	0183	23.531	1,446.40		289.28
54620	Suspension of testis		T	0183	23.531	1,446.40		289.28
54640	Suspension of testis		T	0154	29.2182	1,795.98	464.85	359.20
54660	Revision of testis		T	0183	23.531	1,446.40		289.28
54670	Repair testis injury		T	0183	23.531	1,446.40		289.28
54680	Relocation of testis(es)		T	0183	23.531	1,446.40		289.28
54690	Laparoscopy, orchiectomy		T	0131	43.5488	2,676.86	1,001.89	535.37
54692	Laparoscopy, orchiopexy		T	0132	70.5066	4,333.90	1,239.22	866.78
54699	Laparoscope proc, testis		T	0130	32.1241	1,974.60	659.53	394.92
54700	Drainage of scrotum		T	0183	23.531	1,446.40		289.28
54800	Biopsy of epididymis		T	0004	2.0687	127.16		25.43
54820	Exploration of epididymis	CH	D					
54830	Remove epididymis lesion		T	0183	23.531	1,446.40		289.28
54840	Remove epididymis lesion		T	0183	23.531	1,446.40		289.28
54860	Removal of epididymis		T	0183	23.531	1,446.40		289.28
54861	Removal of epididymis		T	0183	23.531	1,446.40		289.28
54865	Explore epididymis	NI	T	0183	23.531	1,446.40		289.28
54900	Fusion of spermatic ducts		T	0183	23.531	1,446.40		289.28
54901	Fusion of spermatic ducts		T	0183	23.531	1,446.40		289.28
55000	Drainage of hydrocele		T	0004	2.0687	127.16		25.43
55040	Removal of hydrocele		T	0154	29.2182	1,795.98	464.85	359.20
55041	Removal of hydroceles		T	0154	29.2182	1,795.98	464.85	359.20
55060	Repair of hydrocele		T	0183	23.531	1,446.40		289.28
55100	Drainage of scrotum abscess	CH	T	0007	11.1535	685.58		137.12
55110	Explore scrotum		T	0183	23.531	1,446.40		289.28
55120	Removal of scrotum lesion		T	0183	23.531	1,446.40		289.28
55150	Removal of scrotum		T	0183	23.531	1,446.40		289.28
55175	Revision of scrotum		T	0183	23.531	1,446.40		289.28

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
55180	Revision of scrotum		T	0183	23.531	1,446.40		289.28
55200	Incision of sperm duct		T	0183	23.531	1,446.40		289.28
55250	Removal of sperm duct(s)		T	0183	23.531	1,446.40		289.28
55300	Prepare, sperm duct x-ray		N					
55400	Repair of sperm duct		T	0183	23.531	1,446.40		289.28
55450	Ligation of sperm duct		T	0183	23.531	1,446.40		289.28
55500	Removal of hydrocele		T	0183	23.531	1,446.40		289.28
55520	Removal of sperm cord lesion		T	0183	23.531	1,446.40		289.28
55530	Revise spermatic cord veins		T	0183	23.531	1,446.40		289.28
55535	Revise spermatic cord veins		T	0154	29.2182	1,795.98	464.85	359.20
55540	Revise hernia & sperm veins		T	0154	29.2182	1,795.98	464.85	359.20
55550	Laparo ligate spermatic vein		T	0131	43.5488	2,676.86	1,001.89	535.37
55559	Laparo proc, spermatic cord		T	0130	32.1241	1,974.60	659.53	394.92
55600	Incise sperm duct pouch		T	0183	23.531	1,446.40		289.28
55680	Remove sperm pouch lesion		T	0183	23.531	1,446.40		289.28
55700	Biopsy of prostate		T	0184	5.6262	345.83	96.27	69.17
55705	Biopsy of prostate		T	0184	5.6262	345.83	96.27	69.17
55720	Drainage of prostate abscess		T	0162	23.87	1,467.24		293.45
55725	Drainage of prostate abscess		T	0162	23.87	1,467.24		293.45
55859	Percut/needle insert, pros	CH	D					
55860	Surgical exposure, prostate		T	0165	18.1679	1,116.74		223.35
55870	Electroejaculation		T	0197	4.0007	245.92		49.18
55873	Cryoablate prostate		T	0674	108.7566	6,685.05		1,337.01
55875	Transperi needle place, pros	NI	T	0163	34.9261	2,146.84		429.37
55876	Place rt device/marker, pros	NI	T	0156	3.4079	209.48		41.90
55899	Genital surgery procedure	CH	T	0126	1.0887	66.92	16.45	13.38
56405	I & D of vulva/perineum		T	0189	2.8966	178.05		35.61
56420	Drainage of gland abscess	CH	T	0188	1.29	79.29		15.86
56440	Surgery for vulva lesion		T	0194	20.5081	1,260.59	397.84	252.12
56441	Lysis of labial lesion(s)		T	0193	14.8489	912.73		182.55
56442	Hymenotomy	NI	T	0193	14.8489	912.73		182.55
56501	Destroy, vulva lesions, sim		T	0017	17.4423	1,072.14	227.84	214.43
56515	Destroy vulva lesion/s compl		T	0695	20.4276	1,255.64	266.59	251.13
56605	Biopsy of vulva/perineum		T	0019	4.0919	251.52	71.87	50.30
56606	Biopsy of vulva/perineum		T	0019	4.0919	251.52	71.87	50.30
56620	Partial removal of vulva		T	0195	28.5095	1,752.42	483.80	350.48
56625	Complete removal of vulva		T	0195	28.5095	1,752.42	483.80	350.48
56700	Partial removal of hymen		T	0194	20.5081	1,260.59	397.84	252.12
56720	Incision of hymen	CH	D					
56740	Remove vagina gland lesion		T	0194	20.5081	1,260.59	397.84	252.12
56800	Repair of vagina		T	0194	20.5081	1,260.59	397.84	252.12
56805	Repair clitoris		T	0193	14.8489	912.73		182.55
56810	Repair of perineum		T	0194	20.5081	1,260.59	397.84	252.12
56820	Exam of vulva w/scope		T	0188	1.29	79.29		15.86
56821	Exam/biopsy of vulva w/scope		T	0189	2.8966	178.05		35.61
57000	Exploration of vagina		T	0193	14.8489	912.73		182.55
57010	Drainage of pelvic abscess		T	0193	14.8489	912.73		182.55
57020	Drainage of pelvic fluid		T	0192	6.6592	409.33		81.87
57022	I & d vaginal hematoma, pp		T	0007	11.1535	685.58		137.12
57023	I & d vag hematoma, non-ob		T	0008	17.5086	1,076.22		215.24
57061	Destroy vag lesions, simple		T	0194	20.5081	1,260.59	397.84	252.12
57065	Destroy vag lesions, complex		T	0194	20.5081	1,260.59	397.84	252.12
57100	Biopsy of vagina		T	0192	6.6592	409.33		81.87
57105	Biopsy of vagina		T	0194	20.5081	1,260.59	397.84	252.12
57106	Remove vagina wall, partial		T	0194	20.5081	1,260.59	397.84	252.12
57107	Remove vagina tissue, part		T	0195	28.5095	1,752.42	483.80	350.48
57109	Vaginectomy partial w/nodes		T	0195	28.5095	1,752.42	483.80	350.48
57120	Closure of vagina		T	0195	28.5095	1,752.42	483.80	350.48
57130	Remove vagina lesion		T	0194	20.5081	1,260.59	397.84	252.12
57135	Remove vagina lesion		T	0194	20.5081	1,260.59	397.84	252.12
57150	Treat vagina infection		T	0191	0.1468	9.02	2.55	1.80
57155	Insert uteri tandems/ovoids		T	0192	6.6592	409.33		81.87
57160	Insert pessary/other device		T	0188	1.29	79.29		15.86
57170	Fitting of diaphragm/cap		T	0191	0.1468	9.02	2.55	1.80
57180	Treat vaginal bleeding		T	0189	2.8966	178.05		35.61
57200	Repair of vagina		T	0194	20.5081	1,260.59	397.84	252.12
57210	Repair vagina/perineum		T	0194	20.5081	1,260.59	397.84	252.12
57220	Revision of urethra		T	0202	42.9896	2,642.48	981.50	528.50
57230	Repair of urethral lesion		T	0195	28.5095	1,752.42	483.80	350.48
57240	Repair bladder & vagina		T	0195	28.5095	1,752.42	483.80	350.48

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57250	Repair rectum & vagina		T	0195	28.5095	1,752.42	483.80	350.48
57260	Repair of vagina		T	0195	28.5095	1,752.42	483.80	350.48
57265	Extensive repair of vagina		T	0202	42.9896	2,642.48	981.50	528.50
57267	Insert mesh/pelvic flr addon	CH	T	0195	28.5095	1,752.42	483.80	350.48
57268	Repair of bowel bulge		T	0195	28.5095	1,752.42	483.80	350.48
57282	Colpopexy, extraperitoneal	CH	T	0202	42.9896	2,642.48	981.50	528.50
57283	Colpopexy, intraperitoneal	CH	T	0202	42.9896	2,642.48	981.50	528.50
57284	Repair paravaginal defect		T	0202	42.9896	2,642.48	981.50	528.50
57287	Revise/remove sling repair	CH	T	0195	28.5095	1,752.42	483.80	350.48
57288	Repair bladder defect		T	0202	42.9896	2,642.48	981.50	528.50
57289	Repair bladder & vagina		T	0195	28.5095	1,752.42	483.80	350.48
57291	Construction of vagina		T	0195	28.5095	1,752.42	483.80	350.48
57292	Construct vagina with graft	CH	T	0195	28.5095	1,752.42	483.80	350.48
57295	Change vaginal graft		T	0194	20.5081	1,260.59	397.84	252.12
57296	Revise vag graft, open abd	NI	C					
57300	Repair rectum-vagina fistula		T	0195	28.5095	1,752.42	483.80	350.48
57310	Repair urethrovaginal lesion		T	0202	42.9896	2,642.48	981.50	528.50
57320	Repair bladder-vagina lesion		T	0195	28.5095	1,752.42	483.80	350.48
57330	Repair bladder-vagina lesion		T	0195	28.5095	1,752.42	483.80	350.48
57335	Repair vagina	CH	T	0195	28.5095	1,752.42	483.80	350.48
57400	Dilation of vagina		T	0194	20.5081	1,260.59	397.84	252.12
57410	Pelvic examination		T	0193	14.8489	912.73		182.55
57415	Remove vaginal foreign body		T	0194	20.5081	1,260.59	397.84	252.12
57420	Exam of vagina w/scope		T	0189	2.8966	178.05		35.61
57421	Exam/biopsy of vag w/scope		T	0189	2.8966	178.05		35.61
57425	Laparoscopy, surg, colpopexy		T	0130	32.1241	1,974.60	659.53	394.92
57452	Exam of cervix w/scope	CH	T	0188	1.29	79.29		15.86
57454	Bx/curett of cervix w/scope		T	0189	2.8966	178.05		35.61
57455	Biopsy of cervix w/scope		T	0189	2.8966	178.05		35.61
57456	Endocerv curettage w/scope		T	0189	2.8966	178.05		35.61
57460	Bx of cervix w/scope, leep		T	0193	14.8489	912.73		182.55
57461	Conz of cervix w/scope, leep		T	0194	20.5081	1,260.59	397.84	252.12
57500	Biopsy of cervix	CH	T	0189	2.8966	178.05		35.61
57505	Endocervical curettage		T	0189	2.8966	178.05		35.61
57510	Cauterization of cervix		T	0193	14.8489	912.73		182.55
57511	Cryocautery of cervix	CH	T	0188	1.29	79.29		15.86
57513	Laser surgery of cervix		T	0193	14.8489	912.73		182.55
57520	Conization of cervix		T	0194	20.5081	1,260.59	397.84	252.12
57522	Conization of cervix		T	0195	28.5095	1,752.42	483.80	350.48
57530	Removal of cervix		T	0195	28.5095	1,752.42	483.80	350.48
57550	Removal of residual cervix		T	0195	28.5095	1,752.42	483.80	350.48
57555	Remove cervix/repair vagina		T	0195	28.5095	1,752.42	483.80	350.48
57556	Remove cervix, repair bowel		T	0202	42.9896	2,642.48	981.50	528.50
57558	D&c of cervical stump	NI	T	0196	17.7499	1,091.05	338.23	218.21
57700	Revision of cervix		T	0194	20.5081	1,260.59	397.84	252.12
57720	Revision of cervix		T	0194	20.5081	1,260.59	397.84	252.12
57800	Dilation of cervical canal		T	0193	14.8489	912.73		182.55
57820	D & c of residual cervix	CH	D					
58100	Biopsy of uterus lining		T	0188	1.29	79.29		15.86
58110	Bx done w/colposcopy add-on		T	0188	1.29	79.29		15.86
58120	Dilation and curettage		T	0196	17.7499	1,091.05	338.23	218.21
58145	Myomectomy vag method		T	0195	28.5095	1,752.42	483.80	350.48
58260	Vaginal hysterectomy	CH	T	0195	28.5095	1,752.42	483.80	350.48
58262	Vag hyst including t/o	CH	T	0195	28.5095	1,752.42	483.80	350.48
58263	Vag hyst w/t/o & vag repair	CH	T	0195	28.5095	1,752.42	483.80	350.48
58270	Vag hyst w/enterocele repair	CH	T	0195	28.5095	1,752.42	483.80	350.48
58290	Vag hyst complex	CH	T	0202	42.9896	2,642.48	981.50	528.50
58291	Vag hyst incl t/o, complex	CH	T	0202	42.9896	2,642.48	981.50	528.50
58292	Vag hyst t/o & repair, compl	CH	T	0202	42.9896	2,642.48	981.50	528.50
58294	Vag hyst w/enterocele, compl	CH	T	0202	42.9896	2,642.48	981.50	528.50
58301	Remove intrauterine device	CH	T	0188	1.29	79.29		15.86
58321	Artificial insemination		T	0197	4.0007	245.92		49.18
58322	Artificial insemination		T	0197	4.0007	245.92		49.18
58323	Sperm washing		T	0197	4.0007	245.92		49.18
58340	Catheter for hysterography		N					
58345	Reopen fallopian tube		T	0193	14.8489	912.73		182.55
58346	Insert heyman uteri capsule		T	0193	14.8489	912.73		182.55
58350	Reopen fallopian tube		T	0195	28.5095	1,752.42	483.80	350.48
58353	Endometr ablate, thermal		T	0195	28.5095	1,752.42	483.80	350.48
58356	Endometrial cryoablation		T	0202	42.9896	2,642.48	981.50	528.50

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58541	Lsh, uterus 250 g or less	NI	T	0131	43.5488	2,676.86	1,001.89	535.37
58542	Lsh w/t/o ut 250 g or less	NI	T	0131	43.5488	2,676.86	1,001.89	535.37
58543	Lsh uterus above 250 g	NI	T	0131	43.5488	2,676.86	1,001.89	535.37
58544	Lsh w/t/o uterus above 250 g	NI	T	0131	43.5488	2,676.86	1,001.89	535.37
58545	Laparoscopic myomectomy		T	0130	32.1241	1,974.60	659.53	394.92
58546	Laparo-myomectomy, complex		T	0131	43.5488	2,676.86	1,001.89	535.37
58548	Lap radical hyst	NI	C					
58550	Laparo-asst vag hysterectomy		T	0132	70.5066	4,333.90	1,239.22	866.78
58552	Laparo-vag hyst incl t/o		T	0131	43.5488	2,676.86	1,001.89	535.37
58553	Laparo-vag hyst, complex		T	0131	43.5488	2,676.86	1,001.89	535.37
58554	Laparo-vag hyst w/t/o, compl		T	0131	43.5488	2,676.86	1,001.89	535.37
58555	Hysteroscopy, dx, sep proc		T	0190	21.3586	1,312.87	424.28	262.57
58558	Hysteroscopy, biopsy		T	0190	21.3586	1,312.87	424.28	262.57
58559	Hysteroscopy, lysis		T	0190	21.3586	1,312.87	424.28	262.57
58560	Hysteroscopy, resect septum		T	0387	34.0155	2,090.86	655.55	418.17
58561	Hysteroscopy, remove myoma		T	0387	34.0155	2,090.86	655.55	418.17
58562	Hysteroscopy, remove fb		T	0190	21.3586	1,312.87	424.28	262.57
58563	Hysteroscopy, ablation		T	0387	34.0155	2,090.86	655.55	418.17
58565	Hysteroscopy, sterilization		T	0202	42.9896	2,642.48	981.50	528.50
58578	Laparo proc, uterus		T	0130	32.1241	1,974.60	659.53	394.92
58579	Hysteroscope procedure		T	0190	21.3586	1,312.87	424.28	262.57
58600	Division of fallopian tube		T	0195	28.5095	1,752.42	483.80	350.48
58615	Occlude fallopian tube(s)		T	0194	20.5081	1,260.59	397.84	252.12
58660	Laparoscopy, lysis		T	0131	43.5488	2,676.86	1,001.89	535.37
58661	Laparoscopy, remove adnexa		T	0131	43.5488	2,676.86	1,001.89	535.37
58662	Laparoscopy, excise lesions		T	0131	43.5488	2,676.86	1,001.89	535.37
58670	Laparoscopy, tubal cautery		T	0131	43.5488	2,676.86	1,001.89	535.37
58671	Laparoscopy, tubal block		T	0131	43.5488	2,676.86	1,001.89	535.37
58672	Laparoscopy, fimbrioplasty		T	0131	43.5488	2,676.86	1,001.89	535.37
58673	Laparoscopy, salpingostomy		T	0131	43.5488	2,676.86	1,001.89	535.37
58679	Laparo proc, oviduct-ovary		T	0130	32.1241	1,974.60	659.53	394.92
58770	Create new tubal opening		T	0195	28.5095	1,752.42	483.80	350.48
58800	Drainage of ovarian cyst(s)		T	0193	14.8489	912.73		182.55
58820	Drain ovary abscess, open		T	0195	28.5095	1,752.42	483.80	350.48
58823	Drain pelvic abscess, percut		T	0193	14.8489	912.73		182.55
58900	Biopsy of ovary(s)		T	0193	14.8489	912.73		182.55
58920	Partial removal of ovary(s)		T	0195	28.5095	1,752.42	483.80	350.48
58925	Removal of ovarian cyst(s)		T	0195	28.5095	1,752.42	483.80	350.48
58957	Resect recurrent gyn mal	NI	C					
58958	Resect recur gyn mal w/lym	NI	C					
58970	Retrieval of oocyte		T	0197	4.0007	245.92		49.18
58974	Transfer of embryo		T	0197	4.0007	245.92		49.18
58976	Transfer of embryo		T	0197	4.0007	245.92		49.18
58999	Genital surgery procedure		T	0191	0.1468	9.02	2.55	1.80
59000	Amniocentesis, diagnostic		T	0198	1.4222	87.42	32.19	17.48
59001	Amniocentesis, therapeutic		T	0192	6.6592	409.33		81.87
59012	Fetal cord puncture,prenatal		T	0198	1.4222	87.42	32.19	17.48
59015	Chorion biopsy		T	0198	1.4222	87.42	32.19	17.48
59020	Fetal contract stress test	CH	T	0189	2.8966	178.05		35.61
59025	Fetal non-stress test		T	0198	1.4222	87.42	32.19	17.48
59030	Fetal scalp blood sample		T	0198	1.4222	87.42	32.19	17.48
59070	Transabdom amnioinfus w/us		T	0198	1.4222	87.42	32.19	17.48
59072	Umbilical cord occlud w/us		T	0198	1.4222	87.42	32.19	17.48
59074	Fetal fluid drainage w/us		T	0198	1.4222	87.42	32.19	17.48
59076	Fetal shunt placement, w/us		T	0198	1.4222	87.42	32.19	17.48
59100	Remove uterus lesion		T	0195	28.5095	1,752.42	483.80	350.48
59150	Treat ectopic pregnancy		T	0131	43.5488	2,676.86	1,001.89	535.37
59151	Treat ectopic pregnancy		T	0131	43.5488	2,676.86	1,001.89	535.37
59160	D& c after delivery		T	0196	17.7499	1,091.05	338.23	218.21
59200	Insert cervical dilator		T	0189	2.8966	178.05		35.61
59300	Episiotomy or vaginal repair		T	0193	14.8489	912.73		182.55
59320	Revision of cervix		T	0194	20.5081	1,260.59	397.84	252.12
59409	Obstetrical care		T	0194	20.5081	1,260.59	397.84	252.12
59412	Antepartum manipulation		T	0700	2.3864	146.69		29.34
59414	Deliver placenta		T	0193	14.8489	912.73		182.55
59612	Vbac delivery only		T	0194	20.5081	1,260.59	397.84	252.12
59812	Treatment of miscarriage		T	0201	18.5201	1,138.39	329.65	227.68
59820	Care of miscarriage		T	0201	18.5201	1,138.39	329.65	227.68
59821	Treatment of miscarriage		T	0201	18.5201	1,138.39	329.65	227.68
59840	Abortion		T	0200	16.9328	1,040.83	243.36	208.17

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
59841	Abortion		T	0200	16.9328	1,040.83	243.36	208.17
59866	Abortion (mpr)		T	0198	1.4222	87.42	32.19	17.48
59870	Evacuate mole of uterus		T	0201	18.5201	1,138.39	329.65	227.68
59871	Remove cerclage suture		T	0194	20.5081	1,260.59	397.84	252.12
59897	Fetal invas px w/us		T	0198	1.4222	87.42	32.19	17.48
59898	Laparo proc, ob care/deliver		T	0130	32.1241	1,974.60	659.53	394.92
59899	Maternity care procedure		T	0198	1.4222	87.42	32.19	17.48
60000	Drain thyroid/tongue cyst		T	0252	7.5511	464.15	109.16	92.83
60001	Aspirate/inject thyriod cyst		T	0004	2.0687	127.16		25.43
60100	Biopsy of thyroid		T	0004	2.0687	127.16		25.43
60200	Remove thyroid lesion		T	0114	37.7224	2,318.72	467.95	463.74
60210	Partial thyroid excision		T	0114	37.7224	2,318.72	467.95	463.74
60212	Partial thyroid excision		T	0114	37.7224	2,318.72	467.95	463.74
60220	Partial removal of thyroid		T	0114	37.7224	2,318.72	467.95	463.74
60225	Partial removal of thyroid		T	0114	37.7224	2,318.72	467.95	463.74
60240	Removal of thyroid		T	0114	37.7224	2,318.72	467.95	463.74
60252	Removal of thyroid		T	0256	38.1991	2,348.02		469.60
60260	Repeat thyroid surgery		T	0256	38.1991	2,348.02		469.60
60280	Remove thyroid duct lesion		T	0114	37.7224	2,318.72	467.95	463.74
60281	Remove thyroid duct lesion		T	0114	37.7224	2,318.72	467.95	463.74
60500	Explore parathyroid glands		T	0256	38.1991	2,348.02		469.60
60502	Re-explore parathyroids	CH	T	0256	38.1991	2,348.02		469.60
60512	Autotransplant parathyroid		T	0022	20.0656	1,233.39	354.45	246.68
60520	Removal of thymus gland	CH	T	0256	38.1991	2,348.02		469.60
60659	Laparo proc, endocrine		T	0130	32.1241	1,974.60	659.53	394.92
60699	Endocrine surgery procedure		T	0114	37.7224	2,318.72	467.95	463.74
61000	Remove cranial cavity fluid		T	0212	2.9907	183.83	65.96	36.77
61001	Remove cranial cavity fluid		T	0212	2.9907	183.83	65.96	36.77
61020	Remove brain cavity fluid		T	0212	2.9907	183.83	65.96	36.77
61026	Injection into brain canal		T	0212	2.9907	183.83	65.96	36.77
61050	Remove brain canal fluid		T	0212	2.9907	183.83	65.96	36.77
61055	Injection into brain canal		T	0212	2.9907	183.83	65.96	36.77
61070	Brain canal shunt procedure		T	0212	2.9907	183.83	65.96	36.77
61215	Insert brain-fluid device		T	0224	47.0342	2,891.10		578.22
61330	Decompress eye socket		T	0256	38.1991	2,348.02		469.60
61334	Explore orbit/remove object		T	0256	38.1991	2,348.02		469.60
61623	Endovasc tempory vessel occl		T	0081	42.936	2,639.19		527.84
61626	Transcath occlusion, non-cns		T	0081	42.936	2,639.19		527.84
61720	Incise skull/brain surgery	CH	T	0221	33.152	2,037.79	463.62	407.56
61790	Treat trigeminal nerve		T	0220	17.8499	1,097.20		219.44
61791	Treat trigeminal tract		T	0206	5.7253	351.92	75.55	70.38
61795	Brain surgery using computer		S	0302	4.9138	302.04	105.94	60.41
61880	Revise/remove neuroelectrode		T	0687	17.8334	1,096.18	438.47	219.24
61885	Insrt/redo neurostim 1 array		S	0039	187.3821	11,518.00		2,303.60
61886	Implant neurostim arrays		T	0315	242.9363	14,932.81		2,986.56
61888	Revise/remove neuroreceiver		T	0688	35.5702	2,186.43	874.57	437.29
62000	Treat skull fracture	CH	T	0254	23.3299	1,434.04	321.35	286.81
62160	Neuroendoscopy add-on		T	0122	7.48	459.78		91.96
62194	Replace/irrigate catheter		T	0427	11.6575	716.56		143.31
62225	Replace/irrigate catheter		T	0427	11.6575	716.56		143.31
62230	Replace/revise brain shunt		T	0224	47.0342	2,891.10		578.22
62252	Csf shunt reprogram		S	0691	2.8942	177.90	60.61	35.58
62263	Epidural lysis mult sessions		T	0203	12.1702	748.08	240.33	149.62
62264	Epidural lysis on single day		T	0203	12.1702	748.08	240.33	149.62
62268	Drain spinal cord cyst		T	0212	2.9907	183.83	65.96	36.77
62269	Needle biopsy, spinal cord		T	0685	6.1384	377.32	115.47	75.46
62270	Spinal fluid tap, diagnostic		T	0204	2.2614	139.00	40.13	27.80
62272	Drain cerebro spinal fluid		T	0204	2.2614	139.00	40.13	27.80
62273	Inject epidural patch		T	0206	5.7253	351.92	75.55	70.38
62280	Treat spinal cord lesion		T	0207	6.3603	390.95	86.92	78.19
62281	Treat spinal cord lesion		T	0207	6.3603	390.95	86.92	78.19
62282	Treat spinal canal lesion		T	0207	6.3603	390.95	86.92	78.19
62284	Injection for myelogram		N					
62287	Percutaneous diskectomy		T	0221	33.152	2,037.79	463.62	407.56
62290	Inject for spine disk x-ray		N					
62291	Inject for spine disk x-ray		N					
62292	Injection into disk lesion		T	0212	2.9907	183.83	65.96	36.77
62294	Injection into spinal artery		T	0212	2.9907	183.83	65.96	36.77
62310	Inject spine c/t		T	0207	6.3603	390.95	86.92	78.19
62311	Inject spine l/s (cd)		T	0207	6.3603	390.95	86.92	78.19

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
62318	Inject spine w/cath, c/t		T	0207	6.3603	390.95	86.92	78.19
62319	Inject spine w/cath l/s (cd)		T	0207	6.3603	390.95	86.92	78.19
62350	Implant spinal canal cath		T	0223	30.8394	1,895.64		379.13
62351	Implant spinal canal cath		T	0208	44.1489	2,713.74		542.75
62355	Remove spinal canal catheter		T	0203	12.1702	748.08	240.33	149.62
62360	Insert spine infusion device		T	0226	112.6322	6,923.28		1,384.66
62361	Implant spine infusion pump		T	0227	174.4056	10,720.36		2,144.07
62362	Implant spine infusion pump		T	0227	174.4056	10,720.36		2,144.07
62365	Remove spine infusion device		T	0221	33.152	2,037.79	463.62	407.56
62367	Analyze spine infusion pump		S	0691	2.8942	177.90	60.61	35.58
62368	Analyze spine infusion pump		S	0691	2.8942	177.90	60.61	35.58
63001	Removal of spinal lamina		T	0208	44.1489	2,713.74		542.75
63003	Removal of spinal lamina		T	0208	44.1489	2,713.74		542.75
63005	Removal of spinal lamina		T	0208	44.1489	2,713.74		542.75
63011	Removal of spinal lamina		T	0208	44.1489	2,713.74		542.75
63012	Removal of spinal lamina		T	0208	44.1489	2,713.74		542.75
63015	Removal of spinal lamina		T	0208	44.1489	2,713.74		542.75
63016	Removal of spinal lamina		T	0208	44.1489	2,713.74		542.75
63017	Removal of spinal lamina		T	0208	44.1489	2,713.74		542.75
63020	Neck spine disk surgery		T	0208	44.1489	2,713.74		542.75
63030	Low back disk surgery		T	0208	44.1489	2,713.74		542.75
63035	Spinal disk surgery add-on		T	0208	44.1489	2,713.74		542.75
63040	Laminotomy, single cervical		T	0208	44.1489	2,713.74		542.75
63042	Laminotomy, single lumbar		T	0208	44.1489	2,713.74		542.75
63045	Removal of spinal lamina		T	0208	44.1489	2,713.74		542.75
63046	Removal of spinal lamina		T	0208	44.1489	2,713.74		542.75
63047	Removal of spinal lamina		T	0208	44.1489	2,713.74		542.75
63048	Remove spinal lamina add-on		T	0208	44.1489	2,713.74		542.75
63055	Decompress spinal cord		T	0208	44.1489	2,713.74		542.75
63056	Decompress spinal cord		T	0208	44.1489	2,713.74		542.75
63057	Decompress spine cord add-on		T	0208	44.1489	2,713.74		542.75
63064	Decompress spinal cord		T	0208	44.1489	2,713.74		542.75
63066	Decompress spine cord add-on		T	0208	44.1489	2,713.74		542.75
63075	Neck spine disk surgery		T	0208	44.1489	2,713.74		542.75
63600	Remove spinal cord lesion		T	0220	17.8499	1,097.20		219.44
63610	Stimulation of spinal cord		T	0220	17.8499	1,097.20		219.44
63615	Remove lesion of spinal cord		T	0220	17.8499	1,097.20		219.44
63650	Implant neuroelectrodes		S	0040	56.5705	3,477.28		695.46
63655	Implant neuroelectrodes		S	0061	84.1967	5,175.40		1,035.08
63660	Revise/remove neuroelectrode		T	0687	17.8334	1,096.18	438.47	219.24
63685	Insrt/redo spine n generator		T	0222	181.6249	11,164.12		2,232.82
63688	Revise/remove neuroreceiver		T	0688	35.5702	2,186.43	874.57	437.29
63741	Install spinal shunt		T	0228	39.2633	2,413.44		482.69
63744	Revision of spinal shunt		T	0228	39.2633	2,413.44		482.69
63746	Removal of spinal shunt		T	0109	10.9918	675.64		135.13
64400	Nblock inj, trigeminal		T	0204	2.2614	139.00	40.13	27.80
64402	Nblock inj, facial		T	0204	2.2614	139.00	40.13	27.80
64405	Nblock inj, occipital		T	0204	2.2614	139.00	40.13	27.80
64408	Nblock inj, vagus		T	0204	2.2614	139.00	40.13	27.80
64410	Nblock inj, phrenic		T	0206	5.7253	351.92	75.55	70.38
64412	Nblock inj, spinal accessor		T	0206	5.7253	351.92	75.55	70.38
64413	Nblock inj, cervical plexus		T	0204	2.2614	139.00	40.13	27.80
64415	Nblock inj, brachial plexus		T	0204	2.2614	139.00	40.13	27.80
64416	Nblock cont infuse, b plex		T	0204	2.2614	139.00	40.13	27.80
64417	Nblock inj, axillary		T	0204	2.2614	139.00	40.13	27.80
64418	Nblock inj, suprascapular		T	0204	2.2614	139.00	40.13	27.80
64420	Nblock inj, intercost, sng		T	0204	2.2614	139.00	40.13	27.80
64421	Nblock inj, intercost, mlt		T	0206	5.7253	351.92	75.55	70.38
64425	Nblock inj, ilio-ing/hypogi		T	0204	2.2614	139.00	40.13	27.80
64430	Nblock inj, pudendal		T	0204	2.2614	139.00	40.13	27.80
64435	Nblock inj, paracervical		T	0204	2.2614	139.00	40.13	27.80
64445	Nblock inj, sciatic, sng		T	0204	2.2614	139.00	40.13	27.80
64446	Nblk inj, sciatic, cont inf		T	0206	5.7253	351.92	75.55	70.38
64447	Nblock inj fem, single		T	0204	2.2614	139.00	40.13	27.80
64448	Nblock inj fem, cont inf		T	0204	2.2614	139.00	40.13	27.80
64449	Nblock inj, lumbar plexus		T	0204	2.2614	139.00	40.13	27.80
64450	Nblock, other peripheral		T	0204	2.2614	139.00	40.13	27.80
64470	Inj paravertebral c/t		T	0207	6.3603	390.95	86.92	78.19
64472	Inj paravertebral c/t add-on		T	0206	5.7253	351.92	75.55	70.38
64475	Inj paravertebral l/s		T	0207	6.3603	390.95	86.92	78.19

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64476	Inj paravertebral l/s add-on		T	0206	5.7253	351.92	75.55	70.38
64479	Inj foramen epidural c/t		T	0207	6.3603	390.95	86.92	78.19
64480	Inj foramen epidural add-on		T	0207	6.3603	390.95	86.92	78.19
64483	Inj foramen epidural l/s		T	0207	6.3603	390.95	86.92	78.19
64484	Inj foramen epidural add-on		T	0207	6.3603	390.95	86.92	78.19
64505	Nblock, spenopalatine gangl		T	0204	2.2614	139.00	40.13	27.80
64508	Nblock, carotid sinus s/p		T	0204	2.2614	139.00	40.13	27.80
64510	Nblock, stellate ganglion		T	0207	6.3603	390.95	86.92	78.19
64517	Nblock inj, hypogas plxs		T	0204	2.2614	139.00	40.13	27.80
64520	Nblock, lumbar/thoracic		T	0207	6.3603	390.95	86.92	78.19
64530	Nblock inj, celiac pelus		T	0207	6.3603	390.95	86.92	78.19
64553	Implant neuroelectrodes		S	0225	221.1512	13,593.72		2,718.74
64555	Implant neuroelectrodes		S	0040	56.5705	3,477.28		695.46
64560	Implant neuroelectrodes		S	0040	56.5705	3,477.28		695.46
64561	Implant neuroelectrodes		S	0040	56.5705	3,477.28		695.46
64565	Implant neuroelectrodes		S	0040	56.5705	3,477.28		695.46
64573	Implant neuroelectrodes		S	0225	221.1512	13,593.72		2,718.74
64575	Implant neuroelectrodes		S	0061	84.1967	5,175.40		1,035.08
64577	Implant neuroelectrodes		S	0061	84.1967	5,175.40		1,035.08
64580	Implant neuroelectrodes		S	0061	84.1967	5,175.40		1,035.08
64581	Implant neuroelectrodes		S	0061	84.1967	5,175.40		1,035.08
64585	Revise/remove neuroelectrode		T	0687	17.8334	1,096.18	438.47	219.24
64590	Insrt/redo pn/gastr stimul		T	0222	181.6249	11,164.12		2,232.82
64595	Revise/rmv pn/gastr stimul		T	0688	35.5702	2,186.43	874.57	437.29
64600	Injection treatment of nerve		T	0203	12.1702	748.08	240.33	149.62
64605	Injection treatment of nerve		T	0203	12.1702	748.08	240.33	149.62
64610	Injection treatment of nerve		T	0203	12.1702	748.08	240.33	149.62
64612	Destroy nerve, face muscle		T	0204	2.2614	139.00	40.13	27.80
64613	Destroy nerve, neck muscle		T	0204	2.2614	139.00	40.13	27.80
64614	Destroy nerve, extrem musc		T	0204	2.2614	139.00	40.13	27.80
64620	Injection treatment of nerve		T	0203	12.1702	748.08	240.33	149.62
64622	Destr paravertebrl nerve l/s		T	0203	12.1702	748.08	240.33	149.62
64623	Destr paravertebral n add-on		T	0207	6.3603	390.95	86.92	78.19
64626	Destr paravertebrl nerve c/t		T	0203	12.1702	748.08	240.33	149.62
64627	Destr paravertebral n add-on		T	0207	6.3603	390.95	86.92	78.19
64630	Injection treatment of nerve		T	0206	5.7253	351.92	75.55	70.38
64640	Injection treatment of nerve		T	0206	5.7253	351.92	75.55	70.38
64650	Chemodenerv eccrine glands		T	0204	2.2614	139.00	40.13	27.80
64653	Chemodenerv eccrine glands		T	0204	2.2614	139.00	40.13	27.80
64680	Injection treatment of nerve		T	0207	6.3603	390.95	86.92	78.19
64681	Injection treatment of nerve		T	0203	12.1702	748.08	240.33	149.62
64702	Revise finger/toe nerve		T	0220	17.8499	1,097.20		219.44
64704	Revise hand/foot nerve		T	0220	17.8499	1,097.20		219.44
64708	Revise arm/leg nerve		T	0220	17.8499	1,097.20		219.44
64712	Revision of sciatic nerve		T	0220	17.8499	1,097.20		219.44
64713	Revision of arm nerve(s)		T	0220	17.8499	1,097.20		219.44
64714	Revise low back nerve(s)		T	0220	17.8499	1,097.20		219.44
64716	Revision of cranial nerve		T	0220	17.8499	1,097.20		219.44
64718	Revise ulnar nerve at elbow		T	0220	17.8499	1,097.20		219.44
64719	Revise ulnar nerve at wrist		T	0220	17.8499	1,097.20		219.44
64721	Carpal tunnel surgery		T	0220	17.8499	1,097.20		219.44
64722	Relieve pressure on nerve(s)		T	0220	17.8499	1,097.20		219.44
64726	Release foot/toe nerve		T	0220	17.8499	1,097.20		219.44
64727	Internal nerve revision		T	0220	17.8499	1,097.20		219.44
64732	Incision of brow nerve		T	0220	17.8499	1,097.20		219.44
64734	Incision of cheek nerve		T	0220	17.8499	1,097.20		219.44
64736	Incision of chin nerve		T	0220	17.8499	1,097.20		219.44
64738	Incision of jaw nerve		T	0220	17.8499	1,097.20		219.44
64740	Incision of tongue nerve		T	0220	17.8499	1,097.20		219.44
64742	Incision of facial nerve		T	0220	17.8499	1,097.20		219.44
64744	Incise nerve, back of head		T	0220	17.8499	1,097.20		219.44
64746	Incise diaphragm nerve		T	0220	17.8499	1,097.20		219.44
64761	Incision of pelvis nerve		T	0220	17.8499	1,097.20		219.44
64763	Incise hip/thigh nerve		T	0220	17.8499	1,097.20		219.44
64766	Incise hip/thigh nerve		T	0221	33.152	2,037.79	463.62	407.56
64771	Sever cranial nerve		T	0220	17.8499	1,097.20		219.44
64772	Incision of spinal nerve		T	0220	17.8499	1,097.20		219.44
64774	Remove skin nerve lesion		T	0220	17.8499	1,097.20		219.44
64776	Remove digit nerve lesion		T	0220	17.8499	1,097.20		219.44
64778	Digit nerve surgery add-on		T	0220	17.8499	1,097.20		219.44

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64782	Remove limb nerve lesion		T	0220	17.8499	1,097.20		219.44
64783	Limb nerve surgery add-on		T	0220	17.8499	1,097.20		219.44
64784	Remove nerve lesion		T	0220	17.8499	1,097.20		219.44
64786	Remove sciatic nerve lesion		T	0221	33.152	2,037.79	463.62	407.56
64787	Implant nerve end		T	0220	17.8499	1,097.20		219.44
64788	Remove skin nerve lesion		T	0220	17.8499	1,097.20		219.44
64790	Removal of nerve lesion		T	0220	17.8499	1,097.20		219.44
64792	Removal of nerve lesion		T	0221	33.152	2,037.79	463.62	407.56
64795	Biopsy of nerve		T	0220	17.8499	1,097.20		219.44
64802	Remove sympathetic nerves		T	0220	17.8499	1,097.20		219.44
64804	Remove sympathetic nerves	CH	T	0220	17.8499	1,097.20		219.44
64820	Remove sympathetic nerves		T	0220	17.8499	1,097.20		219.44
64821	Remove sympathetic nerves		T	0054	25.8758	1,590.53		318.11
64822	Remove sympathetic nerves		T	0054	25.8758	1,590.53		318.11
64823	Remove sympathetic nerves		T	0054	25.8758	1,590.53		318.11
64831	Repair of digit nerve		T	0221	33.152	2,037.79	463.62	407.56
64832	Repair nerve add-on		T	0221	33.152	2,037.79	463.62	407.56
64834	Repair of hand or foot nerve		T	0221	33.152	2,037.79	463.62	407.56
64835	Repair of hand or foot nerve		T	0221	33.152	2,037.79	463.62	407.56
64836	Repair of hand or foot nerve		T	0221	33.152	2,037.79	463.62	407.56
64837	Repair nerve add-on		T	0221	33.152	2,037.79	463.62	407.56
64840	Repair of leg nerve		T	0221	33.152	2,037.79	463.62	407.56
64856	Repair/transpose nerve		T	0221	33.152	2,037.79	463.62	407.56
64857	Repair arm/leg nerve		T	0221	33.152	2,037.79	463.62	407.56
64858	Repair sciatic nerve		T	0221	33.152	2,037.79	463.62	407.56
64859	Nerve surgery		T	0221	33.152	2,037.79	463.62	407.56
64861	Repair of arm nerves		T	0221	33.152	2,037.79	463.62	407.56
64862	Repair of low back nerves		T	0221	33.152	2,037.79	463.62	407.56
64864	Repair of facial nerve		T	0221	33.152	2,037.79	463.62	407.56
64865	Repair of facial nerve		T	0221	33.152	2,037.79	463.62	407.56
64870	Fusion of facial/other nerve		T	0221	33.152	2,037.79	463.62	407.56
64872	Subsequent repair of nerve		T	0221	33.152	2,037.79	463.62	407.56
64874	Repair & revise nerve add-on		T	0221	33.152	2,037.79	463.62	407.56
64876	Repair nerve/shorten bone		T	0221	33.152	2,037.79	463.62	407.56
64885	Nerve graft, head or neck		T	0221	33.152	2,037.79	463.62	407.56
64886	Nerve graft, head or neck		T	0221	33.152	2,037.79	463.62	407.56
64890	Nerve graft, hand or foot		T	0221	33.152	2,037.79	463.62	407.56
64891	Nerve graft, hand or foot		T	0221	33.152	2,037.79	463.62	407.56
64892	Nerve graft, arm or leg		T	0221	33.152	2,037.79	463.62	407.56
64893	Nerve graft, arm or leg		T	0221	33.152	2,037.79	463.62	407.56
64895	Nerve graft, hand or foot		T	0221	33.152	2,037.79	463.62	407.56
64896	Nerve graft, hand or foot		T	0221	33.152	2,037.79	463.62	407.56
64897	Nerve graft, arm or leg		T	0221	33.152	2,037.79	463.62	407.56
64898	Nerve graft, arm or leg		T	0221	33.152	2,037.79	463.62	407.56
64901	Nerve graft add-on		T	0221	33.152	2,037.79	463.62	407.56
64902	Nerve graft add-on		T	0221	33.152	2,037.79	463.62	407.56
64905	Nerve pedicle transfer		T	0221	33.152	2,037.79	463.62	407.56
64907	Nerve pedicle transfer		T	0221	33.152	2,037.79	463.62	407.56
64910	Nerve repair w/allograft	NI	T	0220	17.8499	1,097.20		219.44
64911	Neurorraphy w/vein autograft	NI	T	0220	17.8499	1,097.20		219.44
64999	Nervous system surgery		T	0204	2.2614	139.00	40.13	27.80
65091	Revise eye		T	0242	35.2292	2,165.47	597.36	433.09
65093	Revise eye with implant	CH	T	0242	35.2292	2,165.47	597.36	433.09
65101	Removal of eye		T	0242	35.2292	2,165.47	597.36	433.09
65103	Remove eye/insert implant		T	0242	35.2292	2,165.47	597.36	433.09
65105	Remove eye/attach implant		T	0242	35.2292	2,165.47	597.36	433.09
65110	Removal of eye		T	0242	35.2292	2,165.47	597.36	433.09
65112	Remove eye/revise socket		T	0242	35.2292	2,165.47	597.36	433.09
65114	Remove eye/revise socket		T	0242	35.2292	2,165.47	597.36	433.09
65125	Revise ocular implant		T	0240	17.1243	1,052.60	309.52	210.52
65130	Insert ocular implant		T	0241	25.255	1,552.37	384.47	310.47
65135	Insert ocular implant		T	0241	25.255	1,552.37	384.47	310.47
65140	Attach ocular implant		T	0242	35.2292	2,165.47	597.36	433.09
65150	Revise ocular implant		T	0241	25.255	1,552.37	384.47	310.47
65155	Reinsert ocular implant		T	0242	35.2292	2,165.47	597.36	433.09
65175	Removal of ocular implant		T	0240	17.1243	1,052.60	309.52	210.52
65205	Remove foreign body from eye		S	0698	1.1607	71.35		14.27
65210	Remove foreign body from eye		S	0698	1.1607	71.35		14.27
65220	Remove foreign body from eye		S	0698	1.1607	71.35		14.27
65222	Remove foreign body from eye		S	0698	1.1607	71.35		14.27

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65235	Remove foreign body from eye		T	0233	15.2259	935.91	266.33	187.18
65260	Remove foreign body from eye		T	0236	16.5239	1,015.69		203.14
65265	Remove foreign body from eye		T	0237	27.602	1,696.64		339.33
65270	Repair of eye wound		T	0240	17.1243	1,052.60	309.52	210.52
65272	Repair of eye wound		T	0234	22.997	1,413.58	511.31	282.72
65275	Repair of eye wound		T	0234	22.997	1,413.58	511.31	282.72
65280	Repair of eye wound		T	0236	16.5239	1,015.69		203.14
65285	Repair of eye wound		T	0672	37.429	2,300.69		460.14
65286	Repair of eye wound		T	0232	6.0673	372.94	93.43	74.59
65290	Repair of eye socket wound		T	0243	21.2801	1,308.05	430.35	261.61
65400	Removal of eye lesion		T	0233	15.2259	935.91	266.33	187.18
65410	Biopsy of cornea		T	0233	15.2259	935.91	266.33	187.18
65420	Removal of eye lesion		T	0233	15.2259	935.91	266.33	187.18
65426	Removal of eye lesion		T	0234	22.997	1,413.58	511.31	282.72
65430	Corneal smear		S	0698	1.1607	71.35		14.27
65435	Curette/treat cornea		T	0239	7.2819	447.60		89.52
65436	Curette/treat cornea		T	0233	15.2259	935.91	266.33	187.18
65450	Treatment of corneal lesion		S	0231	2.1451	131.86		26.37
65600	Revision of cornea		T	0240	17.1243	1,052.60	309.52	210.52
65710	Corneal transplant		T	0244	38.2707	2,352.42	803.26	470.48
65730	Corneal transplant		T	0244	38.2707	2,352.42	803.26	470.48
65750	Corneal transplant		T	0244	38.2707	2,352.42	803.26	470.48
65755	Corneal transplant		T	0244	38.2707	2,352.42	803.26	470.48
65770	Revise cornea with implant	CH	T	0293	51.9894	3,195.68	1,128.29	639.14
65772	Correction of astigmatism		T	0233	15.2259	935.91	266.33	187.18
65775	Correction of astigmatism		T	0233	15.2259	935.91	266.33	187.18
65780	Ocular reconst, transplant		T	0244	38.2707	2,352.42	803.26	470.48
65781	Ocular reconst, transplant		T	0244	38.2707	2,352.42	803.26	470.48
65782	Ocular reconst, transplant		T	0244	38.2707	2,352.42	803.26	470.48
65800	Drainage of eye		T	0233	15.2259	935.91	266.33	187.18
65805	Drainage of eye		T	0233	15.2259	935.91	266.33	187.18
65810	Drainage of eye		T	0234	22.997	1,413.58	511.31	282.72
65815	Drainage of eye		T	0234	22.997	1,413.58	511.31	282.72
65820	Relieve inner eye pressure		T	0232	6.0673	372.94	93.43	74.59
65850	Incision of eye		T	0234	22.997	1,413.58	511.31	282.72
65855	Laser surgery of eye		T	0247	5.0839	312.50	104.31	62.50
65860	Incise inner eye adhesions		T	0247	5.0839	312.50	104.31	62.50
65865	Incise inner eye adhesions		T	0233	15.2259	935.91	266.33	187.18
65870	Incise inner eye adhesions		T	0234	22.997	1,413.58	511.31	282.72
65875	Incise inner eye adhesions		T	0234	22.997	1,413.58	511.31	282.72
65880	Incise inner eye adhesions		T	0233	15.2259	935.91	266.33	187.18
65900	Remove eye lesion		T	0233	15.2259	935.91	266.33	187.18
65920	Remove implant of eye		T	0234	22.997	1,413.58	511.31	282.72
65930	Remove blood clot from eye		T	0234	22.997	1,413.58	511.31	282.72
66020	Injection treatment of eye		T	0233	15.2259	935.91	266.33	187.18
66030	Injection treatment of eye		T	0232	6.0673	372.94	93.43	74.59
66130	Remove eye lesion		T	0234	22.997	1,413.58	511.31	282.72
66150	Glaucoma surgery		T	0234	22.997	1,413.58	511.31	282.72
66155	Glaucoma surgery		T	0234	22.997	1,413.58	511.31	282.72
66160	Glaucoma surgery		T	0234	22.997	1,413.58	511.31	282.72
66165	Glaucoma surgery		T	0234	22.997	1,413.58	511.31	282.72
66170	Glaucoma surgery		T	0234	22.997	1,413.58	511.31	282.72
66172	Incision of eye	CH	T	0234	22.997	1,413.58	511.31	282.72
66180	Implant eye shunt		T	0673	37.8967	2,329.43	649.56	465.89
66185	Revise eye shunt		T	0673	37.8967	2,329.43	649.56	465.89
66220	Repair eye lesion		T	0672	37.429	2,300.69		460.14
66225	Repair/graft eye lesion		T	0673	37.8967	2,329.43	649.56	465.89
66250	Follow-up surgery of eye		T	0233	15.2259	935.91	266.33	187.18
66500	Incision of iris		T	0232	6.0673	372.94	93.43	74.59
66505	Incision of iris		T	0232	6.0673	372.94	93.43	74.59
66600	Remove iris and lesion		T	0234	22.997	1,413.58	511.31	282.72
66605	Removal of iris		T	0234	22.997	1,413.58	511.31	282.72
66625	Removal of iris		T	0232	6.0673	372.94	93.43	74.59
66630	Removal of iris		T	0234	22.997	1,413.58	511.31	282.72
66635	Removal of iris		T	0234	22.997	1,413.58	511.31	282.72
66680	Repair iris & ciliary body		T	0234	22.997	1,413.58	511.31	282.72
66682	Repair iris & ciliary body		T	0234	22.997	1,413.58	511.31	282.72
66700	Destruction, ciliary body		T	0233	15.2259	935.91	266.33	187.18
66710	Ciliary transsleral therapy		T	0233	15.2259	935.91	266.33	187.18
66711	Ciliary endoscopic ablation		T	0233	15.2259	935.91	266.33	187.18

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
66720	Destruction, ciliary body		T	0233	15.2259	935.91	266.33	187.18
66740	Destruction, ciliary body		T	0234	22.997	1,413.58	511.31	282.72
66761	Revision of iris		T	0247	5.0839	312.50	104.31	62.50
66762	Revision of iris		T	0247	5.0839	312.50	104.31	62.50
66770	Removal of inner eye lesion		T	0247	5.0839	312.50	104.31	62.50
66820	Incision, secondary cataract		T	0232	6.0673	372.94	93.43	74.59
66821	After cataract laser surgery		T	0247	5.0839	312.50	104.31	62.50
66825	Reposition intraocular lens		T	0234	22.997	1,413.58	511.31	282.72
66830	Removal of lens lesion		T	0232	6.0673	372.94	93.43	74.59
66840	Removal of lens material		T	0245	14.8702	914.04	217.05	182.81
66850	Removal of lens material		T	0249	29.2281	1,796.59	524.67	359.32
66852	Removal of lens material		T	0249	29.2281	1,796.59	524.67	359.32
66920	Extraction of lens		T	0249	29.2281	1,796.59	524.67	359.32
66930	Extraction of lens		T	0249	29.2281	1,796.59	524.67	359.32
66940	Extraction of lens		T	0245	14.8702	914.04	217.05	182.81
66982	Cataract surgery, complex		T	0246	23.6313	1,452.57	495.96	290.51
66983	Cataract surg w/iol, 1 stage		T	0246	23.6313	1,452.57	495.96	290.51
66984	Cataract surg w/iol, 1 stage		T	0246	23.6313	1,452.57	495.96	290.51
66985	Insert lens prosthesis		T	0246	23.6313	1,452.57	495.96	290.51
66986	Exchange lens prosthesis		T	0246	23.6313	1,452.57	495.96	290.51
66990	Ophthalmic endoscope add-on		N					
66999	Eye surgery procedure		T	0232	6.0673	372.94	93.43	74.59
67005	Partial removal of eye fluid		T	0237	27.602	1,696.64		339.33
67010	Partial removal of eye fluid		T	0237	27.602	1,696.64		339.33
67015	Release of eye fluid		T	0237	27.602	1,696.64		339.33
67025	Replace eye fluid		T	0237	27.602	1,696.64		339.33
67027	Implant eye drug system		T	0672	37.429	2,300.69		460.14
67028	Injection eye drug		T	0235	3.9333	241.77	58.93	48.35
67030	Incise inner eye strands		T	0236	16.5239	1,015.69		203.14
67031	Laser surgery, eye strands		T	0247	5.0839	312.50	104.31	62.50
67036	Removal of inner eye fluid		T	0672	37.429	2,300.69		460.14
67038	Strip retinal membrane		T	0672	37.429	2,300.69		460.14
67039	Laser treatment of retina		T	0672	37.429	2,300.69		460.14
67040	Laser treatment of retina		T	0672	37.429	2,300.69		460.14
67101	Repair detached retina		T	0236	16.5239	1,015.69		203.14
67105	Repair detached retina		T	0248	5.0841	312.51	95.08	62.50
67107	Repair detached retina		T	0672	37.429	2,300.69		460.14
67108	Repair detached retina		T	0672	37.429	2,300.69		460.14
67110	Repair detached retina		T	0236	16.5239	1,015.69		203.14
67112	Rerepair detached retina		T	0672	37.429	2,300.69		460.14
67115	Release encircling material		T	0236	16.5239	1,015.69		203.14
67120	Remove eye implant material		T	0236	16.5239	1,015.69		203.14
67121	Remove eye implant material		T	0237	27.602	1,696.64		339.33
67141	Treatment of retina		T	0235	3.9333	241.77	58.93	48.35
67145	Treatment of retina		T	0248	5.0841	312.51	95.08	62.50
67208	Treatment of retinal lesion		T	0236	16.5239	1,015.69		203.14
67210	Treatment of retinal lesion		T	0248	5.0841	312.51	95.08	62.50
67218	Treatment of retinal lesion		T	0236	16.5239	1,015.69		203.14
67220	Treatment of choroid lesion		T	0235	3.9333	241.77	58.93	48.35
67221	Ocular photodynamic ther		T	0235	3.9333	241.77	58.93	48.35
67225	Eye photodynamic ther add-on		T	0235	3.9333	241.77	58.93	48.35
67227	Treatment of retinal lesion	CH	T	0237	27.602	1,696.64		339.33
67228	Treatment of retinal lesion		T	0248	5.0841	312.51	95.08	62.50
67250	Reinforce eye wall		T	0240	17.1243	1,052.60	309.52	210.52
67255	Reinforce/graft eye wall		T	0237	27.602	1,696.64		339.33
67299	Eye surgery procedure		T	0235	3.9333	241.77	58.93	48.35
67311	Revise eye muscle		T	0243	21.2801	1,308.05	430.35	261.61
67312	Revise two eye muscles		T	0243	21.2801	1,308.05	430.35	261.61
67314	Revise eye muscle		T	0243	21.2801	1,308.05	430.35	261.61
67316	Revise two eye muscles		T	0243	21.2801	1,308.05	430.35	261.61
67318	Revise eye muscle(s)		T	0243	21.2801	1,308.05	430.35	261.61
67320	Revise eye muscle(s) add-on		T	0243	21.2801	1,308.05	430.35	261.61
67331	Eye surgery follow-up add-on		T	0243	21.2801	1,308.05	430.35	261.61
67332	Rerevise eye muscles add-on		T	0243	21.2801	1,308.05	430.35	261.61
67334	Revise eye muscle w/suture		T	0243	21.2801	1,308.05	430.35	261.61
67335	Eye suture during surgery		T	0243	21.2801	1,308.05	430.35	261.61
67340	Revise eye muscle add-on		T	0243	21.2801	1,308.05	430.35	261.61
67343	Release eye tissue		T	0243	21.2801	1,308.05	430.35	261.61
67345	Destroy nerve of eye muscle		T	0238	2.8954	177.97		35.59
67346	Biopsy, eye muscle	NI	T	0699	14.3845	884.19		176.84

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67350	Biopsy eye muscle	CH	D					
67399	Eye muscle surgery procedure		T	0243	21.2801	1,308.05	430.35	261.61
67400	Explore/biopsy eye socket		T	0241	25.255	1,552.37	384.47	310.47
67405	Explore/drain eye socket		T	0241	25.255	1,552.37	384.47	310.47
67412	Explore/treat eye socket		T	0241	25.255	1,552.37	384.47	310.47
67413	Explore/treat eye socket		T	0241	25.255	1,552.37	384.47	310.47
67414	Explr/decompress eye socket		T	0242	35.2292	2,165.47	597.36	433.09
67415	Aspiration, orbital contents		T	0240	17.1243	1,052.60	309.52	210.52
67420	Explore/treat eye socket		T	0242	35.2292	2,165.47	597.36	433.09
67430	Explore/treat eye socket		T	0242	35.2292	2,165.47	597.36	433.09
67440	Explore/drain eye socket		T	0242	35.2292	2,165.47	597.36	433.09
67445	Explr/decompress eye socket		T	0242	35.2292	2,165.47	597.36	433.09
67450	Explore/biopsy eye socket		T	0242	35.2292	2,165.47	597.36	433.09
67500	Inject/treat eye socket		S	0231	2.1451	131.86		26.37
67505	Inject/treat eye socket		T	0238	2.8954	177.97		35.59
67515	Inject/treat eye socket		T	0238	2.8954	177.97		35.59
67550	Insert eye socket implant		T	0242	35.2292	2,165.47	597.36	433.09
67560	Revise eye socket implant		T	0241	25.255	1,552.37	384.47	310.47
67570	Decompress optic nerve		T	0242	35.2292	2,165.47	597.36	433.09
67599	Orbit surgery procedure		T	0238	2.8954	177.97		35.59
67700	Drainage of eyelid abscess		T	0238	2.8954	177.97		35.59
67710	Incision of eyelid		T	0239	7.2819	447.60		89.52
67715	Incision of eyelid fold		T	0240	17.1243	1,052.60	309.52	210.52
67800	Remove eyelid lesion		T	0238	2.8954	177.97		35.59
67801	Remove eyelid lesions		T	0239	7.2819	447.60		89.52
67805	Remove eyelid lesions		T	0238	2.8954	177.97		35.59
67808	Remove eyelid lesion(s)		T	0240	17.1243	1,052.60	309.52	210.52
67810	Biopsy of eyelid		T	0238	2.8954	177.97		35.59
67820	Revise eyelashes		S	0698	1.1607	71.35		14.27
67825	Revise eyelashes		T	0238	2.8954	177.97		35.59
67830	Revise eyelashes		T	0239	7.2819	447.60		89.52
67835	Revise eyelashes		T	0240	17.1243	1,052.60	309.52	210.52
67840	Remove eyelid lesion		T	0239	7.2819	447.60		89.52
67850	Treat eyelid lesion		T	0239	7.2819	447.60		89.52
67875	Closure of eyelid by suture		T	0239	7.2819	447.60		89.52
67880	Revision of eyelid		T	0233	15.2259	935.91	266.33	187.18
67882	Revision of eyelid		T	0240	17.1243	1,052.60	309.52	210.52
67900	Repair brow defect		T	0240	17.1243	1,052.60	309.52	210.52
67901	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67902	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67903	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67904	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67906	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67908	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67909	Revise eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67911	Revise eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67912	Correction eyelid w/implant		T	0240	17.1243	1,052.60	309.52	210.52
67914	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67915	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67916	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67917	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67921	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67922	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67923	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67924	Repair eyelid defect		T	0240	17.1243	1,052.60	309.52	210.52
67930	Repair eyelid wound		T	0240	17.1243	1,052.60	309.52	210.52
67935	Repair eyelid wound		T	0240	17.1243	1,052.60	309.52	210.52
67938	Remove eyelid foreign body		S	0698	1.1607	71.35		14.27
67950	Revision of eyelid		T	0240	17.1243	1,052.60	309.52	210.52
67961	Revision of eyelid		T	0240	17.1243	1,052.60	309.52	210.52
67966	Revision of eyelid		T	0240	17.1243	1,052.60	309.52	210.52
67971	Reconstruction of eyelid		T	0241	25.255	1,552.37	384.47	310.47
67973	Reconstruction of eyelid		T	0241	25.255	1,552.37	384.47	310.47
67974	Reconstruction of eyelid		T	0241	25.255	1,552.37	384.47	310.47
67975	Reconstruction of eyelid		T	0240	17.1243	1,052.60	309.52	210.52
67999	Revision of eyelid		T	0238	2.8954	177.97		35.59
68020	Incise/drain eyelid lining		T	0240	17.1243	1,052.60	309.52	210.52
68040	Treatment of eyelid lesions		S	0698	1.1607	71.35		14.27
68100	Biopsy of eyelid lining		T	0232	6.0673	372.94	93.43	74.59
68110	Remove eyelid lining lesion		T	0699	14.3845	884.19		176.84

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
68115	Remove eyelid lining lesion		T	0240	17.1243	1,052.60	309.52	210.52
68130	Remove eyelid lining lesion		T	0233	15.2259	935.91	266.33	187.18
68135	Remove eyelid lining lesion		T	0239	7.2819	447.60		89.52
68200	Treat eyelid by injection		S	0230	0.7898	48.55	14.97	9.71
68320	Revise/graft eyelid lining		T	0240	17.1243	1,052.60	309.52	210.52
68325	Revise/graft eyelid lining	CH	T	0241	25.255	1,552.37	384.47	310.47
68326	Revise/graft eyelid lining		T	0241	25.255	1,552.37	384.47	310.47
68328	Revise/graft eyelid lining		T	0241	25.255	1,552.37	384.47	310.47
68330	Revise eyelid lining		T	0234	22.997	1,413.58	511.31	282.72
68335	Revise/graft eyelid lining		T	0241	25.255	1,552.37	384.47	310.47
68340	Separate eyelid adhesions		T	0240	17.1243	1,052.60	309.52	210.52
68360	Revise eyelid lining		T	0234	22.997	1,413.58	511.31	282.72
68362	Revise eyelid lining		T	0234	22.997	1,413.58	511.31	282.72
68371	Harvest eye tissue, alograft		T	0233	15.2259	935.91	266.33	187.18
68399	Eyelid lining surgery		T	0238	2.8954	177.97		35.59
68400	Incise/drain tear gland		T	0238	2.8954	177.97		35.59
68420	Incise/drain tear sac		T	0240	17.1243	1,052.60	309.52	210.52
68440	Incise tear duct opening		T	0238	2.8954	177.97		35.59
68500	Removal of tear gland		T	0241	25.255	1,552.37	384.47	310.47
68505	Partial removal, tear gland		T	0241	25.255	1,552.37	384.47	310.47
68510	Biopsy of tear gland		T	0240	17.1243	1,052.60	309.52	210.52
68520	Removal of tear sac		T	0241	25.255	1,552.37	384.47	310.47
68525	Biopsy of tear sac		T	0240	17.1243	1,052.60	309.52	210.52
68530	Clearance of tear duct		T	0240	17.1243	1,052.60	309.52	210.52
68540	Remove tear gland lesion		T	0241	25.255	1,552.37	384.47	310.47
68550	Remove tear gland lesion	CH	T	0241	25.255	1,552.37	384.47	310.47
68700	Repair tear ducts		T	0241	25.255	1,552.37	384.47	310.47
68705	Revise tear duct opening		T	0238	2.8954	177.97		35.59
68720	Create tear sac drain	CH	T	0241	25.255	1,552.37	384.47	310.47
68745	Create tear duct drain		T	0241	25.255	1,552.37	384.47	310.47
68750	Create tear duct drain	CH	T	0241	25.255	1,552.37	384.47	310.47
68760	Close tear duct opening	CH	S	0231	2.1451	131.86		26.37
68761	Close tear duct opening		S	0231	2.1451	131.86		26.37
68770	Close tear system fistula		T	0240	17.1243	1,052.60	309.52	210.52
68801	Dilate tear duct opening		S	0698	1.1607	71.35		14.27
68810	Probe nasolacrimal duct		S	0231	2.1451	131.86		26.37
68811	Probe nasolacrimal duct		T	0240	17.1243	1,052.60	309.52	210.52
68815	Probe nasolacrimal duct		T	0240	17.1243	1,052.60	309.52	210.52
68840	Explore/irrigate tear ducts	CH	S	0698	1.1607	71.35		14.27
68850	Injection for tear sac x-ray		N					
68899	Tear duct system surgery	CH	T	0238	2.8954	177.97		35.59
69000	Drain external ear lesion		T	0006	1.4392	88.46		17.69
69005	Drain external ear lesion		T	0008	17.5086	1,076.22		215.24
69020	Drain outer ear canal lesion		T	0006	1.4392	88.46		17.69
69100	Biopsy of external ear		T	0019	4.0919	251.52	71.87	50.30
69105	Biopsy of external ear canal		T	0253	16.4266	1,009.71	282.29	201.94
69110	Remove external ear, partial		T	0021	15.1024	928.31	219.48	185.66
69120	Removal of external ear		T	0254	23.3299	1,434.04	321.35	286.81
69140	Remove ear canal lesion(s)		T	0254	23.3299	1,434.04	321.35	286.81
69145	Remove ear canal lesion(s)		T	0021	15.1024	928.31	219.48	185.66
69150	Extensive ear canal surgery		T	0252	7.5511	464.15	109.16	92.83
69200	Clear outer ear canal		X	0340	0.6102	37.51		7.50
69205	Clear outer ear canal		T	0022	20.0656	1,233.39	354.45	246.68
69210	Remove impacted ear wax		X	0340	0.6102	37.51		7.50
69220	Clean out mastoid cavity		T	0012	0.8432	51.83	11.18	10.37
69222	Clean out mastoid cavity	CH	T	0252	7.5511	464.15	109.16	92.83
69300	Revise external ear		T	0254	23.3299	1,434.04	321.35	286.81
69310	Rebuild outer ear canal		T	0256	38.1991	2,348.02		469.60
69320	Rebuild outer ear canal		T	0256	38.1991	2,348.02		469.60
69399	Outer ear surgery procedure		T	0251	2.452	150.72		30.14
69400	Inflate middle ear canal		T	0251	2.452	150.72		30.14
69401	Inflate middle ear canal		T	0251	2.452	150.72		30.14
69405	Catheterize middle ear canal		T	0252	7.5511	464.15	109.16	92.83
69420	Incision of eardrum		T	0251	2.452	150.72		30.14
69421	Incision of eardrum		T	0253	16.4266	1,009.71	282.29	201.94
69424	Remove ventilating tube		T	0252	7.5511	464.15	109.16	92.83
69433	Create eardrum opening		T	0252	7.5511	464.15	109.16	92.83
69436	Create eardrum opening		T	0253	16.4266	1,009.71	282.29	201.94
69440	Exploration of middle ear		T	0254	23.3299	1,434.04	321.35	286.81
69450	Eardrum revision		T	0256	38.1991	2,348.02		469.60

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69501	Mastoidectomy		T	0256	38.1991	2,348.02		469.60
69502	Mastoidectomy		T	0254	23.3299	1,434.04	321.35	286.81
69505	Remove mastoid structures		T	0256	38.1991	2,348.02		469.60
69511	Extensive mastoid surgery		T	0256	38.1991	2,348.02		469.60
69530	Extensive mastoid surgery		T	0256	38.1991	2,348.02		469.60
69540	Remove ear lesion		T	0253	16.4266	1,009.71	282.29	201.94
69550	Remove ear lesion		T	0256	38.1991	2,348.02		469.60
69552	Remove ear lesion		T	0256	38.1991	2,348.02		469.60
69601	Mastoid surgery revision		T	0256	38.1991	2,348.02		469.60
69602	Mastoid surgery revision		T	0256	38.1991	2,348.02		469.60
69603	Mastoid surgery revision		T	0256	38.1991	2,348.02		469.60
69604	Mastoid surgery revision		T	0256	38.1991	2,348.02		469.60
69605	Mastoid surgery revision		T	0256	38.1991	2,348.02		469.60
69610	Repair of eardrum		T	0254	23.3299	1,434.04	321.35	286.81
69620	Repair of eardrum		T	0254	23.3299	1,434.04	321.35	286.81
69631	Repair eardrum structures		T	0256	38.1991	2,348.02		469.60
69632	Rebuild eardrum structures		T	0256	38.1991	2,348.02		469.60
69633	Rebuild eardrum structures		T	0256	38.1991	2,348.02		469.60
69635	Repair eardrum structures		T	0256	38.1991	2,348.02		469.60
69636	Rebuild eardrum structures		T	0256	38.1991	2,348.02		469.60
69637	Rebuild eardrum structures		T	0256	38.1991	2,348.02		469.60
69641	Revise middle ear & mastoid		T	0256	38.1991	2,348.02		469.60
69642	Revise middle ear & mastoid		T	0256	38.1991	2,348.02		469.60
69643	Revise middle ear & mastoid		T	0256	38.1991	2,348.02		469.60
69644	Revise middle ear & mastoid		T	0256	38.1991	2,348.02		469.60
69645	Revise middle ear & mastoid		T	0256	38.1991	2,348.02		469.60
69646	Revise middle ear & mastoid		T	0256	38.1991	2,348.02		469.60
69650	Release middle ear bone		T	0254	23.3299	1,434.04	321.35	286.81
69660	Revise middle ear bone		T	0256	38.1991	2,348.02		469.60
69661	Revise middle ear bone		T	0256	38.1991	2,348.02		469.60
69662	Revise middle ear bone		T	0256	38.1991	2,348.02		469.60
69666	Repair middle ear structures		T	0256	38.1991	2,348.02		469.60
69667	Repair middle ear structures		T	0256	38.1991	2,348.02		469.60
69670	Remove mastoid air cells		T	0256	38.1991	2,348.02		469.60
69676	Remove middle ear nerve		T	0256	38.1991	2,348.02		469.60
69700	Close mastoid fistula		T	0256	38.1991	2,348.02		469.60
69711	Remove/repair hearing aid		T	0256	38.1991	2,348.02		469.60
69714	Implant temple bone w/stimul		T	0256	38.1991	2,348.02		469.60
69715	Temple bne implnt w/stimulat		T	0256	38.1991	2,348.02		469.60
69717	Temple bone implant revision		T	0256	38.1991	2,348.02		469.60
69718	Revise temple bone implant		T	0256	38.1991	2,348.02		469.60
69720	Release facial nerve		T	0256	38.1991	2,348.02		469.60
69725	Release facial nerve		T	0256	38.1991	2,348.02		469.60
69740	Repair facial nerve		T	0256	38.1991	2,348.02		469.60
69745	Repair facial nerve		T	0256	38.1991	2,348.02		469.60
69799	Middle ear surgery procedure		T	0251	2.452	150.72		30.14
69801	Incise inner ear		T	0256	38.1991	2,348.02		469.60
69802	Incise inner ear		T	0256	38.1991	2,348.02		469.60
69805	Explore inner ear		T	0256	38.1991	2,348.02		469.60
69806	Explore inner ear		T	0256	38.1991	2,348.02		469.60
69820	Establish inner ear window		T	0256	38.1991	2,348.02		469.60
69840	Revise inner ear window		T	0256	38.1991	2,348.02		469.60
69905	Remove inner ear		T	0256	38.1991	2,348.02		469.60
69910	Remove inner ear & mastoid		T	0256	38.1991	2,348.02		469.60
69915	Incise inner ear nerve		T	0256	38.1991	2,348.02		469.60
69930	Implant cochlear device		T	0259	414.8455	25,499.72	8,698.43	5,099.94
69949	Inner ear surgery procedure		T	0251	2.452	150.72		30.14
69955	Release facial nerve		T	0256	38.1991	2,348.02		469.60
69960	Release inner ear canal		T	0256	38.1991	2,348.02		469.60
69979	Temporal bone surgery		T	0251	2.452	150.72		30.14
69990	Microsurgery add-on		N					
70010	Contrast x-ray of brain		S	0274	2.5544	157.01	62.80	31.40
70015	Contrast x-ray of brain		S	0274	2.5544	157.01	62.80	31.40
70030	X-ray eye for foreign body		X	0260	0.7093	43.60		8.72
70100	X-ray exam of jaw		X	0260	0.7093	43.60		8.72
70110	X-ray exam of jaw		X	0260	0.7093	43.60		8.72
70120	X-ray exam of mastoids		X	0260	0.7093	43.60		8.72
70130	X-ray exam of mastoids		X	0260	0.7093	43.60		8.72
70134	X-ray exam of middle ear		X	0261	1.2224	75.14		15.03
70140	X-ray exam of facial bones		X	0260	0.7093	43.60		8.72

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
70150	X-ray exam of facial bones		X	0260	0.7093	43.60		8.72
70160	X-ray exam of nasal bones		X	0260	0.7093	43.60		8.72
70170	X-ray exam of tear duct		X	0264	2.9586	181.86	70.27	36.37
70190	X-ray exam of eye sockets		X	0260	0.7093	43.60		8.72
70200	X-ray exam of eye sockets		X	0260	0.7093	43.60		8.72
70210	X-ray exam of sinuses		X	0260	0.7093	43.60		8.72
70220	X-ray exam of sinuses		X	0260	0.7093	43.60		8.72
70240	X-ray exam, pituitary saddle		X	0260	0.7093	43.60		8.72
70250	X-ray exam of skull		X	0260	0.7093	43.60		8.72
70260	X-ray exam of skull		X	0261	1.2224	75.14		15.03
70300	X-ray exam of teeth		X	0262	0.655	40.26		8.05
70310	X-ray exam of teeth		X	0262	0.655	40.26		8.05
70320	Full mouth x-ray of teeth		X	0262	0.655	40.26		8.05
70328	X-ray exam of jaw joint		X	0260	0.7093	43.60		8.72
70330	X-ray exam of jaw joints		X	0260	0.7093	43.60		8.72
70332	X-ray exam of jaw joint		S	0275	3.6915	226.91	69.09	45.38
70336	Magnetic image, jaw joint		S	0335	4.5523	279.82	111.92	55.96
70350	X-ray head for orthodontia		X	0260	0.7093	43.60		8.72
70355	Panoramic x-ray of jaws		X	0260	0.7093	43.60		8.72
70360	X-ray exam of neck		X	0260	0.7093	43.60		8.72
70370	Throat x-ray & fluoroscopy		X	0272	1.2908	79.34	31.64	15.87
70371	Speech evaluation, complex		X	0272	1.2908	79.34	31.64	15.87
70373	Contrast x-ray of larynx		X	0263	1.6956	104.23	23.77	20.85
70380	X-ray exam of salivary gland		X	0260	0.7093	43.60		8.72
70390	X-ray exam of salivary duct		X	0263	1.6956	104.23	23.77	20.85
70450	Ct head/brain w/o dye		S	0332	3.0908	189.99	75.24	38.00
70460	Ct head/brain w/dye		S	0283	4.0825	250.94	100.37	50.19
70470	Ct head/brain w/o & w/dye		S	0333	4.8405	297.54	119.01	59.51
70480	Ct orbit/ear/fossa w/o dye		S	0332	3.0908	189.99	75.24	38.00
70481	Ct orbit/ear/fossa w/dye		S	0283	4.0825	250.94	100.37	50.19
70482	Ct orbit/ear/fossa w/o&w/dye		S	0333	4.8405	297.54	119.01	59.51
70486	Ct maxillofacial w/o dye		S	0332	3.0908	189.99	75.24	38.00
70487	Ct maxillofacial w/dye		S	0283	4.0825	250.94	100.37	50.19
70488	Ct maxillofacial w/o & w/dye		S	0333	4.8405	297.54	119.01	59.51
70490	Ct soft tissue neck w/o dye		S	0332	3.0908	189.99	75.24	38.00
70491	Ct soft tissue neck w/dye		S	0283	4.0825	250.94	100.37	50.19
70492	Ct sft tsue nck w/o & w/dye		S	0333	4.8405	297.54	119.01	59.51
70496	Ct angiography, head		S	0662	4.8552	298.44	118.88	59.69
70498	Ct angiography, neck		S	0662	4.8552	298.44	118.88	59.69
70540	Mri orbit/face/neck w/o dye		S	0336	5.6745	348.80	139.51	69.76
70542	Mri orbit/face/neck w/dye		S	0284	6.1231	376.37	148.40	75.27
70543	Mri orbt/fac/nck w/o & w/dye		S	0337	8.1155	498.84	199.53	99.77
70544	Mr angiography head w/o dye		S	0336	5.6745	348.80	139.51	69.76
70545	Mr angiography head w/dye		S	0284	6.1231	376.37	148.40	75.27
70546	Mr angiograph head w/o&w/dye		S	0337	8.1155	498.84	199.53	99.77
70547	Mr angiography neck w/o dye		S	0336	5.6745	348.80	139.51	69.76
70548	Mr angiography neck w/dye		S	0284	6.1231	376.37	148.40	75.27
70549	Mr angiograph neck w/o&w/dye		S	0337	8.1155	498.84	199.53	99.77
70551	Mri brain w/o dye		S	0336	5.6745	348.80	139.51	69.76
70552	Mri brain w/dye		S	0284	6.1231	376.37	148.40	75.27
70553	Mri brain w/o & w/dye		S	0337	8.1155	498.84	199.53	99.77
70554	Fmri brain by tech	NI	S	0336	5.6745	348.80	139.51	69.76
70555	Fmri brain by phys/psych	NI	S	0336	5.6745	348.80	139.51	69.76
70557	Mri brain w/o dye		S	0336	5.6745	348.80	139.51	69.76
70558	Mri brain w/dye		S	0284	6.1231	376.37	148.40	75.27
70559	Mri brain w/o & w/dye		S	0337	8.1155	498.84	199.53	99.77
71010	Chest x-ray		X	0260	0.7093	43.60		8.72
71015	Chest x-ray		X	0260	0.7093	43.60		8.72
71020	Chest x-ray		X	0260	0.7093	43.60		8.72
71021	Chest x-ray		X	0260	0.7093	43.60		8.72
71022	Chest x-ray		X	0260	0.7093	43.60		8.72
71023	Chest x-ray and fluoroscopy		X	0272	1.2908	79.34	31.64	15.87
71030	Chest x-ray		X	0260	0.7093	43.60		8.72
71034	Chest x-ray and fluoroscopy		X	0272	1.2908	79.34	31.64	15.87
71035	Chest x-ray		X	0260	0.7093	43.60		8.72
71040	Contrast x-ray of bronchi		X	0263	1.6956	104.23	23.77	20.85
71060	Contrast x-ray of bronchi		X	0263	1.6956	104.23	23.77	20.85
71090	X-ray & pacemaker insertion		X	0272	1.2908	79.34	31.64	15.87
71100	X-ray exam of ribs		X	0260	0.7093	43.60		8.72
71101	X-ray exam of ribs/chest		X	0260	0.7093	43.60		8.72

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
71110	X-ray exam of ribs		X	0260	0.7093	43.60		8.72
71111	X-ray exam of ribs/chest		X	0261	1.2224	75.14		15.03
71120	X-ray exam of breastbone		X	0260	0.7093	43.60		8.72
71130	X-ray exam of breastbone		X	0260	0.7093	43.60		8.72
71250	Ct thorax w/o dye		S	0332	3.0908	189.99	75.24	38.00
71260	Ct thorax w/dye		S	0283	4.0825	250.94	100.37	50.19
71270	Ct thorax w/o & w/dye		S	0333	4.8405	297.54	119.01	59.51
71275	Ct angiography, chest		S	0662	4.8552	298.44	118.88	59.69
71550	Mri chest w/o dye		S	0336	5.6745	348.80	139.51	69.76
71551	Mri chest w/dye		S	0284	6.1231	376.37	148.40	75.27
71552	Mri chest w/o & w/dye		S	0337	8.1155	498.84	199.53	99.77
72010	X-ray exam of spine		X	0260	0.7093	43.60		8.72
72020	X-ray exam of spine		X	0260	0.7093	43.60		8.72
72040	X-ray exam of neck spine		X	0260	0.7093	43.60		8.72
72050	X-ray exam of neck spine		X	0261	1.2224	75.14		15.03
72052	X-ray exam of neck spine		X	0261	1.2224	75.14		15.03
72069	X-ray exam of trunk spine		X	0260	0.7093	43.60		8.72
72070	X-ray exam of thoracic spine		X	0260	0.7093	43.60		8.72
72072	X-ray exam of thoracic spine		X	0260	0.7093	43.60		8.72
72074	X-ray exam of thoracic spine		X	0260	0.7093	43.60		8.72
72080	X-ray exam of trunk spine		X	0260	0.7093	43.60		8.72
72090	X-ray exam of trunk spine		X	0261	1.2224	75.14		15.03
72100	X-ray exam of lower spine		X	0260	0.7093	43.60		8.72
72110	X-ray exam of lower spine		X	0261	1.2224	75.14		15.03
72114	X-ray exam of lower spine		X	0261	1.2224	75.14		15.03
72120	X-ray exam of lower spine		X	0261	1.2224	75.14		15.03
72125	Ct neck spine w/o dye		S	0332	3.0908	189.99	75.24	38.00
72126	Ct neck spine w/dye		S	0283	4.0825	250.94	100.37	50.19
72127	Ct neck spine w/o & w/dye		S	0333	4.8405	297.54	119.01	59.51
72128	Ct chest spine w/o dye		S	0332	3.0908	189.99	75.24	38.00
72129	Ct chest spine w/dye		S	0283	4.0825	250.94	100.37	50.19
72130	Ct chest spine w/o & w/dye		S	0333	4.8405	297.54	119.01	59.51
72131	Ct lumbar spine w/o dye		S	0332	3.0908	189.99	75.24	38.00
72132	Ct lumbar spine w/dye		S	0283	4.0825	250.94	100.37	50.19
72133	Ct lumbar spine w/o & w/dye		S	0333	4.8405	297.54	119.01	59.51
72141	Mri neck spine w/o dye		S	0336	5.6745	348.80	139.51	69.76
72142	Mri neck spine w/dye		S	0284	6.1231	376.37	148.40	75.27
72146	Mri chest spine w/o dye		S	0336	5.6745	348.80	139.51	69.76
72147	Mri chest spine w/dye		S	0284	6.1231	376.37	148.40	75.27
72148	Mri lumbar spine w/o dye		S	0336	5.6745	348.80	139.51	69.76
72149	Mri lumbar spine w/dye		S	0284	6.1231	376.37	148.40	75.27
72156	Mri neck spine w/o & w/dye		S	0337	8.1155	498.84	199.53	99.77
72157	Mri chest spine w/o & w/dye		S	0337	8.1155	498.84	199.53	99.77
72158	Mri lumbar spine w/o & w/dye		S	0337	8.1155	498.84	199.53	99.77
72170	X-ray exam of pelvis		X	0260	0.7093	43.60		8.72
72190	X-ray exam of pelvis		X	0260	0.7093	43.60		8.72
72191	Ct angiograph pelv w/o&w/dye		S	0662	4.8552	298.44	118.88	59.69
72192	Ct pelvis w/o dye		S	0332	3.0908	189.99	75.24	38.00
72193	Ct pelvis w/dye		S	0283	4.0825	250.94	100.37	50.19
72194	Ct pelvis w/o & w/dye		S	0333	4.8405	297.54	119.01	59.51
72195	Mri pelvis w/o dye		S	0336	5.6745	348.80	139.51	69.76
72196	Mri pelvis w/dye		S	0284	6.1231	376.37	148.40	75.27
72197	Mri pelvis w/o & w/dye		S	0337	8.1155	498.84	199.53	99.77
72200	X-ray exam sacroiliac joints		X	0260	0.7093	43.60		8.72
72202	X-ray exam sacroiliac joints		X	0260	0.7093	43.60		8.72
72220	X-ray exam of tailbone		X	0260	0.7093	43.60		8.72
72240	Contrast x-ray of neck spine		S	0274	2.5544	157.01	62.80	31.40
72255	Contrast x-ray, thorax spine		S	0274	2.5544	157.01	62.80	31.40
72265	Contrast x-ray, lower spine		S	0274	2.5544	157.01	62.80	31.40
72270	Contrast x-ray, spine		S	0274	2.5544	157.01	62.80	31.40
72275	Epidurography		S	0274	2.5544	157.01	62.80	31.40
72285	X-ray c/t spine disk		S	0388	15.9758	982.00	289.72	196.40
72291	Perq vertebroplasty, fluor	NI	S	0274	2.5544	157.01	62.80	31.40
72292	Perq vertebroplasty, ct	NI	S	0274	2.5544	157.01	62.80	31.40
72295	X-ray of lower spine disk		S	0388	15.9758	982.00	289.72	196.40
73000	X-ray exam of collar bone		X	0260	0.7093	43.60		8.72
73010	X-ray exam of shoulder blade		X	0260	0.7093	43.60		8.72
73020	X-ray exam of shoulder		X	0260	0.7093	43.60		8.72
73030	X-ray exam of shoulder		X	0260	0.7093	43.60		8.72
73040	Contrast x-ray of shoulder		S	0275	3.6915	226.91	69.09	45.38

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
73050	X-ray exam of shoulders		X	0260	0.7093	43.60		8.72
73060	X-ray exam of humerus		X	0260	0.7093	43.60		8.72
73070	X-ray exam of elbow		X	0260	0.7093	43.60		8.72
73080	X-ray exam of elbow		X	0260	0.7093	43.60		8.72
73085	Contrast x-ray of elbow		S	0275	3.6915	226.91	69.09	45.38
73090	X-ray exam of forearm		X	0260	0.7093	43.60		8.72
73092	X-ray exam of arm, infant		X	0260	0.7093	43.60		8.72
73100	X-ray exam of wrist		X	0260	0.7093	43.60		8.72
73110	X-ray exam of wrist		X	0260	0.7093	43.60		8.72
73115	Contrast x-ray of wrist		S	0275	3.6915	226.91	69.09	45.38
73120	X-ray exam of hand		X	0260	0.7093	43.60		8.72
73130	X-ray exam of hand		X	0260	0.7093	43.60		8.72
73140	X-ray exam of finger(s)		X	0260	0.7093	43.60		8.72
73200	Ct upper extremity w/o dye		S	0332	3.0908	189.99	75.24	38.00
73201	Ct upper extremity w/dye		S	0283	4.0825	250.94	100.37	50.19
73202	Ct uppr extremity w/o&w/dye		S	0333	4.8405	297.54	119.01	59.51
73206	Ct angio upr extrm w/o&w/dye		S	0662	4.8552	298.44	118.88	59.69
73218	Mri upper extremity w/o dye		S	0336	5.6745	348.80	139.51	69.76
73219	Mri upper extremity w/dye		S	0284	6.1231	376.37	148.40	75.27
73220	Mri uppr extremity w/o&w/dye		S	0337	8.1155	498.84	199.53	99.77
73221	Mri joint upr extrem w/o dye		S	0336	5.6745	348.80	139.51	69.76
73222	Mri joint upr extrem w/dye		S	0284	6.1231	376.37	148.40	75.27
73223	Mri joint upr extr w/o&w/dye		S	0337	8.1155	498.84	199.53	99.77
73500	X-ray exam of hip		X	0260	0.7093	43.60		8.72
73510	X-ray exam of hip		X	0260	0.7093	43.60		8.72
73520	X-ray exam of hips		X	0261	1.2224	75.14		15.03
73525	Contrast x-ray of hip		S	0275	3.6915	226.91	69.09	45.38
73530	X-ray exam of hip		X	0261	1.2224	75.14		15.03
73540	X-ray exam of pelvis & hips		X	0260	0.7093	43.60		8.72
73542	X-ray exam, sacroiliac joint		S	0275	3.6915	226.91	69.09	45.38
73550	X-ray exam of thigh		X	0260	0.7093	43.60		8.72
73560	X-ray exam of knee, 1 or 2		X	0260	0.7093	43.60		8.72
73562	X-ray exam of knee, 3		X	0260	0.7093	43.60		8.72
73564	X-ray exam, knee, 4 or more		X	0260	0.7093	43.60		8.72
73565	X-ray exam of knees		X	0260	0.7093	43.60		8.72
73580	Contrast x-ray of knee joint		S	0275	3.6915	226.91	69.09	45.38
73590	X-ray exam of lower leg		X	0260	0.7093	43.60		8.72
73592	X-ray exam of leg, infant		X	0260	0.7093	43.60		8.72
73600	X-ray exam of ankle		X	0260	0.7093	43.60		8.72
73610	X-ray exam of ankle		X	0260	0.7093	43.60		8.72
73615	Contrast x-ray of ankle		S	0275	3.6915	226.91	69.09	45.38
73620	X-ray exam of foot		X	0260	0.7093	43.60		8.72
73630	X-ray exam of foot		X	0260	0.7093	43.60		8.72
73650	X-ray exam of heel		X	0260	0.7093	43.60		8.72
73660	X-ray exam of toe(s)		X	0260	0.7093	43.60		8.72
73700	Ct lower extremity w/o dye		S	0332	3.0908	189.99	75.24	38.00
73701	Ct lower extremity w/dye		S	0283	4.0825	250.94	100.37	50.19
73702	Ct lwr extremity w/o&w/dye		S	0333	4.8405	297.54	119.01	59.51
73706	Ct angio lwr extr w/o&w/dye		S	0662	4.8552	298.44	118.88	59.69
73718	Mri lower extremity w/o dye		S	0336	5.6745	348.80	139.51	69.76
73719	Mri lower extremity w/dye		S	0284	6.1231	376.37	148.40	75.27
73720	Mri lwr extremity w/o&w/dye		S	0337	8.1155	498.84	199.53	99.77
73721	Mri jnt of lwr extre w/o dye		S	0336	5.6745	348.80	139.51	69.76
73722	Mri joint of lwr extr w/dye		S	0284	6.1231	376.37	148.40	75.27
73723	Mri joint lwr extr w/o&w/dye		S	0337	8.1155	498.84	199.53	99.77
74000	X-ray exam of abdomen		X	0260	0.7093	43.60		8.72
74010	X-ray exam of abdomen		X	0260	0.7093	43.60		8.72
74020	X-ray exam of abdomen		X	0260	0.7093	43.60		8.72
74022	X-ray exam series, abdomen		X	0261	1.2224	75.14		15.03
74150	Ct abdomen w/o dye		S	0332	3.0908	189.99	75.24	38.00
74160	Ct abdomen w/dye		S	0283	4.0825	250.94	100.37	50.19
74170	Ct abdomen w/o & w/dye		S	0333	4.8405	297.54	119.01	59.51
74175	Ct angio abdom w/o & w/dye		S	0662	4.8552	298.44	118.88	59.69
74181	Mri abdomen w/o dye		S	0336	5.6745	348.80	139.51	69.76
74182	Mri abdomen w/dye		S	0284	6.1231	376.37	148.40	75.27
74183	Mri abdomen w/o & w/dye		S	0337	8.1155	498.84	199.53	99.77
74190	X-ray exam of peritoneum		X	0264	2.9586	181.86	70.27	36.37
74210	Contrst x-ray exam of throat		S	0276	1.4294	87.86	34.97	17.57
74220	Contrast x-ray, esophagus		S	0276	1.4294	87.86	34.97	17.57
74230	Cine/vid x-ray, throat/esoph		S	0276	1.4294	87.86	34.97	17.57

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
74235	Remove esophagus obstruction	CH	S	0257	1.0974	67.45		13.49
74240	X-ray exam, upper gi tract		S	0276	1.4294	87.86	34.97	17.57
74241	X-ray exam, upper gi tract		S	0276	1.4294	87.86	34.97	17.57
74245	X-ray exam, upper gi tract		S	0277	2.2176	136.31	54.52	27.26
74246	Contrst x-ray uppr gi tract		S	0276	1.4294	87.86	34.97	17.57
74247	Contrst x-ray uppr gi tract		S	0276	1.4294	87.86	34.97	17.57
74249	Contrst x-ray uppr gi tract		S	0277	2.2176	136.31	54.52	27.26
74250	X-ray exam of small bowel		S	0276	1.4294	87.86	34.97	17.57
74251	X-ray exam of small bowel		S	0277	2.2176	136.31	54.52	27.26
74260	X-ray exam of small bowel	CH	S	0276	1.4294	87.86	34.97	17.57
74270	Contrast x-ray exam of colon		S	0276	1.4294	87.86	34.97	17.57
74280	Contrast x-ray exam of colon		S	0277	2.2176	136.31	54.52	27.26
74283	Contrast x-ray exam of colon		S	0276	1.4294	87.86	34.97	17.57
74290	Contrast x-ray, gallbladder		S	0276	1.4294	87.86	34.97	17.57
74291	Contrast x-rays, gallbladder		S	0276	1.4294	87.86	34.97	17.57
74300	X-ray bile ducts/pancreas		X	0263	1.6956	104.23	23.77	20.85
74301	X-rays at surgery add-on		X	0263	1.6956	104.23	23.77	20.85
74305	X-ray bile ducts/pancreas		X	0263	1.6956	104.23	23.77	20.85
74320	Contrast x-ray of bile ducts		X	0264	2.9586	181.86	70.27	36.37
74327	X-ray bile stone removal		S	0296	2.6802	164.75	53.99	32.95
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		X	0272	1.2908	79.34	31.64	15.87
74350	X-ray guide, stomach tube		X	0263	1.6956	104.23	23.77	20.85
74355	X-ray guide, intestinal tube		X	0263	1.6956	104.23	23.77	20.85
74360	X-ray guide, GI dilation	CH	S	0257	1.0974	67.45		13.49
74363	X-ray, bile duct dilation		S	0297	3.6392	223.69	89.47	44.74
74400	Contrst x-ray, urinary tract		S	0278	2.4159	148.50	59.40	29.70
74410	Contrst x-ray, urinary tract		S	0278	2.4159	148.50	59.40	29.70
74415	Contrst x-ray, urinary tract		S	0278	2.4159	148.50	59.40	29.70
74420	Contrst x-ray, urinary tract		S	0278	2.4159	148.50	59.40	29.70
74425	Contrst x-ray, urinary tract		S	0278	2.4159	148.50	59.40	29.70
74430	Contrast x-ray, bladder		S	0278	2.4159	148.50	59.40	29.70
74440	X-ray, male genital tract		S	0278	2.4159	148.50	59.40	29.70
74445	X-ray exam of penis		S	0278	2.4159	148.50	59.40	29.70
74450	X-ray, urethra/bladder		S	0278	2.4159	148.50	59.40	29.70
74455	X-ray, urethra/bladder		S	0278	2.4159	148.50	59.40	29.70
74470	X-ray exam of kidney lesion		X	0263	1.6956	104.23	23.77	20.85
74475	X-ray control, cath insert		S	0297	3.6392	223.69	89.47	44.74
74480	X-ray control, cath insert		S	0296	2.6802	164.75	53.99	32.95
74485	X-ray guide, GU dilation		S	0296	2.6802	164.75	53.99	32.95
74710	X-ray measurement of pelvis		X	0261	1.2224	75.14		15.03
74740	X-ray, female genital tract		X	0264	2.9586	181.86	70.27	36.37
74742	X-ray, fallopian tube		X	0264	2.9586	181.86	70.27	36.37
74775	X-ray exam of perineum		S	0278	2.4159	148.50	59.40	29.70
75552	Heart mri for morph w/o dye		S	0336	5.6745	348.80	139.51	69.76
75553	Heart mri for morph w/dye		S	0284	6.1231	376.37	148.40	75.27
75554	Cardiac MRI/function		S	0336	5.6745	348.80	139.51	69.76
75555	Cardiac MRI/limited study		S	0336	5.6745	348.80	139.51	69.76
75600	Contrast x-ray exam of aorta		S	0280	20.8225	1,279.92	353.85	255.98
75605	Contrast x-ray exam of aorta		S	0280	20.8225	1,279.92	353.85	255.98
75625	Contrast x-ray exam of aorta		S	0280	20.8225	1,279.92	353.85	255.98
75630	X-ray aorta, leg arteries		S	0280	20.8225	1,279.92	353.85	255.98
75635	Ct angio abdominal arteries		S	0662	4.8552	298.44	118.88	59.69
75650	Artery x-rays, head & neck		S	0280	20.8225	1,279.92	353.85	255.98
75658	Artery x-rays, arm		S	0279	9.5061	584.32	150.03	116.86
75660	Artery x-rays, head & neck		S	0668	6.2463	383.95	88.26	76.79
75662	Artery x-rays, head & neck		S	0280	20.8225	1,279.92	353.85	255.98
75665	Artery x-rays, head & neck		S	0280	20.8225	1,279.92	353.85	255.98
75671	Artery x-rays, head & neck		S	0280	20.8225	1,279.92	353.85	255.98
75676	Artery x-rays, neck		S	0280	20.8225	1,279.92	353.85	255.98
75680	Artery x-rays, neck		S	0280	20.8225	1,279.92	353.85	255.98
75685	Artery x-rays, spine		S	0280	20.8225	1,279.92	353.85	255.98
75705	Artery x-rays, spine		S	0668	6.2463	383.95	88.26	76.79
75710	Artery x-rays, arm/leg		S	0280	20.8225	1,279.92	353.85	255.98
75716	Artery x-rays, arms/legs		S	0280	20.8225	1,279.92	353.85	255.98
75722	Artery x-rays, kidney		S	0280	20.8225	1,279.92	353.85	255.98
75724	Artery x-rays, kidneys		S	0280	20.8225	1,279.92	353.85	255.98
75726	Artery x-rays, abdomen		S	0280	20.8225	1,279.92	353.85	255.98

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75731	Artery x-rays, adrenal gland		S	0280	20.8225	1,279.92	353.85	255.98
75733	Artery x-rays, adrenals		S	0668	6.2463	383.95	88.26	76.79
75736	Artery x-rays, pelvis		S	0280	20.8225	1,279.92	353.85	255.98
75741	Artery x-rays, lung		S	0279	9.5061	584.32	150.03	116.86
75743	Artery x-rays, lungs		S	0280	20.8225	1,279.92	353.85	255.98
75746	Artery x-rays, lung		S	0279	9.5061	584.32	150.03	116.86
75756	Artery x-rays, chest		S	0279	9.5061	584.32	150.03	116.86
75774	Artery x-ray, each vessel		S	0279	9.5061	584.32	150.03	116.86
75790	Visualize A–V shunt		S	0279	9.5061	584.32	150.03	116.86
75801	Lymph vessel x-ray, arm/leg		X	0264	2.9586	181.86	70.27	36.37
75803	Lymph vessel x-ray,arms/legs		X	0264	2.9586	181.86	70.27	36.37
75805	Lymph vessel x-ray, trunk		X	0264	2.9586	181.86	70.27	36.37
75807	Lymph vessel x-ray, trunk		X	0264	2.9586	181.86	70.27	36.37
75809	Nonvascular shunt, x-ray		X	0263	1.6956	104.23	23.77	20.85
75810	Vein x-ray, spleen/liver		S	0279	9.5061	584.32	150.03	116.86
75820	Vein x-ray, arm/leg		S	0668	6.2463	383.95	88.26	76.79
75822	Vein x-ray, arms/legs		S	0668	6.2463	383.95	88.26	76.79
75825	Vein x-ray, trunk		S	0279	9.5061	584.32	150.03	116.86
75827	Vein x-ray, chest		S	0279	9.5061	584.32	150.03	116.86
75831	Vein x-ray, kidney		S	0279	9.5061	584.32	150.03	116.86
75833	Vein x-ray, kidneys		S	0279	9.5061	584.32	150.03	116.86
75840	Vein x-ray, adrenal gland		S	0280	20.8225	1,279.92	353.85	255.98
75842	Vein x-ray, adrenal glands		S	0280	20.8225	1,279.92	353.85	255.98
75860	Vein x-ray, neck		S	0668	6.2463	383.95	88.26	76.79
75870	Vein x-ray, skull		S	0668	6.2463	383.95	88.26	76.79
75872	Vein x-ray, skull		S	0279	9.5061	584.32	150.03	116.86
75880	Vein x-ray, eye socket		S	0668	6.2463	383.95	88.26	76.79
75885	Vein x-ray, liver		S	0280	20.8225	1,279.92	353.85	255.98
75887	Vein x-ray, liver		S	0279	9.5061	584.32	150.03	116.86
75889	Vein x-ray, liver		S	0280	20.8225	1,279.92	353.85	255.98
75891	Vein x-ray, liver		S	0279	9.5061	584.32	150.03	116.86
75893	Venous sampling by catheter	CH	Q	0668	6.2463	383.95	88.26	76.79
75894	X-rays, transcath therapy	CH	S	0298	8.3906	515.75	206.30	103.15
75896	X-rays, transcath therapy	CH	S	0298	8.3906	515.75	206.30	103.15
75898	Follow-up angiography		X	0263	1.6956	104.23	23.77	20.85
75901	Remove cva device obstruct		X	0263	1.6956	104.23	23.77	20.85
75902	Remove cva lumen obstruct		X	0263	1.6956	104.23	23.77	20.85
75940	X-ray placement, vein filter	CH	S	0298	8.3906	515.75	206.30	103.15
75945	Intravascular us		S	0267	2.4606	151.25	60.50	30.25
75946	Intravascular us add-on		S	0266	1.5607	95.93	37.80	19.19
75960	Transcath iv stent rs&i		S	0668	6.2463	383.95	88.26	76.79
75961	Retrieval, broken catheter		S	0668	6.2463	383.95	88.26	76.79
75962	Repair arterial blockage		S	0668	6.2463	383.95	88.26	76.79
75964	Repair artery blockage, each		S	0668	6.2463	383.95	88.26	76.79
75966	Repair arterial blockage		S	0668	6.2463	383.95	88.26	76.79
75968	Repair artery blockage, each		S	0668	6.2463	383.95	88.26	76.79
75970	Vascular biopsy		S	0668	6.2463	383.95	88.26	76.79
75978	Repair venous blockage		S	0668	6.2463	383.95	88.26	76.79
75980	Contrast xray exam bile duct		S	0297	3.6392	223.69	89.47	44.74
75982	Contrast xray exam bile duct		S	0297	3.6392	223.69	89.47	44.74
75984	Xray control catheter change		X	0263	1.6956	104.23	23.77	20.85
75989	Abscess drainage under x-ray		N					
75992	Atherectomy, x-ray exam	CH	S	0668	6.2463	383.95	88.26	76.79
75993	Atherectomy, x-ray exam	CH	S	0668	6.2463	383.95	88.26	76.79
75994	Atherectomy, x-ray exam	CH	S	0668	6.2463	383.95	88.26	76.79
75995	Atherectomy, x-ray exam	CH	S	0668	6.2463	383.95	88.26	76.79
75996	Atherectomy, x-ray exam	CH	S	0668	6.2463	383.95	88.26	76.79
75998	Fluoroguide for vein device	CH	D					
76000	Fluoroscope examination		X	0272	1.2908	79.34	31.64	15.87
76001	Fluoroscope exam, extensive		N					
76003	Needle localization by x-ray	CH	D					
76005	Fluoroguide for spine inject	CH	D					
76006	X-ray stress view	CH	D					
76010	X-ray, nose to rectum		X	0260	0.7093	43.60		8.72
76012	Percut vertebroplasty fluor	CH	D					
76013	Percut vertebroplasty, ct	CH	D					
76020	X-rays for bone age	CH	D					
76040	X-rays, bone evaluation	CH	D					
76061	X-rays, bone survey	CH	D					
76062	X-rays, bone survey	CH	D					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76065	X-rays, bone evaluation	CH	D					
76066	Joint survey, single view	CH	D					
76070	Ct bone density, axial	CH	D					
76071	Ct bone density, peripheral	CH	D					
76075	Dxa bone density, axial	CH	D					
76076	Dxa bone density/peripheral	CH	D					
76077	Dxa bone density/v-fracture	CH	D					
76078	Radiographic absorptiometry	CH	D					
76080	X-ray exam of fistula		X	0263	1.6956	104.23	23.77	20.85
76082	Computer mammogram add-on	CH	D					
76083	Computer mammogram add-on	CH	D					
76086	X-ray of mammary duct	CH	D					
76088	X-ray of mammary ducts	CH	D					
76090	Mammogram, one breast	CH	D					
76091	Mammogram, both breasts	CH	D					
76092	Mammogram, screening	CH	D					
76093	Magnetic image, breast	CH	D					
76094	Magnetic image, both breasts	CH	D					
76095	Stereotactic breast biopsy	CH	D					
76096	X-ray of needle wire, breast	CH	D					
76098	X-ray exam, breast specimen		X	0260	0.7093	43.60		8.72
76100	X-ray exam of body section		X	0261	1.2224	75.14		15.03
76101	Complex body section x-ray		X	0263	1.6956	104.23	23.77	20.85
76102	Complex body section x-rays		X	0264	2.9586	181.86	70.27	36.37
76120	Cine/video x-rays		X	0272	1.2908	79.34	31.64	15.87
76125	Cine/video x-rays add-on		X	0260	0.7093	43.60		8.72
76150	X-ray exam, dry process		X	0260	0.7093	43.60		8.72
76350	Special x-ray contrast study		N					
76355	Ct scan for localization	CH	D					
76360	Ct scan for needle biopsy	CH	D					
76362	Ct guide for tissue ablation	CH	D					
76370	Ct scan for therapy guide	CH	D					
76376	3d render w/o postprocess		X	0340	0.6102	37.51		7.50
76377	3d rendering w/postprocess		S	0282	1.5379	94.53	37.81	18.91
76380	CAT scan follow-up study		S	0282	1.5379	94.53	37.81	18.91
76393	Mr guidance for needle place	CH	D					
76394	Mri for tissue ablation	CH	D					
76400	Magnetic image, bone marrow	CH	D					
76496	Fluoroscopic procedure		X	0272	1.2908	79.34	31.64	15.87
76497	Ct procedure		S	0282	1.5379	94.53	37.81	18.91
76498	Mri procedure		S	0335	4.5523	279.82	111.92	55.96
76499	Radiographic procedure		X	0260	0.7093	43.60		8.72
76506	Echo exam of head		S	0265	0.9923	60.99	23.63	12.20
76510	Ophth us, b & quant a		S	0266	1.5607	95.93	37.80	19.19
76511	Ophth us, quant a only		S	0266	1.5607	95.93	37.80	19.19
76512	Ophth us, b w/non-quant a		S	0266	1.5607	95.93	37.80	19.19
76513	Echo exam of eye, water bath		S	0266	1.5607	95.93	37.80	19.19
76514	Echo exam of eye, thickness		X	0340	0.6102	37.51		7.50
76516	Echo exam of eye		S	0265	0.9923	60.99	23.63	12.20
76519	Echo exam of eye		S	0266	1.5607	95.93	37.80	19.19
76529	Echo exam of eye		S	0265	0.9923	60.99	23.63	12.20
76536	Us exam of head and neck		S	0266	1.5607	95.93	37.80	19.19
76604	Us exam, chest	CH	S	0265	0.9923	60.99	23.63	12.20
76645	Us exam, breast(s)		S	0265	0.9923	60.99	23.63	12.20
76700	Us exam, abdom, complete		S	0266	1.5607	95.93	37.80	19.19
76705	Echo exam of abdomen		S	0266	1.5607	95.93	37.80	19.19
76770	Us exam abdo back wall, comp		S	0266	1.5607	95.93	37.80	19.19
76775	Us exam abdo back wall, lim		S	0266	1.5607	95.93	37.80	19.19
76776	Us exam k transpl w/doppler	NI	S	0266	1.5607	95.93	37.80	19.19
76778	Us exam kidney transplant	CH	D					
76800	Us exam, spinal canal		S	0266	1.5607	95.93	37.80	19.19
76801	Ob us < 14 wks, single fetus		S	0266	1.5607	95.93	37.80	19.19
76802	Ob us < 14 wks, addÆl fetus		S	0265	0.9923	60.99	23.63	12.20
76805	Ob us ≧ 14 wks, sngl fetus		S	0266	1.5607	95.93	37.80	19.19
76810	Ob us ≧ 14 wks, addl fetus		S	0266	1.5607	95.93	37.80	19.19
76811	Ob us, detailed, sngl fetus		S	0267	2.4606	151.25	60.50	30.25
76812	Ob us, detailed, addl fetus	CH	S	0265	0.9923	60.99	23.63	12.20
76813	Ob us nuchal meas, 1 gest	NI	S	0266	1.5607	95.93	37.80	19.19
76814	Ob us nuchal meas, add-on	NI	S	0265	0.9923	60.99	23.63	12.20
76815	Ob us, limited, fetus(s)		S	0265	0.9923	60.99	23.63	12.20

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76816	Ob us, follow-up, per fetus		S	0265	0.9923	60.99	23.63	12.20
76817	Transvaginal us, obstetric	CH	S	0265	0.9923	60.99	23.63	12.20
76818	Fetal biophys profile w/nst		S	0266	1.5607	95.93	37.80	19.19
76819	Fetal biophys profil w/o nst		S	0266	1.5607	95.93	37.80	19.19
76820	Umbilical artery echo		S	0096	1.5303	94.06	37.62	18.81
76821	Middle cerebral artery echo		S	0096	1.5303	94.06	37.62	18.81
76825	Echo exam of fetal heart	CH	S	0697	1.5973	98.18	35.99	19.64
76826	Echo exam of fetal heart		S	0697	1.5973	98.18	35.99	19.64
76827	Echo exam of fetal heart	CH	S	0697	1.5973	98.18	35.99	19.64
76828	Echo exam of fetal heart		S	0697	1.5973	98.18	35.99	19.64
76830	Transvaginal us, non-ob		S	0266	1.5607	95.93	37.80	19.19
76831	Echo exam, uterus		S	0267	2.4606	151.25	60.50	30.25
76856	Us exam, pelvic, complete		S	0266	1.5607	95.93	37.80	19.19
76857	Us exam, pelvic, limited		S	0265	0.9923	60.99	23.63	12.20
76870	Us exam, scrotum		S	0266	1.5607	95.93	37.80	19.19
76872	Us, transrectal		S	0266	1.5607	95.93	37.80	19.19
76873	Echograp trans r, pros study		S	0266	1.5607	95.93	37.80	19.19
76880	Us exam, extremity		S	0266	1.5607	95.93	37.80	19.19
76885	Us exam infant hips, dynamic		S	0265	0.9923	60.99	23.63	12.20
76886	Us exam infant hips, static	CH	S	0265	0.9923	60.99	23.63	12.20
76930	Echo guide, cardiocentesis		S	0268	1.1882	73.04		14.61
76932	Echo guide for heart biopsy	CH	S	0309	2.1012	129.16		25.83
76936	Echo guide for artery repair	CH	S	0309	2.1012	129.16		25.83
76937	Us guide, vascular access		N					
76940	Us guide, tissue ablation		S	0268	1.1882	73.04		14.61
76941	Echo guide for transfusion		S	0268	1.1882	73.04		14.61
76942	Echo guide for biopsy		S	0268	1.1882	73.04		14.61
76945	Echo guide, villus sampling		S	0268	1.1882	73.04		14.61
76946	Echo guide for amniocentesis		S	0268	1.1882	73.04		14.61
76948	Echo guide, ova aspiration	CH	S	0309	2.1012	129.16		25.83
76950	Echo guidance radiotherapy		S	0268	1.1882	73.04		14.61
76965	Echo guidance radiotherapy	CH	S	0309	2.1012	129.16		25.83
76970	Ultrasound exam follow-up		S	0265	0.9923	60.99	23.63	12.20
76975	GI endoscopic ultrasound		S	0266	1.5607	95.93	37.80	19.19
76977	Us bone density measure		X	0340	0.6102	37.51		7.50
76986	Ultrasound guide intraoper	CH	D					
76998	Us guide, intraop	NI	S	0266	1.5607	95.93	37.80	19.19
76999	Echo examination procedure		S	0265	0.9923	60.99	23.63	12.20
77001	Fluoroguide for vein device	NI	N					
77002	Needle localization by xray	NI	N					
77003	Fluoroguide for spine inject	NI	N					
77011	Ct scan for localization	NI	S	0283	4.0825	250.94	100.37	50.19
77012	Ct scan for needle biopsy	NI	S	0283	4.0825	250.94	100.37	50.19
77013	Ct guide for tissue ablation	NI	S	0333	4.8405	297.54	119.01	59.51
77014	Ct scan for therapy guide	NI	S	0282	1.5379	94.53	37.81	18.91
77021	Mr guidance for needle place	NI	S	0335	4.5523	279.82	111.92	55.96
77022	Mri for tissue ablation	NI	S	0335	4.5523	279.82	111.92	55.96
77031	Stereotact guide for brst bx	NI	X	0264	2.9586	181.86	70.27	36.37
77032	Guidance for needle, breast	NI	X	0263	1.6956	104.23	23.77	20.85
77051	Computer dx mammogram add-on	NI	A					
77052	Comp screen mammogram add-on	NI	A					
77053	X-ray of mammary duct	NI	X	0263	1.6956	104.23	23.77	20.85
77054	X-ray of mammary ducts	NI	X	0263	1.6956	104.23	23.77	20.85
77055	Mammogram, one breast	NI	A					
77056	Mammogram, both breasts	NI	A					
77057	Mammogram, screening	NI	A					
77058	Mri, one breast	NI	B					
77059	Mri, both breasts	NI	B					
77071	X-ray stress view	NI	X	0260	0.7093	43.60		8.72
77072	X-rays for bone age	NI	X	0260	0.7093	43.60		8.72
77073	X-rays, bone length studies	NI	X	0260	0.7093	43.60		8.72
77074	X-rays, bone survey, limited	NI	X	0261	1.2224	75.14		15.03
77075	X-rays, bone survey complete	NI	X	0261	1.2224	75.14		15.03
77076	X-rays, bone survey, infant	NI	X	0260	0.7093	43.60		8.72
77077	Joint survey, single view	NI	X	0260	0.7093	43.60		8.72
77078	Ct bone density, axial	NI	S	0288	1.1755	72.26	28.90	14.45
77079	Ct bone density, peripheral	NI	S	0282	1.5379	94.53	37.81	18.91
77080	Dxa bone density, axial	NI	S	0288	1.1755	72.26	28.90	14.45
77081	Dxa bone density/peripheral	NI	S	0665	0.5497	33.79	13.51	6.76
77082	Dxa bone density, vert fx	NI	X	0260	0.7093	43.60		8.72

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77083	Radiographic absorptiometry	NI	X	0261	1.2224	75.14		15.03
77084	Magnetic image, bone marrow	NI	S	0335	4.5523	279.82	111.92	55.96
77280	Sbrt management		X	0304	1.5735	96.72	38.68	19.34
77285	Set radiation therapy field		X	0305	3.9723	244.17	91.38	48.83
77290	Set radiation therapy field		X	0305	3.9723	244.17	91.38	48.83
77295	Set radiation therapy field		X	0310	13.8081	848.76	325.27	169.75
77299	Radiation therapy planning		X	0304	1.5735	96.72	38.68	19.34
77300	Radiation therapy dose plan		X	0304	1.5735	96.72	38.68	19.34
77301	Radiotherapy dose plan, imrt		X	0310	13.8081	848.76	325.27	169.75
77305	Teletx isodose plan simple		X	0304	1.5735	96.72	38.68	19.34
77310	Teletx isodose plan intermed		X	0305	3.9723	244.17	91.38	48.83
77315	Teletx isodose plan complex		X	0305	3.9723	244.17	91.38	48.83
77321	Special teletx port plan		X	0305	3.9723	244.17	91.38	48.83
77326	Brachytx isodose calc simp		X	0304	1.5735	96.72	38.68	19.34
77327	Brachytx isodose calc interm		X	0305	3.9723	244.17	91.38	48.83
77328	Brachytx isodose plan compl		X	0305	3.9723	244.17	91.38	48.83
77331	Special radiation dosimetry		X	0304	1.5735	96.72	38.68	19.34
77332	Radiation treatment aid(s)		X	0303	2.943	180.90	66.95	36.18
77333	Radiation treatment aid(s)		X	0303	2.943	180.90	66.95	36.18
77334	Radiation treatment aid(s)		X	0303	2.943	180.90	66.95	36.18
77336	Radiation physics consult		X	0304	1.5735	96.72	38.68	19.34
77370	Radiation physics consult		X	0304	1.5735	96.72	38.68	19.34
77371	Srs, multisource	NI	S	0127	138.4486	8,510.16		1,702.03
77372	Srs, linear based	NI	B					
77373	Sbrt delivery	NI	B					
77399	External radiation dosimetry		X	0304	1.5735	96.72	38.68	19.34
77401	Radiation treatment delivery		S	0300	1.4826	91.13		18.23
77402	Radiation treatment delivery		S	0300	1.4826	91.13		18.23
77403	Radiation treatment delivery		S	0300	1.4826	91.13		18.23
77404	Radiation treatment delivery		S	0300	1.4826	91.13		18.23
77406	Radiation treatment delivery		S	0300	1.4826	91.13		18.23
77407	Radiation treatment delivery		S	0300	1.4826	91.13		18.23
77408	Radiation treatment delivery		S	0300	1.4826	91.13		18.23
77409	Radiation treatment delivery		S	0300	1.4826	91.13		18.23
77411	Radiation treatment delivery		S	0301	2.2295	137.04		27.41
77412	Radiation treatment delivery		S	0301	2.2295	137.04		27.41
77413	Radiation treatment delivery		S	0301	2.2295	137.04		27.41
77414	Radiation treatment delivery		S	0301	2.2295	137.04		27.41
77416	Radiation treatment delivery		S	0301	2.2295	137.04		27.41
77417	Radiology port film(s)		X	0260	0.7093	43.60		8.72
77418	Radiation tx delivery, imrt		S	0412	5.4731	336.42		67.28
77421	Stereoscopic x-ray guidance	CH	S	0257	1.0974	67.45		13.49
77422	Neutron beam tx, simple		S	0301	2.2295	137.04		27.41
77423	Neutron beam tx, complex		S	0301	2.2295	137.04		27.41
77435	Sbrt management	NI	N					
77470	Special radiation treatment		S	0299	5.8839	361.67		72.33
77520	Proton trmt, simple w/o comp		S	0664	18.8926	1,161.29		232.26
77522	Proton trmt, simple w/comp		S	0664	18.8926	1,161.29		232.26
77523	Proton trmt, intermediate		S	0667	22.6031	1,389.37		277.87
77525	Proton treatment, complex		S	0667	22.6031	1,389.37		277.87
77600	Hyperthermia treatment		S	0314	3.3461	205.68	60.88	41.14
77605	Hyperthermia treatment		S	0314	3.3461	205.68	60.88	41.14
77610	Hyperthermia treatment		S	0314	3.3461	205.68	60.88	41.14
77615	Hyperthermia treatment		S	0314	3.3461	205.68	60.88	41.14
77620	Hyperthermia treatment		S	0314	3.3461	205.68	60.88	41.14
77750	Infuse radioactive materials		S	0301	2.2295	137.04		27.41
77761	Apply intrcav radiat simple		S	0312	4.8569	298.54		59.71
77762	Apply intrcav radiat interm		S	0312	4.8569	298.54		59.71
77763	Apply intrcav radiat compl		S	0312	4.8569	298.54		59.71
77776	Apply interstit radiat simpl		S	0312	4.8569	298.54		59.71
77777	Apply interstit radiat inter		S	0312	4.8569	298.54		59.71
77778	Apply interstit radiat compl		S	0651	16.8462	1,035.50		207.10
77781	High intensity brachytherapy		S	0313	12.8473	789.70		157.94
77782	High intensity brachytherapy		S	0313	12.8473	789.70		157.94
77783	High intensity brachytherapy		S	0313	12.8473	789.70		157.94
77784	High intensity brachytherapy		S	0313	12.8473	789.70		157.94
77789	Apply surface radiation		S	0300	1.4826	91.13		18.23
77790	Radiation handling		N					
77799	Radium/radioisotope therapy	CH	S	0312	4.8569	298.54		59.71
78000	Thyroid, single uptake		S	0389	1.3754	84.54	33.81	16.91

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78001	Thyroid, multiple uptakes		S	0389	1.3754	84.54	33.81	16.91
78003	Thyroid suppress/stimul		S	0392	2.0057	123.29	49.31	24.66
78006	Thyroid imaging with uptake		S	0390	2.3432	144.03	57.61	28.81
78007	Thyroid image, mult uptakes		S	0391	2.7146	166.86	66.18	33.37
78010	Thyroid imaging		S	0390	2.3432	144.03	57.61	28.81
78011	Thyroid imaging with flow		S	0390	2.3432	144.03	57.61	28.81
78015	Thyroid met imaging		S	0406	3.9934	245.47	98.18	49.09
78016	Thyroid met imaging/studies		S	0406	3.9934	245.47	98.18	49.09
78018	Thyroid met imaging, body		S	0406	3.9934	245.47	98.18	49.09
78020	Thyroid met uptake		S	0399	1.5054	92.53	35.80	18.51
78070	Parathyroid nuclear imaging		S	0391	2.7146	166.86	66.18	33.37
78075	Adrenal nuclear imaging		S	0391	2.7146	166.86	66.18	33.37
78099	Endocrine nuclear procedure		S	0390	2.3432	144.03	57.61	28.81
78102	Bone marrow imaging, ltd		S	0400	3.9073	240.17	93.22	48.03
78103	Bone marrow imaging, mult		S	0400	3.9073	240.17	93.22	48.03
78104	Bone marrow imaging, body		S	0400	3.9073	240.17	93.22	48.03
78110	Plasma volume, single		S	0393	3.7562	230.89	82.04	46.18
78111	Plasma volume, multiple		S	0393	3.7562	230.89	82.04	46.18
78120	Red cell mass, single		S	0393	3.7562	230.89	82.04	46.18
78121	Red cell mass, multiple		S	0393	3.7562	230.89	82.04	46.18
78122	Blood volume		S	0393	3.7562	230.89	82.04	46.18
78130	Red cell survival study		S	0393	3.7562	230.89	82.04	46.18
78135	Red cell survival kinetics		S	0393	3.7562	230.89	82.04	46.18
78140	Red cell sequestration		S	0393	3.7562	230.89	82.04	46.18
78185	Spleen imaging		S	0400	3.9073	240.17	93.22	48.03
78190	Platelet survival, kinetics		S	0392	2.0057	123.29	49.31	24.66
78191	Platelet survival		S	0392	2.0057	123.29	49.31	24.66
78195	Lymph system imaging		S	0400	3.9073	240.17	93.22	48.03
78199	Blood/lymph nuclear exam		S	0400	3.9073	240.17	93.22	48.03
78201	Liver imaging		S	0394	4.3774	269.07	102.61	53.81
78202	Liver imaging with flow		S	0394	4.3774	269.07	102.61	53.81
78205	Liver imaging (3D)		S	0394	4.3774	269.07	102.61	53.81
78206	Liver image (3d) with flow		S	0394	4.3774	269.07	102.61	53.81
78215	Liver and spleen imaging		S	0394	4.3774	269.07	102.61	53.81
78216	Liver & spleen image/flow		S	0394	4.3774	269.07	102.61	53.81
78220	Liver function study		S	0394	4.3774	269.07	102.61	53.81
78223	Hepatobiliary imaging		S	0394	4.3774	269.07	102.61	53.81
78230	Salivary gland imaging		S	0395	3.6526	224.52	89.73	44.90
78231	Serial salivary imaging		S	0395	3.6526	224.52	89.73	44.90
78232	Salivary gland function exam		S	0395	3.6526	224.52	89.73	44.90
78258	Esophageal motility study		S	0395	3.6526	224.52	89.73	44.90
78261	Gastric mucosa imaging		S	0395	3.6526	224.52	89.73	44.90
78262	Gastroesophageal reflux exam		S	0395	3.6526	224.52	89.73	44.90
78264	Gastric emptying study		S	0395	3.6526	224.52	89.73	44.90
78270	Vit B-12 absorption exam		S	0392	2.0057	123.29	49.31	24.66
78271	Vit b-12 absrp exam, int fac		S	0392	2.0057	123.29	49.31	24.66
78272	Vit B-12 absorp, combined		S	0392	2.0057	123.29	49.31	24.66
78278	Acute GI blood loss imaging		S	0395	3.6526	224.52	89.73	44.90
78282	GI protein loss exam		S	0395	3.6526	224.52	89.73	44.90
78290	MeckelÆs divert exam		S	0395	3.6526	224.52	89.73	44.90
78291	Leveen/shunt patency exam		S	0395	3.6526	224.52	89.73	44.90
78299	GI nuclear procedure		S	0395	3.6526	224.52	89.73	44.90
78300	Bone imaging, limited area		S	0396	3.9174	240.79	95.02	48.16
78305	Bone imaging, multiple areas		S	0396	3.9174	240.79	95.02	48.16
78306	Bone imaging, whole body		S	0396	3.9174	240.79	95.02	48.16
78315	Bone imaging, 3 phase		S	0396	3.9174	240.79	95.02	48.16
78320	Bone imaging (3D)		S	0396	3.9174	240.79	95.02	48.16
78350	Bone mineral, single photon		X	0260	0.7093	43.60		8.72
78399	Musculoskeletal nuclear exam		S	0396	3.9174	240.79	95.02	48.16
78414	Non-imaging heart function		S	0398	4.1265	253.65	100.06	50.73
78428	Cardiac shunt imaging		S	0398	4.1265	253.65	100.06	50.73
78445	Vascular flow imaging		S	0397	2.4204	148.78	49.58	29.76
78456	Acute venous thrombus image		S	0397	2.4204	148.78	49.58	29.76
78457	Venous thrombosis imaging		S	0397	2.4204	148.78	49.58	29.76
78458	Ven thrombosis images, bilat		S	0397	2.4204	148.78	49.58	29.76
78459	Heart muscle imaging (PET)	CH	S	0307	11.8963	731.24	292.49	146.25
78460	Heart muscle blood, single		S	0398	4.1265	253.65	100.06	50.73
78461	Heart muscle blood, multiple		S	0377	6.5012	399.62	158.84	79.92
78464	Heart image (3d), single		S	0398	4.1265	253.65	100.06	50.73
78465	Heart image (3d), multiple		S	0377	6.5012	399.62	158.84	79.92

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78466	Heart infarct image		S	0398	4.1265	253.65	100.06	50.73
78468	Heart infarct image (ef)		S	0398	4.1265	253.65	100.06	50.73
78469	Heart infarct image (3D)		S	0398	4.1265	253.65	100.06	50.73
78472	Gated heart, planar, single		S	0398	4.1265	253.65	100.06	50.73
78473	Gated heart, multiple		S	0376	4.9832	306.31	119.77	61.26
78478	Heart wall motion add-on		S	0399	1.5054	92.53	35.80	18.51
78480	Heart function add-on		S	0399	1.5054	92.53	35.80	18.51
78481	Heart first pass, single		S	0398	4.1265	253.65	100.06	50.73
78483	Heart first pass, multiple		S	0376	4.9832	306.31	119.77	61.26
78491	Heart image (pet), single	CH	S	0307	11.8963	731.24	292.49	146.25
78492	Heart image (pet), multiple		S	0307	11.8963	731.24	292.49	146.25
78494	Heart image, spect		S	0398	4.1265	253.65	100.06	50.73
78496	Heart first pass add-on		S	0399	1.5054	92.53	35.80	18.51
78499	Cardiovascular nuclear exam		S	0398	4.1265	253.65	100.06	50.73
78580	Lung perfusion imaging		S	0401	3.1802	195.48	78.19	39.10
78584	Lung V/Q image single breath		S	0378	5.0975	313.33	125.33	62.67
78585	Lung V/Q imaging		S	0378	5.0975	313.33	125.33	62.67
78586	Aerosol lung image, single		S	0401	3.1802	195.48	78.19	39.10
78587	Aerosol lung image, multiple		S	0401	3.1802	195.48	78.19	39.10
78588	Perfusion lung image		S	0378	5.0975	313.33	125.33	62.67
78591	Vent image, 1 breath, 1 proj		S	0401	3.1802	195.48	78.19	39.10
78593	Vent image, 1 proj, gas		S	0401	3.1802	195.48	78.19	39.10
78594	Vent image, mult proj, gas		S	0401	3.1802	195.48	78.19	39.10
78596	Lung differential function		S	0378	5.0975	313.33	125.33	62.67
78599	Respiratory nuclear exam		S	0401	3.1802	195.48	78.19	39.10
78600	Brain imaging, ltd static		S	0402	4.6418	285.32	114.12	57.06
78601	Brain imaging, ltd w/flow		S	0402	4.6418	285.32	114.12	57.06
78605	Brain imaging, complete		S	0402	4.6418	285.32	114.12	57.06
78606	Brain imaging, compl w/flow		S	0402	4.6418	285.32	114.12	57.06
78607	Brain imaging (3D)		S	0402	4.6418	285.32	114.12	57.06
78608	Brain imaging (PET)	CH	S	0308	13.9166	855.43		171.09
78610	Brain flow imaging only		S	0402	4.6418	285.32	114.12	57.06
78615	Cerebral vascular flow image		S	0402	4.6418	285.32	114.12	57.06
78630	Cerebrospinal fluid scan		S	0403	3.4923	214.66	83.35	42.93
78635	CSF ventriculography		S	0403	3.4923	214.66	83.35	42.93
78645	CSF shunt evaluation		S	0403	3.4923	214.66	83.35	42.93
78647	Cerebrospinal fluid scan		S	0403	3.4923	214.66	83.35	42.93
78650	CSF leakage imaging		S	0403	3.4923	214.66	83.35	42.93
78660	Nuclear exam of tear flow		S	0403	3.4923	214.66	83.35	42.93
78699	Nervous system nuclear exam		S	0402	4.6418	285.32	114.12	57.06
78700	Kidney imaging, morphol		S	0404	3.4209	210.28	84.11	42.06
78701	Kidney imaging with flow		S	0404	3.4209	210.28	84.11	42.06
78704	Imaging renogram	CH	D					
78707	Kflow/funct image w/o drug		S	0404	3.4209	210.28	84.11	42.06
78708	Kflow/funct image w/drug		S	0405	4.0378	248.20	98.77	49.64
78709	Kflow/funct image, multiple		S	0405	4.0378	248.20	98.77	49.64
78710	Kidney imaging (3D)		S	0404	3.4209	210.28	84.11	42.06
78715	Renal vascular flow exam	CH	D					
78725	Kidney function study		S	0389	1.3754	84.54	33.81	16.91
78730	Urinary bladder retention		X	0340	0.6102	37.51		7.50
78740	Ureteral reflux study		S	0404	3.4209	210.28	84.11	42.06
78760	Testicular imaging	CH	D					
78761	Testicular imaging w/flow		S	0404	3.4209	210.28	84.11	42.06
78799	Genitourinary nuclear exam		S	0404	3.4209	210.28	84.11	42.06
78800	Tumor imaging, limited area		S	0406	3.9934	245.47	98.18	49.09
78801	Tumor imaging, mult areas		S	0406	3.9934	245.47	98.18	49.09
78802	Tumor imaging, whole body		S	0406	3.9934	245.47	98.18	49.09
78803	Tumor imaging (3D)		S	0406	3.9934	245.47	98.18	49.09
78804	Tumor imaging, whole body	CH	S	0408	5.9245	364.17		72.83
78805	Abscess imaging, ltd area		S	0406	3.9934	245.47	98.18	49.09
78806	Abscess imaging, whole body		S	0406	3.9934	245.47	98.18	49.09
78807	Nuclear localization/abscess		S	0406	3.9934	245.47	98.18	49.09
78811	Tumor imaging (pet), limited	CH	S	0308	13.9166	855.43		171.09
78812	Tumor image (pet)/skul-thigh	CH	S	0308	13.9166	855.43		171.09
78813	Tumor image (pet) full body	CH	S	0308	13.9166	855.43		171.09
78814	Tumor image pet/ct, limited	CH	S	1511		950.00		190.00
78815	Tumorimage pet/ct skul-thigh	CH	S	1511		950.00		190.00
78816	Tumor image pet/ct full body	CH	S	1511		950.00		190.00
78890	Nuclear medicine data proc		N					
78891	Nuclear med data proc		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78999	Nuclear diagnostic exam		S	0389	1.3754	84.54	33.81	16.91
79005	Nuclear rx, oral admin		S	0407	3.1779	195.34	78.13	39.07
79101	Nuclear rx, iv admin		S	0407	3.1779	195.34	78.13	39.07
79200	Nuclear rx, intracav admin	CH	S	0413	5.2957	325.52		65.10
79300	Nuclr rx, interstit colloid		S	0407	3.1779	195.34	78.13	39.07
79403	Hematopoietic nuclear tx	CH	S	0413	5.2957	325.52		65.10
79440	Nuclear rx, intra-articular	CH	S	0413	5.2957	325.52		65.10
79445	Nuclear rx, intra-arterial		S	0407	3.1779	195.34	78.13	39.07
79999	Nuclear medicine therapy		S	0407	3.1779	195.34	78.13	39.07
80103	Drug analysis, tissue prep		N					
80500	Lab pathology consultation		X	0433	0.2557	15.72	5.93	3.14
80502	Lab pathology consultation		X	0342	0.0824	5.06	2.02	1.01
81099	Urinalysis test procedure		X	0342	0.0824	5.06	2.02	1.01
82107	Alpha-fetoprotein l3	NI	A					
83698	Assay lipoprotein pla2	NI	A					
83913	Molecular, rna stabilization	NI	A					
84999	Clinical chemistry test		X	0342	0.0824	5.06	2.02	1.01
85097	Bone marrow interpretation		X	0343	0.5211	32.03	10.84	6.41
85396	Clotting assay, whole blood		N					
85999	Hematology procedure		X	0342	0.0824	5.06	2.02	1.01
86077	Physician blood bank service		X	0433	0.2557	15.72	5.93	3.14
86078	Physician blood bank service		X	0343	0.5211	32.03	10.84	6.41
86079	Physician blood bank service		X	0433	0.2557	15.72	5.93	3.14
86485	Skin test, candida		X	0341	0.0914	5.62	2.24	1.12
86490	Coccidioidomycosis skin test		X	0341	0.0914	5.62	2.24	1.12
86510	Histoplasmosis skin test		X	0341	0.0914	5.62	2.24	1.12
86580	TB intradermal test		X	0341	0.0914	5.62	2.24	1.12
86788	West nile virus ab, igm	NI	A					
86789	West nile virus antibody	NI	A					
86849	Immunology procedure		X	0342	0.0824	5.06	2.02	1.01
86850	RBC antibody screen		X	0345	0.2178	13.39	2.87	2.68
86860	RBC antibody elution		X	0346	0.3484	21.42	4.39	4.28
86870	RBC antibody identification		X	0346	0.3484	21.42	4.39	4.28
86880	Coombs test, direct		X	0409	0.1227	7.54	2.20	1.51
86885	Coombs test, indirect, qual		X	0409	0.1227	7.54	2.20	1.51
86886	Coombs test, indirect, titer		X	0409	0.1227	7.54	2.20	1.51
86890	Autologous blood process		X	0347	0.7423	45.63	11.28	9.13
86891	Autologous blood, op salvage		X	0346	0.3484	21.42	4.39	4.28
86900	Blood typing, ABO		X	0409	0.1227	7.54	2.20	1.51
86901	Blood typing, Rh (D)		X	0409	0.1227	7.54	2.20	1.51
86903	Blood typing, antigen screen		X	0345	0.2178	13.39	2.87	2.68
86904	Blood typing, patient serum		X	0346	0.3484	21.42	4.39	4.28
86905	Blood typing, RBC antigens		X	0345	0.2178	13.39	2.87	2.68
86906	Blood typing, Rh phenotype		X	0345	0.2178	13.39	2.87	2.68
86920	Compatibility test, spin		X	0346	0.3484	21.42	4.39	4.28
86921	Compatibility test, incubate		X	0345	0.2178	13.39	2.87	2.68
86922	Compatibility test, antiglob		X	0346	0.3484	21.42	4.39	4.28
86923	Compatibility test, electric		X	0345	0.2178	13.39	2.87	2.68
86927	Plasma, fresh frozen		X	0345	0.2178	13.39	2.87	2.68
86930	Frozen blood prep		X	0347	0.7423	45.63	11.28	9.13
86931	Frozen blood thaw		X	0347	0.7423	45.63	11.28	9.13
86932	Frozen blood freeze/thaw		X	0347	0.7423	45.63	11.28	9.13
86945	Blood product/irradiation		X	0345	0.2178	13.39	2.87	2.68
86950	Leukacyte transfusion		X	0345	0.2178	13.39	2.87	2.68
86960	Vol reduction of blood/prod		X	0345	0.2178	13.39	2.87	2.68
86965	Pooling blood platelets	CH	X	0346	0.3484	21.42	4.39	4.28
86970	RBC pretreatment		X	0345	0.2178	13.39	2.87	2.68
86971	RBC pretreatment		X	0345	0.2178	13.39	2.87	2.68
86972	RBC pretreatment		X	0346	0.3484	21.42	4.39	4.28
86975	RBC pretreatment, serum	CH	X	0346	0.3484	21.42	4.39	4.28
86976	RBC pretreatment, serum		X	0345	0.2178	13.39	2.87	2.68
86977	RBC pretreatment, serum	CH	X	0346	0.3484	21.42	4.39	4.28
86978	RBC pretreatment, serum	CH	X	0346	0.3484	21.42	4.39	4.28
86985	Split blood or products		X	0345	0.2178	13.39	2.87	2.68
86999	Transfusion procedure		X	0345	0.2178	13.39	2.87	2.68
87305	Aspergillus ag, eia	NI	A					
87498	Enterovirus, dna, amp probe	NI	A					
87640	Staph a, dna, amp probe	NI	A					
87641	Mr-staph, dna, amp probe	NI	A					
87653	Strep b, dna, amp probe	NI	A					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87808	Trichomonas assay w/optic	NI	A					
87999	Microbiology procedure		X	0342	0.0824	5.06	2.02	1.01
88104	Cytopath fl nongyn, smears		X	0433	0.2557	15.72	5.93	3.14
88106	Cytopath fl nongyn, filter		X	0433	0.2557	15.72	5.93	3.14
88107	Cytopath fl nongyn, sm/fltr		X	0433	0.2557	15.72	5.93	3.14
88108	Cytopath, concentrate tech		X	0433	0.2557	15.72	5.93	3.14
88112	Cytopath, cell enhance tech		X	0343	0.5211	32.03	10.84	6.41
88125	Forensic cytopathology	CH	X	0433	0.2557	15.72	5.93	3.14
88141	Cytopath, c/v, interpret		N					
88160	Cytopath smear, other source		X	0433	0.2557	15.72	5.93	3.14
88161	Cytopath smear, other source		X	0433	0.2557	15.72	5.93	3.14
88162	Cytopath smear, other source		X	0433	0.2557	15.72	5.93	3.14
88172	Cytopathology eval of fna		X	0343	0.5211	32.03	10.84	6.41
88173	Cytopath eval, fna, report		X	0343	0.5211	32.03	10.84	6.41
88182	Cell marker study	CH	X	0343	0.5211	32.03	10.84	6.41
88184	Flowcytometry/ tc, 1 marker	CH	X	0433	0.2557	15.72	5.93	3.14
88185	Flowcytometry/tc, add-on	CH	X	0433	0.2557	15.72	5.93	3.14
88187	Flowcytometry/read, 2–8		X	0433	0.2557	15.72	5.93	3.14
88188	Flowcytometry/read, 9–15		X	0433	0.2557	15.72	5.93	3.14
88189	Flowcytometry/read, 16 & >		X	0343	0.5211	32.03	10.84	6.41
88199	Cytopathology procedure		X	0342	0.0824	5.06	2.02	1.01
88299	Cytogenetic study		X	0342	0.0824	5.06	2.02	1.01
88300	Surgical path, gross		X	0433	0.2557	15.72	5.93	3.14
88302	Tissue exam by pathologist		X	0433	0.2557	15.72	5.93	3.14
88304	Tissue exam by pathologist		X	0343	0.5211	32.03	10.84	6.41
88305	Tissue exam by pathologist		X	0343	0.5211	32.03	10.84	6.41
88307	Tissue exam by pathologist		X	0344	0.7927	48.73	15.66	9.75
88309	Tissue exam by pathologist		X	0344	0.7927	48.73	15.66	9.75
88311	Decalcify tissue	CH	X	0433	0.2557	15.72	5.93	3.14
88312	Special stains		X	0433	0.2557	15.72	5.93	3.14
88313	Special stains		X	0433	0.2557	15.72	5.93	3.14
88314	Histochemical stain		X	0342	0.0824	5.06	2.02	1.01
88318	Chemical histochemistry		X	0433	0.2557	15.72	5.93	3.14
88319	Enzyme histochemistry		X	0343	0.5211	32.03	10.84	6.41
88321	Microslide consultation		X	0433	0.2557	15.72	5.93	3.14
88323	Microslide consultation		X	0343	0.5211	32.03	10.84	6.41
88325	Comprehensive review of data		X	0344	0.7927	48.73	15.66	9.75
88329	Path consult introp		X	0433	0.2557	15.72	5.93	3.14
88331	Path consult intraop, 1 bloc		X	0343	0.5211	32.03	10.84	6.41
88332	Path consult intraop, addÆl		X	0433	0.2557	15.72	5.93	3.14
88333	Intraop cyto path consult, 1		X	0343	0.5211	32.03	10.84	6.41
88334	Intraop cyto path consult, 2		X	0433	0.2557	15.72	5.93	3.14
88342	Immunohistochemistry		X	0343	0.5211	32.03	10.84	6.41
88346	Immunofluorescent study		X	0343	0.5211	32.03	10.84	6.41
88347	Immunofluorescent study		X	0343	0.5211	32.03	10.84	6.41
88348	Electron microscopy		X	0661	2.5255	155.24	62.09	31.05
88349	Scanning electron microscopy		X	0661	2.5255	155.24	62.09	31.05
88355	Analysis, skeletal muscle		X	0343	0.5211	32.03	10.84	6.41
88356	Analysis, nerve		X	0344	0.7927	48.73	15.66	9.75
88358	Analysis, tumor		X	0344	0.7927	48.73	15.66	9.75
88360	Tumor immunohistochem/manual	CH	X	0343	0.5211	32.03	10.84	6.41
88361	Tumor immunohistochem/comput		X	0344	0.7927	48.73	15.66	9.75
88362	Nerve teasing preparations		X	0344	0.7927	48.73	15.66	9.75
88365	Insitu hybridization (fish)		X	0344	0.7927	48.73	15.66	9.75
88367	Insitu hybridization, auto		X	0344	0.7927	48.73	15.66	9.75
88368	Insitu hybridization, manual		X	0344	0.7927	48.73	15.66	9.75
88380	Microdissection		N					
88384	Eval molecular probes, 11–50		X	0433	0.2557	15.72	5.93	3.14
88385	Eval molecul probes, 51–250		X	0343	0.5211	32.03	10.84	6.41
88386	Eval molecul probes, 251–500		X	0344	0.7927	48.73	15.66	9.75
88399	Surgical pathology procedure		X	0342	0.0824	5.06	2.02	1.01
89049	Chct for mal hyperthermia		X	0343	0.5211	32.03	10.84	6.41
89100	Sample intestinal contents		X	0360	1.4154	87.00	33.88	17.40
89105	Sample intestinal contents		X	0360	1.4154	87.00	33.88	17.40
89130	Sample stomach contents		X	0360	1.4154	87.00	33.88	17.40
89132	Sample stomach contents		X	0360	1.4154	87.00	33.88	17.40
89135	Sample stomach contents		X	0360	1.4154	87.00	33.88	17.40
89136	Sample stomach contents		X	0360	1.4154	87.00	33.88	17.40
89140	Sample stomach contents		X	0360	1.4154	87.00	33.88	17.40
89141	Sample stomach contents		X	0360	1.4154	87.00	33.88	17.40

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
89220	Sputum specimen collection		X	0343	0.5211	32.03	10.84	6.41
89230	Collect sweat for test		X	0433	0.2557	15.72	5.93	3.14
89240	Pathology lab procedure		X	0342	0.0824	5.06	2.02	1.01
89250	Cultr oocyte/embryo <4 days		X	0348	0.8321	51.15		10.23
89251	Cultr oocyte/embryo <4 days		X	0348	0.8321	51.15		10.23
89253	Embryo hatching		X	0348	0.8321	51.15		10.23
89254	Oocyte identification		X	0348	0.8321	51.15		10.23
89255	Prepare embryo for transfer		X	0348	0.8321	51.15		10.23
89257	Sperm identification		X	0348	0.8321	51.15		10.23
89258	Cryopreservation; embryo(s)		X	0348	0.8321	51.15		10.23
89259	Cryopreservation, sperm		X	0348	0.8321	51.15		10.23
89260	Sperm isolation, simple		X	0348	0.8321	51.15		10.23
89261	Sperm isolation, complex		X	0348	0.8321	51.15		10.23
89264	Identify sperm tissue		X	0348	0.8321	51.15		10.23
89268	Insemination of oocytes		X	0348	0.8321	51.15		10.23
89272	Extended culture of oocytes		X	0348	0.8321	51.15		10.23
89280	Assist oocyte fertilization		X	0348	0.8321	51.15		10.23
89281	Assist oocyte fertilization		X	0348	0.8321	51.15		10.23
89290	Biopsy, oocyte polar body		X	0348	0.8321	51.15		10.23
89291	Biopsy, oocyte polar body		X	0348	0.8321	51.15		10.23
89335	Cryopreserve testicular tiss		X	0348	0.8321	51.15		10.23
89342	Storage/year; embryo(s)		X	0348	0.8321	51.15		10.23
89343	Storage/year; sperm/semen		X	0348	0.8321	51.15		10.23
89344	Storage/year; reprod tissue		X	0348	0.8321	51.15		10.23
89346	Storage/year; oocyte(s)		X	0348	0.8321	51.15		10.23
89352	Thawing cryopresrved; embryo		X	0348	0.8321	51.15		10.23
89353	Thawing cryopresrved; sperm		X	0348	0.8321	51.15		10.23
89354	Thaw cryoprsvrd; reprod tiss		X	0348	0.8321	51.15		10.23
89356	Thawing cryopresrved; oocyte		X	0348	0.8321	51.15		10.23
90296	Diphtheria antitoxin		N					
90371	Hep b ig, im		K	1630		119.06		23.81
90375	Rabies ig, im/sc		K	9133		64.53		12.91
90376	Rabies ig, heat treated		K	9134		68.24		13.65
90385	Rh ig, minidose, im		N					
90393	Vaccina ig, im		N					
90396	Varicella-zoster ig, im		K	9135		140.92		28.18
90471	Immunization admin	CH	S	0437	0.3945	24.25		4.85
90472	Immunization admin, each add	CH	S	0436	0.1809	11.12		2.22
90473	Immune admin oral/nasal	CH	S	0436	0.1809	11.12		2.22
90474	Immune admin oral/nasal addl	CH	S	0436	0.1809	11.12		2.22
90476	Adenovirus vaccine, type 4	CH	N					
90477	Adenovirus vaccine, type 7		N					
90581	Anthrax vaccine, sc	CH	N					
90585	Bcg vaccine, percut		K	9137		117.39		23.48
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	CH	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	Hpapilloma vacc 3 dose im	CH	B					
90665	Lyme disease vaccine, im	CH	N					
90675	Rabies vaccine, im		K	9139		157.74		31.55
90676	Rabies vaccine, id		K	9140		166.16		33.23
90680	Rotovirus vacc 3 dose, oral		N					
90690	Typhoid vaccine, oral		N					
90691	Typhoid vaccine, im		N					
90692	Typhoid vaccine, h-p, sc/id		N					
90693	Typhoid vaccine, akd, sc	CH	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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90708	Measles-rubella vaccine, sc		K	9141		60.82		12.16
90710	Mmrv vaccine, sc		N					
90712	Oral poliovirus vaccine		N					
90713	Poliovirus, ipv, sc/im		N					
90714	Td vaccine no prsrv ≧ 7 im	CH	N					
90715	Tdap vaccine >7 im		N					
90716	Chicken pox vaccine, sc	CH	B					
90717	Yellow fever vaccine, sc	CH	N					
90718	Td vaccine > 7, im		N					
90719	Diphtheria vaccine, im		N					
90720	Dtp/hib vaccine, im	CH	K	3032		45.01		9.00
90721	Dtap/hib vaccine, im		N					
90725	Cholera vaccine, injectable		N					
90727	Plague vaccine, im	CH	K	0744		150.00		30.00
90733	Meningococcal vaccine, sc		K	9143		84.46		16.89
90734	Meningococcal vaccine, im		K	9145		53.71		10.74
90735	Encephalitis vaccine, sc		K	9144		96.22		19.24
90736	Zoster vacc, sc	CH	B					
90749	Vaccine toxoid		N					
90760	Hydration iv infusion, init	CH	S	0440	1.809	111.20		22.24
90761	Hydrate iv infusion, add-on	CH	S	0437	0.3945	24.25		4.85
90765	Ther/proph/diag iv inf, init	CH	S	0440	1.809	111.20		22.24
90766	Ther/proph/dg iv inf, add-on	CH	S	0437	0.3945	24.25		4.85
90767	Tx/proph/dg addl seq iv inf	CH	S	0437	0.3945	24.25		4.85
90768	Ther/diag concurrent inf	CH	N					
90772	Ther/proph/diag inj, sc/im	CH	S	0437	0.3945	24.25		4.85
90773	Ther/proph/diag inj, ia	CH	S	0438	0.7942	48.82		9.76
90774	Ther/proph/diag inj, iv push	CH	S	0438	0.7942	48.82		9.76
90775	Ther/proph/diag inj add-on	CH	S	0438	0.7942	48.82		9.76
90779	Ther/prop/diag inj/inf proc	CH	S	0436	0.1809	11.12		2.22
90801	Psy dx interview		S	0323	1.7066	104.90		20.98
90802	Intac psy dx interview		S	0323	1.7066	104.90		20.98
90804	Psytx, office, 20–30 min		S	0322	1.1798	72.52		14.50
90805	Psytx, off, 20–30 min w/e&m		S	0322	1.1798	72.52		14.50
90806	Psytx, off, 45–50 min		S	0323	1.7066	104.90		20.98
90807	Psytx, off, 45–50 min w/e&m		S	0323	1.7066	104.90		20.98
90808	Psytx, office, 75–80 min		S	0323	1.7066	104.90		20.98
90809	Psytx, off, 75–80, w/e&m		S	0323	1.7066	104.90		20.98
90810	Intac psytx, off, 20–30 min		S	0322	1.1798	72.52		14.50
90811	Intac psytx, 20–30, w/e&m		S	0322	1.1798	72.52		14.50
90812	Intac psytx, off, 45–50 min		S	0323	1.7066	104.90		20.98
90813	Intac psytx, 45–50 min w/e&m		S	0323	1.7066	104.90		20.98
90814	Intac psytx, off, 75–80 min		S	0323	1.7066	104.90		20.98
90815	Intac psytx, 75–80 w/e&m		S	0323	1.7066	104.90		20.98
90816	Psytx, hosp, 20–30 min		S	0322	1.1798	72.52		14.50
90817	Psytx, hosp, 20–30 min w/e&m		S	0322	1.1798	72.52		14.50
90818	Psytx, hosp, 45–50 min		S	0323	1.7066	104.90		20.98
90819	Psytx, hosp, 45–50 min w/e&m		S	0323	1.7066	104.90		20.98
90821	Psytx, hosp, 75–80 min		S	0323	1.7066	104.90		20.98
90822	Psytx, hosp, 75–80 min w/e&m		S	0323	1.7066	104.90		20.98
90823	Intac psytx, hosp, 20–30 min		S	0322	1.1798	72.52		14.50
90824	Intac psytx, hsp 20–30 w/e&m		S	0322	1.1798	72.52		14.50
90826	Intac psytx, hosp, 45–50 min		S	0323	1.7066	104.90		20.98
90827	Intac psytx, hsp 45–50 w/e&m		S	0323	1.7066	104.90		20.98
90828	Intac psytx, hosp, 75–80 min		S	0323	1.7066	104.90		20.98
90829	Intac psytx, hsp 75–80 w/e&m		S	0323	1.7066	104.90		20.98
90845	Psychoanalysis		S	0323	1.7066	104.90		20.98
90846	Family psytx w/o patient		S	0324	2.1633	132.97		26.59
90847	Family psytx w/patient		S	0324	2.1633	132.97		26.59
90849	Multiple family group psytx		S	0325	1.0765	66.17	14.47	13.23
90853	Group psychotherapy		S	0325	1.0765	66.17	14.47	13.23
90857	Intac group psytx		S	0325	1.0765	66.17	14.47	13.23
90862	Medication management		X	0374	1.1418	70.18		14.04
90865	Narcosynthesis		S	0323	1.7066	104.90		20.98
90870	Electroconvulsive therapy		S	0320	5.5676	342.23	80.06	68.45
90880	Hypnotherapy		S	0323	1.7066	104.90		20.98
90885	Psy evaluation of records		N					
90887	Consultation with family		N					
90889	Preparation of report		N					
90899	Psychiatric service/therapy		S	0322	1.1798	72.52		14.50

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90911	Biofeedback peri/uro/rectal		S	0321	1.3384	82.27	21.72	16.45
90935	Hemodialysis, one evaluation		S	0170	6.6089	406.24		81.25
90940	Hemodialysis access study		N					
90945	Dialysis, one evaluation		S	0170	6.6089	406.24		81.25
91000	Esophageal intubation		X	0361	3.8887	239.03	83.23	47.81
91010	Esophagus motility study		X	0361	3.8887	239.03	83.23	47.81
91011	Esophagus motility study		X	0361	3.8887	239.03	83.23	47.81
91012	Esophagus motility study		X	0361	3.8887	239.03	83.23	47.81
91020	Gastric motility studies		X	0361	3.8887	239.03	83.23	47.81
91022	Duodenal motility study		X	0361	3.8887	239.03	83.23	47.81
91030	Acid perfusion of esophagus		X	0361	3.8887	239.03	83.23	47.81
91034	Gastroesophageal reflux test		X	0361	3.8887	239.03	83.23	47.81
91035	G-esoph reflx tst w/electrod	CH	X	0361	3.8887	239.03	83.23	47.81
91037	Esoph imped function test		X	0361	3.8887	239.03	83.23	47.81
91038	Esoph imped funct test > 1h		X	0361	3.8887	239.03	83.23	47.81
91040	Esoph balloon distension tst		X	0360	1.4154	87.00	33.88	17.40
91052	Gastric analysis test		X	0361	3.8887	239.03	83.23	47.81
91055	Gastric intubation for smear		X	0360	1.4154	87.00	33.88	17.40
91060	Gastric saline load test	CH	D					
91065	Breath hydrogen test		X	0360	1.4154	87.00	33.88	17.40
91100	Pass intestine bleeding tube		X	0360	1.4154	87.00	33.88	17.40
91105	Gastric intubation treatment		X	0360	1.4154	87.00	33.88	17.40
91110	Gi tract capsule endoscopy		T	0142	9.4946	583.61	152.78	116.72
91111	Esophageal capsule endoscopy	NI	T	0141	8.3175	511.26	143.38	102.25
91120	Rectal sensation test	CH	T	0126	1.0887	66.92	16.45	13.38
91122	Anal pressure record	CH	T	0164	2.1393	131.50		26.30
91123	Irrigate fecal impaction		N					
91132	Electrogastrography		X	0360	1.4154	87.00	33.88	17.40
91133	Electrogastrography w/test		X	0360	1.4154	87.00	33.88	17.40
91299	Gastroenterology procedure		X	0360	1.4154	87.00	33.88	17.40
92002	Eye exam, new patient	CH	V	0605	0.984	60.48		12.10
92004	Eye exam, new patient	CH	V	0606	1.3646	83.88		16.78
92012	Eye exam established pat	CH	V	0604	0.8242	50.66		10.13
92014	Eye exam & treatment	CH	V	0605	0.984	60.48		12.10
92018	New eye exam & treatment		T	0699	14.3845	884.19		176.84
92019	Eye exam & treatment		T	0699	14.3845	884.19		176.84
92020	Special eye evaluation		S	0230	0.7898	48.55	14.97	9.71
92025	Corneal topography	NI	S	0698	1.1607	71.35		14.27
92060	Special eye evaluation		S	0230	0.7898	48.55	14.97	9.71
92065	Orthoptic/pleoptic training	CH	S	0230	0.7898	48.55	14.97	9.71
92070	Fitting of contact lens		N					
92081	Visual field examination(s)		S	0230	0.7898	48.55	14.97	9.71
92082	Visual field examination(s)		S	0230	0.7898	48.55	14.97	9.71
92083	Visual field examination(s)		S	0230	0.7898	48.55	14.97	9.71
92100	Serial tonometry exam(s)		N					
92120	Tonography & eye evaluation		S	0230	0.7898	48.55	14.97	9.71
92130	Water provocation tonography		S	0230	0.7898	48.55	14.97	9.71
92135	Opthalmic dx imaging		S	0230	0.7898	48.55	14.97	9.71
92136	Ophthalmic biometry		S	0698	1.1607	71.35		14.27
92140	Glaucoma provocative tests	CH	S	0230	0.7898	48.55	14.97	9.71
92225	Special eye exam, initial	CH	S	0230	0.7898	48.55	14.97	9.71
92226	Special eye exam, subsequent	CH	S	0230	0.7898	48.55	14.97	9.71
92230	Eye exam with photos	CH	S	0231	2.1451	131.86		26.37
92235	Eye exam with photos		S	0231	2.1451	131.86		26.37
92240	Icg angiography		S	0231	2.1451	131.86		26.37
92250	Eye exam with photos		S	0230	0.7898	48.55	14.97	9.71
92260	Ophthalmoscopy/dynamometry	CH	S	0230	0.7898	48.55	14.97	9.71
92265	Eye muscle evaluation		S	0230	0.7898	48.55	14.97	9.71
92270	Electro-oculography		S	0230	0.7898	48.55	14.97	9.71
92275	Electroretinography		S	0231	2.1451	131.86		26.37
92283	Color vision examination		S	0230	0.7898	48.55	14.97	9.71
92284	Dark adaptation eye exam		S	0698	1.1607	71.35		14.27
92285	Eye photography		S	0230	0.7898	48.55	14.97	9.71
92286	Internal eye photography		S	0698	1.1607	71.35		14.27
92287	Internal eye photography		S	0698	1.1607	71.35		14.27
92311	Contact lens fitting		X	0362	0.5865	36.05		7.21
92312	Contact lens fitting		X	0362	0.5865	36.05		7.21
92313	Contact lens fitting		X	0362	0.5865	36.05		7.21
92315	Prescription of contact lens		X	0362	0.5865	36.05		7.21
92316	Prescription of contact lens		X	0362	0.5865	36.05		7.21

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92317	Prescription of contact lens		X	0362	0.5865	36.05		7.21
92325	Modification of contact lens		X	0362	0.5865	36.05		7.21
92326	Replacement of contact lens		X	0362	0.5865	36.05		7.21
92352	Special spectacles fitting		X	0362	0.5865	36.05		7.21
92353	Special spectacles fitting		X	0362	0.5865	36.05		7.21
92354	Special spectacles fitting		X	0362	0.5865	36.05		7.21
92355	Special spectacles fitting		X	0362	0.5865	36.05		7.21
92358	Eye prosthesis service		X	0362	0.5865	36.05		7.21
92371	Repair & adjust spectacles		X	0362	0.5865	36.05		7.21
92499	Eye service or procedure		S	0230	0.7898	48.55	14.97	9.71
92502	Ear and throat examination		T	0251	2.452	150.72		30.14
92504	Ear microscopy examination		N					
92511	Nasopharyngoscopy		T	0071	0.7698	47.32	11.20	9.46
92512	Nasal function studies		X	0363	0.8525	52.40	17.44	10.48
92516	Facial nerve function test		X	0660	1.4461	88.89	28.06	17.78
92520	Laryngeal function studies		X	0660	1.4461	88.89	28.06	17.78
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	0.8525	52.40	17.44	10.48
92542	Positional nystagmus test		X	0363	0.8525	52.40	17.44	10.48
92543	Caloric vestibular test		X	0660	1.4461	88.89	28.06	17.78
92544	Optokinetic nystagmus test		X	0363	0.8525	52.40	17.44	10.48
92545	Oscillating tracking test		X	0363	0.8525	52.40	17.44	10.48
92546	Sinusoidal rotational test		X	0660	1.4461	88.89	28.06	17.78
92547	Supplemental electrical test		X	0363	0.8525	52.40	17.44	10.48
92548	Posturography		X	0660	1.4461	88.89	28.06	17.78
92552	Pure tone audiometry, air		X	0364	0.4627	28.44	7.06	5.69
92553	Audiometry, air & bone		X	0365	1.2419	76.34	18.52	15.27
92555	Speech threshold audiometry		X	0364	0.4627	28.44	7.06	5.69
92556	Speech audiometry, complete		X	0364	0.4627	28.44	7.06	5.69
92557	Comprehensive hearing test		X	0365	1.2419	76.34	18.52	15.27
92561	Bekesy audiometry, diagnosis		X	0364	0.4627	28.44	7.06	5.69
92562	Loudness balance test		X	0364	0.4627	28.44	7.06	5.69
92563	Tone decay hearing test		X	0364	0.4627	28.44	7.06	5.69
92564	Sisi hearing test		X	0364	0.4627	28.44	7.06	5.69
92565	Stenger test, pure tone		X	0364	0.4627	28.44	7.06	5.69
92567	Tympanometry		X	0364	0.4627	28.44	7.06	5.69
92568	Acoustic refl threshold tst		X	0364	0.4627	28.44	7.06	5.69
92569	Acoustic reflex decay test		X	0364	0.4627	28.44	7.06	5.69
92571	Filtered speech hearing test		X	0364	0.4627	28.44	7.06	5.69
92572	Staggered spondaic word test		X	0366	1.8511	113.78	26.14	22.76
92573	Lombard test	CH	D					
92575	Sensorineural acuity test		X	0364	0.4627	28.44	7.06	5.69
92576	Synthetic sentence test		X	0364	0.4627	28.44	7.06	5.69
92577	Stenger test, speech		X	0366	1.8511	113.78	26.14	22.76
92579	Visual audiometry (vra)		X	0365	1.2419	76.34	18.52	15.27
92582	Conditioning play audiometry		X	0365	1.2419	76.34	18.52	15.27
92583	Select picture audiometry		X	0364	0.4627	28.44	7.06	5.69
92584	Electrocochleography		X	0660	1.4461	88.89	28.06	17.78
92585	Auditor evoke potent, compre		S	0216	2.7199	167.19		33.44
92586	Auditor evoke potent, limit		S	0218	1.1872	72.97		14.59
92587	Evoked auditory test		X	0363	0.8525	52.40	17.44	10.48
92588	Evoked auditory test		X	0660	1.4461	88.89	28.06	17.78
92596	Ear protector evaluation		X	0364	0.4627	28.44	7.06	5.69
92601	Cochlear implt f/up exam < 7		X	0366	1.8511	113.78	26.14	22.76
92602	Reprogram cochlear implt < 7		X	0366	1.8511	113.78	26.14	22.76
92603	Cochlear implt f/up exam 7 >		X	0366	1.8511	113.78	26.14	22.76
92604	Reprogram cochlear implt 7 >		X	0366	1.8511	113.78	26.14	22.76
92620	Auditory function, 60 min		X	0365	1.2419	76.34	18.52	15.27
92621	Auditory function, + 15 min		N					
92625	Tinnitus assessment		X	0365	1.2419	76.34	18.52	15.27
92626	Eval aud rehab status		X	0365	1.2419	76.34	18.52	15.27
92627	Eval aud status rehab add-on		N					
92640	Aud brainstem implt programg	NI	X	0365	1.2419	76.34	18.52	15.27
92700	Ent procedure/service		X	0364	0.4627	28.44	7.06	5.69
92950	Heart/lung resuscitation cpr		S	0094	2.4233	148.96	46.29	29.79
92953	Temporary external pacing		S	0094	2.4233	148.96	46.29	29.79
92960	Cardioversion electric, ext		S	0679	5.5233	339.51	95.30	67.90

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92961	Cardioversion, electric, int		S	0679	5.5233	339.51	95.30	67.90
92973	Percut coronary thrombectomy		T	0088	37.7391	2,319.75	655.22	463.95
92974	Cath place, cardio brachytx		T	0103	16.2375	998.09	223.63	199.62
92977	Dissolve clot, heart vessel		T	0676	2.0726	127.40		25.48
92978	Intravasc us, heart add-on		S	0670	32.2854	1,984.52	536.10	396.90
92979	Intravasc us, heart add-on		S	0416	32.5472	2,000.61		400.12
92980	Insert intracoronary stent		T	0104	87.7183	5,391.87		1,078.37
92981	Insert intracoronary stent		T	0104	87.7183	5,391.87		1,078.37
92982	Coronary artery dilation		T	0083	58.7904	3,613.73		722.75
92984	Coronary artery dilation		T	0083	58.7904	3,613.73		722.75
92986	Revision of aortic valve		T	0083	58.7904	3,613.73		722.75
92987	Revision of mitral valve		T	0083	58.7904	3,613.73		722.75
92990	Revision of pulmonary valve		T	0083	58.7904	3,613.73		722.75
92995	Coronary atherectomy		T	0082	72.1982	4,437.88	954.62	887.58
92996	Coronary atherectomy add-on		T	0082	72.1982	4,437.88	954.62	887.58
92997	Pul art balloon repr, percut		T	0081	42.936	2,639.19		527.84
92998	Pul art balloon repr, percut		T	0081	42.936	2,639.19		527.84
93005	Electrocardiogram, tracing		S	0099	0.3789	23.29		4.66
93012	Transmission of ecg		N					
93017	Cardiovascular stress test		X	0100	2.5336	155.74	41.44	31.15
93024	Cardiac drug stress test		X	0100	2.5336	155.74	41.44	31.15
93025	Microvolt t-wave assess		X	0100	2.5336	155.74	41.44	31.15
93041	Rhythm ECG, tracing		S	0099	0.3789	23.29		4.66
93225	ECG monitor/record, 24 hrs		X	0097	1.0225	62.85	23.79	12.57
93226	ECG monitor/report, 24 hrs		X	0097	1.0225	62.85	23.79	12.57
93231	Ecg monitor/record, 24 hrs		X	0097	1.0225	62.85	23.79	12.57
93232	ECG monitor/report, 24 hrs		X	0097	1.0225	62.85	23.79	12.57
93236	ECG monitor/report, 24 hrs		X	0097	1.0225	62.85	23.79	12.57
93270	ECG recording		X	0097	1.0225	62.85	23.79	12.57
93271	Ecg/monitoring and analysis		X	0097	1.0225	62.85	23.79	12.57
93278	ECG/signal-averaged		S	0099	0.3789	23.29		4.66
93303	Echo transthoracic		S	0269	3.2154	197.64	75.60	39.53
93304	Echo transthoracic		S	0697	1.5973	98.18	35.99	19.64
93307	Echo exam of heart		S	0269	3.2154	197.64	75.60	39.53
93308	Echo exam of heart		S	0697	1.5973	98.18	35.99	19.64
93312	Echo transesophageal		S	0270	6.2505	384.21	141.32	76.84
93313	Echo transesophageal		S	0270	6.2505	384.21	141.32	76.84
93314	Echo transesophageal		N					
93315	Echo transesophageal		S	0270	6.2505	384.21	141.32	76.84
93316	Echo transesophageal		S	0270	6.2505	384.21	141.32	76.84
93317	Echo transesophageal		N					
93318	Echo transesophageal intraop		S	0270	6.2505	384.21	141.32	76.84
93320	Doppler echo exam, heart	CH	S	0697	1.5973	98.18	35.99	19.64
93321	Doppler echo exam, heart		S	0697	1.5973	98.18	35.99	19.64
93325	Doppler color flow add-on		S	0697	1.5973	98.18	35.99	19.64
93350	Echo transthoracic		S	0269	3.2154	197.64	75.60	39.53
93501	Right heart catheterization		T	0080	37.0615	2,278.10	838.92	455.62
93503	Insert/place heart catheter		T	0103	16.2375	998.09	223.63	199.62
93505	Biopsy of heart lining		T	0103	16.2375	998.09	223.63	199.62
93508	Cath placement, angiography		T	0080	37.0615	2,278.10	838.92	455.62
93510	Left heart catheterization		T	0080	37.0615	2,278.10	838.92	455.62
93511	Left heart catheterization		T	0080	37.0615	2,278.10	838.92	455.62
93514	Left heart catheterization		T	0080	37.0615	2,278.10	838.92	455.62
93524	Left heart catheterization		T	0080	37.0615	2,278.10	838.92	455.62
93526	Rt & lT heart catheters		T	0080	37.0615	2,278.10	838.92	455.62
93527	Rt & lT heart catheters		T	0080	37.0615	2,278.10	838.92	455.62
93528	Rt & lT heart catheters		T	0080	37.0615	2,278.10	838.92	455.62
93529	Rt, lt heart catheterization		T	0080	37.0615	2,278.10	838.92	455.62
93530	Rt heart cath, congenital		T	0080	37.0615	2,278.10	838.92	455.62
93531	R& l heart cath, congenital		T	0080	37.0615	2,278.10	838.92	455.62
93532	R& l heart cath, congenital		T	0080	37.0615	2,278.10	838.92	455.62
93533	R& l heart cath, congenital		T	0080	37.0615	2,278.10	838.92	455.62
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93556	Imaging, cardiac cath		N					
93561	Cardiac output measurement		N					
93562	Cardiac output measurement		N					
93571	Heart flow reserve measure		S	0670	32.2854	1,984.52	536.10	396.90
93572	Heart flow reserve measure		S	0416	32.5472	2,000.61		400.12
93580	Transcath closure of asd		T	0434	88.0728	5,413.66		1,082.73
93581	Transcath closure of vsd		T	0434	88.0728	5,413.66		1,082.73
93600	Bundle of His recording		T	0087	32.8988	2,022.22		404.44
93602	Intra-atrial recording		T	0087	32.8988	2,022.22		404.44
93603	Right ventricular recording		T	0087	32.8988	2,022.22		404.44
93609	Map tachycardia, add-on		T	0087	32.8988	2,022.22		404.44
93610	Intra-atrial pacing		T	0087	32.8988	2,022.22		404.44
93612	Intraventricular pacing		T	0087	32.8988	2,022.22		404.44
93613	Electrophys map 3d, add-on		T	0087	32.8988	2,022.22		404.44
93615	Esophageal recording		T	0087	32.8988	2,022.22		404.44
93616	Esophageal recording		T	0087	32.8988	2,022.22		404.44
93618	Heart rhythm pacing		T	0087	32.8988	2,022.22		404.44
93619	Electrophysiology evaluation		T	0085	34.2808	2,107.17	426.25	421.43
93620	Electrophysiology evaluation		T	0085	34.2808	2,107.17	426.25	421.43
93621	Electrophysiology evaluation		T	0085	34.2808	2,107.17	426.25	421.43
93622	Electrophysiology evaluation		T	0085	34.2808	2,107.17	426.25	421.43
93623	Stimulation, pacing heart		T	0087	32.8988	2,022.22		404.44
93624	Electrophysiologic study		T	0085	34.2808	2,107.17	426.25	421.43
93631	Heart pacing, mapping		T	0087	32.8988	2,022.22		404.44
93640	Evaluation heart device	CH	N					
93641	Electrophysiology evaluation	CH	N					
93642	Electrophysiology evaluation		S	0084	9.8924	608.07		121.61
93650	Ablate heart dysrhythm focus		T	0086	47.4931	2,919.31	812.36	583.86
93651	Ablate heart dysrhythm focus		T	0086	47.4931	2,919.31	812.36	583.86
93652	Ablate heart dysrhythm focus		T	0086	47.4931	2,919.31	812.36	583.86
93660	Tilt table evaluation		S	0101	4.2769	262.89	100.24	52.58
93662	Intracardiac ecg (ice)		S	0670	32.2854	1,984.52	536.10	396.90
93701	Bioimpedance, thoracic		S	0099	0.3789	23.29		4.66
93721	Plethysmography tracing		X	0368	0.9454	58.11	22.77	11.62
93724	Analyze pacemaker system		S	0690	0.3613	22.21	8.67	4.44
93727	Analyze ilr system		S	0690	0.3613	22.21	8.67	4.44
93731	Analyze pacemaker system		S	0690	0.3613	22.21	8.67	4.44
93732	Analyze pacemaker system		S	0690	0.3613	22.21	8.67	4.44
93733	Telephone analy, pacemaker		S	0690	0.3613	22.21	8.67	4.44
93734	Analyze pacemaker system		S	0690	0.3613	22.21	8.67	4.44
93735	Analyze pacemaker system		S	0690	0.3613	22.21	8.67	4.44
93736	Telephonic analy, pacemaker		S	0690	0.3613	22.21	8.67	4.44
93740	Temperature gradient studies		X	0368	0.9454	58.11	22.77	11.62
93741	Analyze ht pace device sngl		S	0689	0.6003	36.90		7.38
93742	Analyze ht pace device sngl		S	0689	0.6003	36.90		7.38
93743	Analyze ht pace device dual		S	0689	0.6003	36.90		7.38
93744	Analyze ht pace device dual		S	0689	0.6003	36.90		7.38
93745	Set-up cardiovert-defibrill		S	0689	0.6003	36.90		7.38
93770	Measure venous pressure		N					
93786	Ambulatory BP recording		X	0097	1.0225	62.85	23.79	12.57
93788	Ambulatory BP analysis		X	0097	1.0225	62.85	23.79	12.57
93797	Cardiac rehab		S	0095	0.5748	35.33	13.86	7.07
93798	Cardiac rehab/monitor		S	0095	0.5748	35.33	13.86	7.07
93799	Cardiovascular procedure	CH	X	0097	1.0225	62.85	23.79	12.57
93875	Extracranial study		S	0096	1.5303	94.06	37.62	18.81
93880	Extracranial study		S	0267	2.4606	151.25	60.50	30.25
93882	Extracranial study		S	0267	2.4606	151.25	60.50	30.25
93886	Intracranial study		S	0267	2.4606	151.25	60.50	30.25
93888	Intracranial study	CH	S	0265	0.9923	60.99	23.63	12.20
93890	Tcd, vasoreactivity study		S	0266	1.5607	95.93	37.80	19.19
93892	Tcd, emboli detect w/o inj		S	0266	1.5607	95.93	37.80	19.19
93893	Tcd, emboli detect w/inj		S	0266	1.5607	95.93	37.80	19.19
93922	Extremity study		S	0096	1.5303	94.06	37.62	18.81
93923	Extremity study		S	0096	1.5303	94.06	37.62	18.81
93924	Extremity study		S	0096	1.5303	94.06	37.62	18.81
93925	Lower extremity study		S	0267	2.4606	151.25	60.50	30.25
93926	Lower extremity study		S	0266	1.5607	95.93	37.80	19.19
93930	Upper extremity study		S	0267	2.4606	151.25	60.50	30.25
93931	Upper extremity study		S	0266	1.5607	95.93	37.80	19.19
93965	Extremity study		S	0096	1.5303	94.06	37.62	18.81

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93970	Extremity study		S	0267	2.4606	151.25	60.50	30.25
93971	Extremity study		S	0266	1.5607	95.93	37.80	19.19
93975	Vascular study		S	0267	2.4606	151.25	60.50	30.25
93976	Vascular study		S	0267	2.4606	151.25	60.50	30.25
93978	Vascular study		S	0266	1.5607	95.93	37.80	19.19
93979	Vascular study		S	0266	1.5607	95.93	37.80	19.19
93980	Penile vascular study		S	0267	2.4606	151.25	60.50	30.25
93981	Penile vascular study		S	0266	1.5607	95.93	37.80	19.19
93990	Doppler flow testing		S	0266	1.5607	95.93	37.80	19.19
94002	Vent mgmt inpat, init day	NI	S	0079	2.6116	160.53		32.11
94003	Vent mgmt inpat, subq day	NI	S	0079	2.6116	160.53		32.11
94004	Vent mgmt nf per day	NI	B					
94005	Home vent mgmt supervision	NI	E					
94010	Breathing capacity test		X	0368	0.9454	58.11	22.77	11.62
94014	Patient recorded spirometry		X	0367	0.6277	38.58	14.68	7.72
94015	Patient recorded spirometry		X	0367	0.6277	38.58	14.68	7.72
94060	Evaluation of wheezing		X	0368	0.9454	58.11	22.77	11.62
94070	Evaluation of wheezing		X	0369	2.7669	170.08	44.18	34.02
94150	Vital capacity test		X	0367	0.6277	38.58	14.68	7.72
94200	Lung function test (MBC/MVV)		X	0367	0.6277	38.58	14.68	7.72
94240	Residual lung capacity		X	0368	0.9454	58.11	22.77	11.62
94250	Expired gas collection		X	0367	0.6277	38.58	14.68	7.72
94260	Thoracic gas volume	CH	X	0368	0.9454	58.11	22.77	11.62
94350	Lung nitrogen washout curve	CH	X	0368	0.9454	58.11	22.77	11.62
94360	Measure airflow resistance		X	0367	0.6277	38.58	14.68	7.72
94370	Breath airway closing volume		X	0367	0.6277	38.58	14.68	7.72
94375	Respiratory flow volume loop		X	0367	0.6277	38.58	14.68	7.72
94400	CO2 breathing response curve		X	0367	0.6277	38.58	14.68	7.72
94450	Hypoxia response curve		X	0368	0.9454	58.11	22.77	11.62
94452	Hast w/report		X	0368	0.9454	58.11	22.77	11.62
94453	Hast w/oxygen titrate	CH	X	0367	0.6277	38.58	14.68	7.72
94610	Surfactant admin thru tube	NI	S	0077	0.3527	21.68	7.74	4.34
94620	Pulmonary stress test/simple		X	0368	0.9454	58.11	22.77	11.62
94621	Pulm stress test/complex		X	0369	2.7669	170.08	44.18	34.02
94640	Airway inhalation treatment		S	0077	0.3527	21.68	7.74	4.34
94642	Aerosol inhalation treatment		S	0078	1.1206	68.88	14.55	13.78
94644	Cbt, 1st hour	NI	S	0078	1.1206	68.88	14.55	13.78
94645	Cbt, each addl hour	NI	S	0078	1.1206	68.88	14.55	13.78
94656	Initial ventilator mgmt	CH	D					
94657	Continued ventilator mgmt	CH	D					
94660	Pos airway pressure, CPAP		S	0068	1.5353	94.37	29.48	18.87
94662	Neg press ventilation, cnp		S	0079	2.6116	160.53		32.11
94664	Evaluate pt use of inhaler		S	0077	0.3527	21.68	7.74	4.34
94667	Chest wall manipulation		S	0077	0.3527	21.68	7.74	4.34
94668	Chest wall manipulation		S	0077	0.3527	21.68	7.74	4.34
94680	Exhaled air analysis, o2		X	0367	0.6277	38.58	14.68	7.72
94681	Exhaled air analysis, o2/co2		X	0368	0.9454	58.11	22.77	11.62
94690	Exhaled air analysis	CH	X	0367	0.6277	38.58	14.68	7.72
94720	Monoxide diffusing capacity		X	0368	0.9454	58.11	22.77	11.62
94725	Membrane diffusion capacity		X	0368	0.9454	58.11	22.77	11.62
94750	Pulmonary compliance study	CH	X	0367	0.6277	38.58	14.68	7.72
94760	Measure blood oxygen level		N					
94761	Measure blood oxygen level		N					
94762	Measure blood oxygen level	CH	Q	0443	1.0409	63.98	25.59	12.80
94770	Exhaled carbon dioxide test		X	0367	0.6277	38.58	14.68	7.72
94772	Breath recording, infant		X	0369	2.7669	170.08	44.18	34.02
94774	Ped home apnea rec, compl	NI	B					
94775	Ped home apnea rec, hk-up	NI	X	0097	1.0225	62.85	23.79	12.57
94776	Ped home apnea rec, downld	NI	X	0097	1.0225	62.85	23.79	12.57
94777	Ped home apnea rec, report	NI	B					
94799	Pulmonary service/procedure		X	0367	0.6277	38.58	14.68	7.72
95004	Percut allergy skin tests		X	0381	0.2688	16.52		3.30
95010	Percut allergy titrate test		X	0381	0.2688	16.52		3.30
95012	Exhaled nitric oxide meas	NI	X	0367	0.6277	38.58	14.68	7.72
95015	Id allergy titrate-drug/bug		X	0381	0.2688	16.52		3.30
95024	Id allergy test, drug/bug		X	0381	0.2688	16.52		3.30
95027	Id allergy titrate-airborne		X	0381	0.2688	16.52		3.30
95028	Id allergy test-delayed type		X	0381	0.2688	16.52		3.30
95044	Allergy patch tests		X	0381	0.2688	16.52		3.30
95052	Photo patch test		X	0381	0.2688	16.52		3.30

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95056	Photosensitivity tests		X	0370	1.027	63.13		12.63
95060	Eye allergy tests		X	0370	1.027	63.13		12.63
95065	Nose allergy test		X	0381	0.2688	16.52		3.30
95070	Bronchial allergy tests		X	0369	2.7669	170.08	44.18	34.02
95071	Bronchial allergy tests		X	0369	2.7669	170.08	44.18	34.02
95075	Ingestion challenge test		X	0361	3.8887	239.03	83.23	47.81
95078	Provocative testing	CH	D					
95115	Immunotherapy, one injection	CH	S	0436	0.1809	11.12		2.22
95117	Immunotherapy injections	CH	S	0437	0.3945	24.25		4.85
95144	Antigen therapy services	CH	S	0437	0.3945	24.25		4.85
95145	Antigen therapy services	CH	S	0437	0.3945	24.25		4.85
95146	Antigen therapy services	CH	S	0437	0.3945	24.25		4.85
95147	Antigen therapy services	CH	S	0437	0.3945	24.25		4.85
95148	Antigen therapy services	CH	S	0437	0.3945	24.25		4.85
95149	Antigen therapy services	CH	S	0437	0.3945	24.25		4.85
95165	Antigen therapy services	CH	S	0437	0.3945	24.25		4.85
95170	Antigen therapy services	CH	S	0437	0.3945	24.25		4.85
95180	Rapid desensitization		X	0370	1.027	63.13		12.63
95199	Allergy immunology services	CH	X	0381	0.2688	16.52		3.30
95250	Glucose monitoring, cont		X	0421	1.627	100.01		20.00
95805	Multiple sleep latency test		S	0209	11.2463	691.29	268.73	138.26
95806	Sleep study, unattended		S	0213	2.2755	139.87	53.58	27.97
95807	Sleep study, attended		S	0209	11.2463	691.29	268.73	138.26
95808	Polysomnography, 1–3		S	0209	11.2463	691.29	268.73	138.26
95810	Polysomnography, 4 or more		S	0209	11.2463	691.29	268.73	138.26
95811	Polysomnography w/cpap		S	0209	11.2463	691.29	268.73	138.26
95812	Eeg, 41–60 minutes		S	0213	2.2755	139.87	53.58	27.97
95813	Eeg, over 1 hour		S	0213	2.2755	139.87	53.58	27.97
95816	Eeg, awake and drowsy		S	0213	2.2755	139.87	53.58	27.97
95819	Eeg, awake and asleep		S	0213	2.2755	139.87	53.58	27.97
95822	Eeg, coma or sleep only		S	0213	2.2755	139.87	53.58	27.97
95824	Eeg, cerebral death only		S	0214	1.1968	73.56	28.24	14.71
95827	Eeg, all night recording		S	0213	2.2755	139.87	53.58	27.97
95829	Surgery electrocorticogram		S	0214	1.1968	73.56	28.24	14.71
95857	Tensilon test		S	0218	1.1872	72.97		14.59
95860	Muscle test, one limb		S	0218	1.1872	72.97		14.59
95861	Muscle test, 2 limbs		S	0218	1.1872	72.97		14.59
95863	Muscle test, 3 limbs		S	0218	1.1872	72.97		14.59
95864	Muscle test, 4 limbs		S	0218	1.1872	72.97		14.59
95865	Muscle test, larynx		S	0218	1.1872	72.97		14.59
95866	Muscle test, hemidiaphragm		S	0218	1.1872	72.97		14.59
95867	Muscle test cran nerv unilat		S	0218	1.1872	72.97		14.59
95868	Muscle test cran nerve bilat		S	0218	1.1872	72.97		14.59
95869	Muscle test, thor paraspinal		S	0215	0.5741	35.29		7.06
95870	Muscle test, nonparaspinal		S	0215	0.5741	35.29		7.06
95872	Muscle test, one fiber		S	0218	1.1872	72.97		14.59
95873	Guide nerv destr, elec stim		S	0215	0.5741	35.29		7.06
95874	Guide nerv destr, needle emg		S	0215	0.5741	35.29		7.06
95875	Limb exercise test		S	0215	0.5741	35.29		7.06
95900	Motor nerve conduction test		S	0215	0.5741	35.29		7.06
95903	Motor nerve conduction test		S	0215	0.5741	35.29		7.06
95904	Sense nerve conduction test		S	0215	0.5741	35.29		7.06
95920	Intraop nerve test add-on		S	0216	2.7199	167.19		33.44
95921	Autonomic nerv function test	CH	S	0215	0.5741	35.29		7.06
95922	Autonomic nerv function test	CH	S	0215	0.5741	35.29		7.06
95923	Autonomic nerv function test	CH	S	0215	0.5741	35.29		7.06
95925	Somatosensory testing		S	0216	2.7199	167.19		33.44
95926	Somatosensory testing		S	0216	2.7199	167.19		33.44
95927	Somatosensory testing		S	0216	2.7199	167.19		33.44
95928	Cmotor evoked, uppr limbs		S	0218	1.1872	72.97		14.59
95929	Cmotor evoked, lwr limbs		S	0218	1.1872	72.97		14.59
95930	Visual evoked potential test		S	0216	2.7199	167.19		33.44
95933	Blink reflex test		S	0215	0.5741	35.29		7.06
95934	H-reflex test		S	0215	0.5741	35.29		7.06
95936	H-reflex test		S	0215	0.5741	35.29		7.06
95937	Neuromuscular junction test	CH	S	0215	0.5741	35.29		7.06
95950	Ambulatory eeg monitoring		S	0209	11.2463	691.29	268.73	138.26
95951	EEG monitoring/videorecord		S	0209	11.2463	691.29	268.73	138.26
95953	EEG monitoring/computer		S	0209	11.2463	691.29	268.73	138.26
95954	EEG monitoring/giving drugs		S	0214	1.1968	73.56	28.24	14.71

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95955	EEG during surgery		S	0213	2.2755	139.87	53.58	27.97
95956	Eeg monitoring, cable/radio		S	0209	11.2463	691.29	268.73	138.26
95957	EEG digital analysis		S	0214	1.1968	73.56	28.24	14.71
95958	EEG monitoring/function test		S	0213	2.2755	139.87	53.58	27.97
95961	Electrode stimulation, brain		S	0216	2.7199	167.19		33.44
95962	Electrode stim, brain add-on		S	0216	2.7199	167.19		33.44
95965	Meg, spontaneous	CH	S	0038	53.5161	3,289.53		657.91
95966	Meg, evoked, single	CH	S	0209	11.2463	691.29	268.73	138.26
95967	Meg, evoked, each addÆl	CH	S	0209	11.2463	691.29	268.73	138.26
95970	Analyze neurostim, no prog		S	0218	1.1872	72.97		14.59
95971	Analyze neurostim, simple		S	0692	1.9323	118.77	30.16	23.75
95972	Analyze neurostim, complex		S	0692	1.9323	118.77	30.16	23.75
95973	Analyze neurostim, complex	CH	S	0663	1.1067	68.03	17.45	13.61
95974	Cranial neurostim, complex		S	0692	1.9323	118.77	30.16	23.75
95975	Cranial neurostim, complex		S	0692	1.9323	118.77	30.16	23.75
95978	Analyze neurostim brain/1h		S	0692	1.9323	118.77	30.16	23.75
95979	Analyz neurostim brain addon	CH	S	0663	1.1067	68.03	17.45	13.61
95990	Spin/brain pump refil & main		T	0125	2.2041	135.48		27.10
95991	Spin/brain pump refil & main		T	0125	2.2041	135.48		27.10
95999	Neurological procedure		S	0215	0.5741	35.29		7.06
96000	Motion analysis, video/3d		S	0216	2.7199	167.19		33.44
96001	Motion test w/ft press meas		S	0216	2.7199	167.19		33.44
96002	Dynamic surface emg		S	0218	1.1872	72.97		14.59
96003	Dynamic fine wire emg		S	0215	0.5741	35.29		7.06
96020	Functional brain mapping	NI	X	0373	1.7682	108.69		21.74
96040	Genetic counseling, 30 min	NI	E					
96101	Psycho testing by psych/phys		X	0373	1.7682	108.69		21.74
96102	Psycho testing by technician		X	0382	2.846	174.94	69.97	34.99
96103	Psycho testing admin by comp		X	0373	1.7682	108.69		21.74
96110	Developmental test, lim		X	0373	1.7682	108.69		21.74
96111	Developmental test, extend		X	0373	1.7682	108.69		21.74
96116	Neurobehavioral status exam		X	0373	1.7682	108.69		21.74
96118	Neuropsych tst by psych/phys		X	0373	1.7682	108.69		21.74
96119	Neuropsych testing by tec		X	0382	2.846	174.94	69.97	34.99
96120	Neuropsych tst admin w/comp		X	0373	1.7682	108.69		21.74
96150	Assess hlth/behave, init		S	0432	0.6072	37.32		7.46
96151	Assess hlth/behave, subseq		S	0432	0.6072	37.32		7.46
96152	Intervene hlth/behave, indiv		S	0432	0.6072	37.32		7.46
96153	Intervene hlth/behave, group		S	0432	0.6072	37.32		7.46
96154	Interv hlth/behav, fam w/pt		S	0432	0.6072	37.32		7.46
96401	Chemo, anti-neopl, sq/im	CH	S	0438	0.7942	48.82		9.76
96402	Chemo hormon antineopl sq/im	CH	S	0438	0.7942	48.82		9.76
96405	Chemo intralesional, up to 7	CH	S	0438	0.7942	48.82		9.76
96406	Chemo intralesional over 7	CH	S	0438	0.7942	48.82		9.76
96409	Chemo, iv push, sngl drug	CH	S	0439	1.5848	97.41		19.48
96411	Chemo, iv push, addl drug	CH	S	0439	1.5848	97.41		19.48
96413	Chemo, iv infusion, 1 hr	CH	S	0441	2.4851	152.75		30.55
96415	Chemo, iv infusion, addl hr	CH	S	0438	0.7942	48.82		9.76
96416	Chemo prolong infuse w/pump	CH	S	0441	2.4851	152.75		30.55
96417	Chemo iv infus each addl seq	CH	S	0438	0.7942	48.82		9.76
96420	Chemo, ia, push tecnique	CH	S	0439	1.5848	97.41		19.48
96422	Chemo ia infusion up to 1 hr	CH	S	0441	2.4851	152.75		30.55
96423	Chemo ia infuse each addl hr	CH	S	0438	0.7942	48.82		9.76
96425	Chemotherapy,infusion method	CH	S	0441	2.4851	152.75		30.55
96440	Chemotherapy, intracavitary	CH	S	0441	2.4851	152.75		30.55
96445	Chemotherapy, intracavitary	CH	S	0441	2.4851	152.75		30.55
96450	Chemotherapy, into CNS	CH	S	0441	2.4851	152.75		30.55
96521	Refill/maint, portable pump	CH	S	0440	1.809	111.20		22.24
96522	Refill/maint pump/resvr syst	CH	S	0440	1.809	111.20		22.24
96523	Irrig drug delivery device	CH	Q	0624	0.5145	31.63	12.65	6.33
96542	Chemotherapy injection	CH	S	0438	0.7942	48.82		9.76
96549	Chemotherapy, unspecified	CH	S	0436	0.1809	11.12		2.22
96567	Photodynamic tx, skin		T	0016	2.6749	164.42		32.88
96570	Photodynamic tx, 30 min		T	0015	1.6241	99.83	20.13	19.97
96571	Photodynamic tx, addl 15 min		T	0015	1.6241	99.83	20.13	19.97
96900	Ultraviolet light therapy		S	0001	0.4914	30.21	7.00	6.04
96902	Trichogram		N					
96904	Whole body photography	NI	N					
96910	Photochemotherapy with UV–B		S	0001	0.4914	30.21	7.00	6.04
96912	Photochemotherapy with UV–A		S	0001	0.4914	30.21	7.00	6.04

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
96913	Photochemotherapy, UV–A or B		S	0683	2.6734	164.33		32.87
96920	Laser tx, skin < 250 sq cm		T	0013	1.0918	67.11		13.42
96921	Laser tx, skin 250–500 sq cm		T	0013	1.0918	67.11		13.42
96922	Laser tx, skin > 500 sq cm		T	0013	1.0918	67.11		13.42
96999	Dermatological procedure		T	0010	0.476	29.26	8.02	5.85
97597	Active wound care/20 cm or <		T	0012	0.8432	51.83	11.18	10.37
97598	Active wound care > 20 cm		T	0013	1.0918	67.11		13.42
97602	Wound(s) care non-selective		X	0340	0.6102	37.51		7.50
97605	Neg press wound tx, < 50 cm		T	0012	0.8432	51.83	11.18	10.37
97606	Neg press wound tx, > 50 cm		T	0013	1.0918	67.11		13.42
98925	Osteopathic manipulation		S	0060	0.4657	28.63		5.73
98926	Osteopathic manipulation		S	0060	0.4657	28.63		5.73
98927	Osteopathic manipulation		S	0060	0.4657	28.63		5.73
98928	Osteopathic manipulation		S	0060	0.4657	28.63		5.73
98929	Osteopathic manipulation		S	0060	0.4657	28.63		5.73
98940	Chiropractic manipulation		S	0060	0.4657	28.63		5.73
98941	Chiropractic manipulation		S	0060	0.4657	28.63		5.73
98942	Chiropractic manipulation		S	0060	0.4657	28.63		5.73
99078	Group health education		N					
99091	Collect/review data from pt		N					
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	0.1468	9.02	2.55	1.80
99175	Induction of vomiting		N					
99185	Regional hypothermia		N					
99186	Total body hypothermia		N					
99195	Phlebotomy		X	0372	0.5723	35.18	10.09	7.04
99201	Office/outpatient visit, new	CH	V	0604	0.8242	50.66		10.13
99202	Office/outpatient visit, new	CH	V	0605	0.984	60.48		12.10
99203	Office/outpatient visit, new	CH	V	0606	1.3646	83.88		16.78
99204	Office/outpatient visit, new	CH	V	0607	1.7096	105.09		21.02
99205	Office/outpatient visit, new	CH	V	0608	2.1794	133.96		26.79
99211	Office/outpatient visit, est	CH	V	0604	0.8242	50.66		10.13
99212	Office/outpatient visit, est	CH	V	0605	0.984	60.48		12.10
99213	Office/outpatient visit, est	CH	V	0605	0.984	60.48		12.10
99214	Office/outpatient visit, est	CH	V	0606	1.3646	83.88		16.78
99215	Office/outpatient visit, est	CH	V	0607	1.7096	105.09		21.02
99241	Office consultation	CH	V	0604	0.8242	50.66		10.13
99242	Office consultation	CH	V	0605	0.984	60.48		12.10
99243	Office consultation	CH	V	0605	0.984	60.48		12.10
99244	Office consultation	CH	V	0606	1.3646	83.88		16.78
99245	Office consultation	CH	V	0607	1.7096	105.09		21.02
99281	Emergency dept visit	CH	V	0609	0.8136	50.01	12.70	10.00
99282	Emergency dept visit	CH	V	0613	1.3497	82.96	21.06	16.59
99283	Emergency dept visit	CH	V	0614	2.115	130.00	34.50	26.00
99284	Emergency dept visit	CH	V	0615	3.4163	209.99	48.49	42.00
99285	Emergency dept visit	CH	V	0616	5.2915	325.26	75.11	65.05
99289	Ped crit care transport		N					
99290	Ped crit care transport addl		N					
99291	Critical care, first hour	CH	S	0617	6.5894	405.04	111.59	81.01
99292	Critical care, add'l 30 min		N					
99300	Ic, infant pbw 2501–5000 gm		N					
99354	Prolonged service, office		N					
99355	Prolonged service, office		N					
99358	Prolonged serv, w/o contact		N					
99359	Prolonged serv, w/o contact		N					
99361	Physician/team conference		N					
99362	Physician/team conference		N					
99363	Anticoag mgmt, init	NI	E					
99364	Anticoag mgmt, subseq	NI	E					
99431	Initial care, normal newborn	CH	V	0605	0.984	60.48		12.10
99432	Newborn care, not in hosp		N					
99436	Attendance, birth		N					
99440	Newborn resuscitation		S	0094	2.4233	148.96	46.29	29.79
0003T	Cervicography	CH	D					
0008T	Upper gi endoscopy w/suture	CH	D					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0012F	Cap bacterial assess	NI	M					
0016T	Thermotx choroid vasc lesion		T	0235	3.9333	241.77	58.93	48.35
0017T	Photocoagulat macular drusen		T	0235	3.9333	241.77	58.93	48.35
0018T	Transcranial magnetic stimul	CH	D					
0021T	Fetal oximetry, trnsvag/cerv	CH	D					
0027T	Endoscopic epidural lysis		T	0220	17.8499	1,097.20		219.44
0028T	Dexa body composition study		N					
0031T	Speculoscopy		N					
0032T	Speculoscopy w/direct sample		N					
0042T	Ct perfusion w/contrast, cbf		N					
0044T	Whole body photography	CH	D					
0045T	Whole body photography	CH	D					
0046T	Cath lavage, mammary duct(s)		T	0021	15.1024	928.31	219.48	185.66
0047T	Cath lavage, mammary duct(s)		T	0021	15.1024	928.31	219.48	185.66
0054T	Bone surgery using computer		S	0302	4.9138	302.04	105.94	60.41
0055T	Bone surgery using computer		S	0302	4.9138	302.04	105.94	60.41
0056T	Bone surgery using computer		S	0302	4.9138	302.04	105.94	60.41
0058T	Cryopreservation, ovary tiss		X	0348	0.8321	51.15		10.23
0059T	Cryopreservation, oocyte		X	0348	0.8321	51.15		10.23
0062T	Rep intradisc annulus;1 lev		T	0050	25.1296	1,544.67		308.93
0063T	Rep intradisc annulus;>1lev		T	0050	25.1296	1,544.67		308.93
0064T	Spectroscop eval expired gas		X	0367	0.6277	38.58	14.68	7.72
0067T	Ct colonography;dx		S	0333	4.8405	297.54	119.01	59.51
0069T	Analysis only heart sound		N					
0071T	U/s leiomyomata ablate <200		T	0195	28.5095	1,752.42	483.80	350.48
0072T	U/s leiomyomata ablate >200		T	0202	42.9896	2,642.48	981.50	528.50
0073T	Delivery, comp imrt		S	0412	5.4731	336.42		67.28
0082T	Stereotactic rad delivery	CH	D					
0083T	Stereotactic rad tx mngmt	CH	D					
0084T	Temp prostate urethral stent		T	0164	2.1393	131.50		26.30
0085T	Breath test heart reject		X	0340	0.6102	37.51		7.50
0086T	Lventricle fill pressure		N					
0087T	Sperm eval hyaluronan		X	0348	0.8321	51.15		10.23
0088T	Rf tongue base vol reduxn		T	0253	16.4266	1,009.71	282.29	201.94
0089T	Actigraphy testing, 3-day		S	0218	1.1872	72.97		14.59
0090T	Cervical artific disc	CH	E					
0091T	Lumbar artific disc	CH	D					
0094T	Lumbar artific diskectomy	CH	D					
0097T	Rev lumbar artific disc	CH	D					
0099T	Implant corneal ring		T	0233	15.2259	935.91	266.33	187.18
0100T	Prosth retina receive&gen		T	0672	37.429	2,300.69		460.14
0101T	Extracorp shockwv tx,hi enrg	CH	T	0050	25.1296	1,544.67		308.93
0102T	Extracorp shockwv tx,anesth	CH	T	0050	25.1296	1,544.67		308.93
0106T	Touch quant sensory test		X	0341	0.0914	5.62	2.24	1.12
0107T	Vibrate quant sensory test		X	0341	0.0914	5.62	2.24	1.12
0108T	Cool quant sensory test		X	0341	0.0914	5.62	2.24	1.12
0109T	Heat quant sensory test		X	0341	0.0914	5.62	2.24	1.12
0110T	Nos quant sensory test		X	0341	0.0914	5.62	2.24	1.12
0120T	Fibroadenoma cryoablate, ea	CH	D					
0123T	Scleral fistulization		T	0234	22.997	1,413.58	511.31	282.72
0124T	Conjunctival drug placement		T	0232	6.0673	372.94	93.43	74.59
0126T	Chd risk imt study		N					
0133T	Esophageal implant injexn	CH	T	0422	25.7552	1,583.12	448.81	316.62
0135T	Perq cryoablate renal tumor	CH	T	0423	37.3604	2,296.47		459.29
0137T	Prostate saturation sampling		T	0184	5.6262	345.83	96.27	69.17
0144T	CT heart wo dye; qual calc		S	0398	4.1265	253.65	100.06	50.73
0145T	CT heart w/wo dye funct		S	0376	4.9832	306.31	119.77	61.26
0146T	CCTA w/wo dye		S	0376	4.9832	306.31	119.77	61.26
0147T	CCTA w/wo, quan calcium		S	0376	4.9832	306.31	119.77	61.26
0148T	CCTA w/wo, strxr		S	0377	6.5012	399.62	158.84	79.92
0149T	CCTA w/wo, strxr quan calc		S	0377	6.5012	399.62	158.84	79.92
0150T	CCTA w/wo, disease strxr		S	0398	4.1265	253.65	100.06	50.73
0151T	CT heart funct add-on		S	0282	1.5379	94.53	37.81	18.91
0152T	Computer chest add-on		N					
0154T	Study sensor aneurysm sac		X	0097	1.0225	62.85	23.79	12.57
0155T	Lap impl gast curve electrd	NF	T	0130	32.1241	1,974.60	659.53	394.92
0156T	Lap remv gast curve electrd	NF	T	0130	32.1241	1,974.60	659.53	394.92
0157T	Open impl gast curve electrd	NF	C					
0158T	Open remv gast curve electrd	NF	C					
0159T	Cad breast mri	NF	N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0160T	Tcranial magn stim tx plan	CH	S	0216	2.7199	167.19		33.44
0161T	Tcranial magn stim tx deliv	CH	S	0216	2.7199	167.19		33.44
0162T	Anal program gast neurostim	NI	S	0692	1.9323	118.77	30.16	23.75
0163T	Lumb artif diskectomy addl	NI	C					
0164T	Remove lumb artif disc addl	NI	C					
0165T	Revise lumb artif disc addl	NI	C					
0166T	Tcath vsd close w/o bypass	NI	C					
0167T	Tcath vsd close w bypass	NI	C					
0168T	Rhinophototx light app bilat	NI	T	0251	2.452	150.72		30.14
0169T	Place stereo cath brain	NI	C					
0170T	Anorectal fistula plug rpr	NI	T	0150	29.6189	1,820.61	437.12	364.12
0171T	Lumbar spine proces distract	NI	T	0050	25.1296	1,544.67		308.93
0172T	Lumbar spine proces addl	NI	T	0050	25.1296	1,544.67		308.93
0173T	Iop monit io pressure	NI	N					
0174T	Cad cxr with interp	NI	N					
0175T	Cad cxr remote	NI	N					
0176T	Aqu canal dilat w/o retent	NI	T	0673	37.8967	2,329.43	649.56	465.89
0177T	Aqu canal dilat w retent	NI	T	0673	37.8967	2,329.43	649.56	465.89
0505F	Hemodialysis plan doc'd	NI	M					
0507F	Periton dialysis plan doc'd	NI	M					
1001F	Tobacco use, non-smoking	CH	D					
1015F	Copd symptoms assess	NI	M					
1018F	Assess dyspnea not present	NI	M					
1019F	Assess dyspnea present	NI	M					
1022F	Pneumo imm status assess	NI	M					
1026F	Co-morbid condition assess	NI	M					
1030F	Influenza imm status assess	NI	M					
1034F	Current tobacco smoker	NI	M					
1035F	Smokeless tobacco user	NI	M					
1036F	Tobacco non-user	NI	M					
1038F	Persistent asthma	NI	M					
1039F	Intermittent asthma	NI	M					
1040F	Dsm-ivÖ info mdd doc'd	NI	M					
2003F	Auscultation heart perform	CH	D					
2010F	Vital signs recorded	NI	M					
2014F	Mental status assess	NI	M					
2018F	Hydration status assess	NI	M					
2022F	Dil retina exam interp rev	NI	M					
2024F	7 field photo interp doc rev	NI	M					
2026F	Eye image valid to dx rev	NI	M					
2028F	Foot exam performed	NI	M					
2030F	H2O stat docÆd, normal	NI	M					
2031F	H2O stat docÆd, dehydrated	NI	M					
3000F	Blood press ≦ 140/90 mmhg	CH	D					
3002F	Blood pressure > 140/90 mmhg	CH	D					
3006F	Cxr doc rev	NI	M					
3011F	Lipid panel doc rev	NI	M					
3014F	Screen mammo doc rev	NI	M					
3017F	Colorectal ca screen doc rev	NI	M					
3020F	Lvf assess	NI	M					
3021F	Lvef mod/sever deprs syst	NI	M					
3022F	Lvef ?40% systolic	NI	M					
3023F	Spirom doc rev	NI	M					
3025F	Spirom fev/fvc<70% w copd	NI	M					
3027F	Spirom fev/fvc?70%/ w/o copd	NI	M					
3028F	O2 saturation doc rev	NI	M					
3035F	O2 saturation ?88% /pa0 ?55	NI	M					
3037F	O2 saturation> 88% /pa0>55	NI	M					
3040F	Fev<40% predicted value	NI	M					
3042F	Fev? 40% predicted value	NI	M					
3046F	Hemoglobin a1c level > 9.0%	NI	M					
3047F	Hemoglobin A1c level ? 9.0%	NI	M					
3048F	LDL–C <100 mg/dL	NI	M					
3049F	LDL–C 100–129 mg/dL	NI	M					
3050F	LDL–C ? 130 mg/dL	NI	M					
3060F	Pos microalbuminuria rev	NI	M					
3061F	Neg microalbuminuria rev	NI	M					
3062F	Pos macroalbuminuria rev	NI	M					
3066F	Nephropathy doc tx	NI	M					
3072F	Low risk for retinopathy	NI	M					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
3076F	Syst bp < 140 mm hg	NI	M					
3077F	Syst bp ? 140 mm hg	NI	M					
3078F	Diast bp < 80 mm hg	NI	M					
3079F	Diast bp 80–89 mm hg	NI	M					
3080F	Diast bp ? 90 mm hg	NI	M					
3082F	Kt/v <1.2	NI	M					
3083F	Kt/v ≧ 1.2 and <1.7	NI	M					
3084F	Kt/v ? 1.7	NI	M					
3085F	Suicide risk assessed	NI	M					
3088F	Mdd, mild	NI	M					
3089F	Mdd, moderate	NI	M					
3090F	Mdd, severe; w/o psych	NI	M					
3091F	Mdd, severe; w/ psych	NI	M					
3092F	Mdd, in remission	NI	M					
3093F	Doc new diag 1st/addl. mdd	NI	M					
4025F	Inhaled broncholidator rx	NI	M					
4030F	Oxygen therapy rx	NI	M					
4033F	Pulmonary rehab rec	NI	M					
4035F	Influenza imm rec	NI	M					
4037F	Influenza imm order/admin	NI	M					
4040F	pneumoc imm order/admin	NI	M					
4045F	Empiric antibiotic rx	NI	M					
4050F	Ht care plan doc	NI	M					
4051F	Referred for an av fistula	NI	M					
4052F	Hemodialysis via av fistula	NI	M					
4053F	Hemodialysis via av graft	NI	M					
4054F	Hemodialysis via catheter	NI	M					
4055F	Pt. rcvng periton dialysis	NI	M					
4056F	Approp. oral rehyd. recommÆd	NI	M					
4058F	Ped gastro ed given, caregvr	NI	M					
4060F	Psych svcs provided	NI	M					
4062F	Pt referral psych docÆd	NI	M					
4064F	Antidepressant rx	NI	M					
4065F	Antipsychotic rx	NI	M					
4066F	Ect provided	NI	M					
4067F	Pt referral for ect docÆd	NI	M					
6005F	Care level rationale doc	NI	M					
A0800	Amb trans 7pm–7am	CH	D					
A4211	Supp for self-adm injections	CH	E					
A4218	Sterile saline or water		N					
A4220	Infusion pump refill kit		N					
A4248	Chlorhexidine antisept		N					
A4262	Temporary tear duct plug		N					
A4263	Permanent tear duct plug		N					
A4270	Disposable endoscope sheath		N					
A4300	Cath impl vasc access portal		N					
A4301	Implantable access syst perc		N					
A4305	Drug delivery system ≧50 ML	CH	N					
A4306	Drug delivery system ≦50 ml	CH	N					
A4348	Male ext cath extended wear	CH	D					
A4359	Urinary suspensory w/o leg b	CH	D					
A4461	Surgicl dress hold non-reuse	NI	A					
A4462	Abdmnl drssng holder/binder	CH	D					
A4463	Surgical dress holder reuse	NI	A					
A4559	Coupling gel or paste	NI	Y					
A4561	Pessary rubber, any type		N					
A4562	Pessary, non rubber,any type		N					
A4600	Sleeve, inter limb comp dev	NI	Y					
A4601	Lith ion batt, non-pros use	NI	Y					
A4614	Hand-held PEFR meter	CH	N					
A4632	Infus pump rplcemnt battery	CH	D					
A4641	Radiopharm dx agent noc		N					
A4642	In111 satumomab		H	0704				
A5512	Multi den insert direct form	CH	Y					
A5513	Multi den insert custom mold	CH	Y					
A8000	Soft protect helmet prefab	NI	Y					
A8001	Hard protect helmet prefab	NI	Y					
A8002	Soft protect helmet custom	NI	Y					
A8003	Hard protect helmet custom	NI	Y					
A8004	Repl soft interface, helmet	NI	Y					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A9279	Monitoring feature/deviceNOC	NI	E					
A9500	Tc99m sestamibi		H	1600				
A9502	Tc99m tetrofosmin		H	0705				
A9503	Tc99m medronate		N					
A9504	Tc99m apcitide	CH	N					
A9505	TL201 thallium		H	1603				
A9507	In111 capromab		H	1604				
A9508	I131 iodobenguate, dx		H	1045				
A9510	Tc99m disofenin	CH	N					
A9512	Tc99m pertechnetate		N					
A9516	I123 iodide cap, dx	CH	H	9148				
A9517	I131 iodide cap, rx	CH	H	1064				
A9521	Tc99m exametazime		H	1096				
A9524	I131 serum albumin, dx		H	9100				
A9526	Nitrogen N–13 ammonia		H	0737				
A9527	Iodine I–125 sodium iodide	NI	K	2632	0.3321	20.41		4.08
A9528	Iodine I–131 iodide cap, dx		H	1088				
A9529	I131 iodide sol, dx	CH	N					
A9530	I131 iodide sol, rx		H	1150				
A9531	I131 max 100uCi	CH	N					
A9532	I125 serum albumin, dx	CH	N					
A9535	Injection, methylene blue	CH	N					
A9536	Tc99m depreotide	CH	H	0739				
A9537	Tc99m mebrofenin		N					
A9538	Tc99m pyrophosphate		N					
A9539	Tc99m pentetate	CH	H	0722				
A9540	Tc99m MAA		N					
A9541	Tc99m sulfur colloid		N					
A9542	In111 ibritumomab, dx		H	1642				
A9543	Y90 ibritumomab, rx		H	1643				
A9544	I131 tositumomab, dx		H	1644				
A9545	I131 tositumomab, rx		H	1645				
A9546	Co57/58	CH	H	0723				
A9547	In111 oxyquinoline		H	1646				
A9548	In111 pentetate		H	1647				
A9549	Tc99m arcitumomab	CH	D					
A9550	Tc99m gluceptate	CH	H	0740				
A9551	Tc99m succimer		H	1650				
A9552	F18 fdg		H	1651				
A9553	Cr51 chromate	CH	H	0741				
A9554	I125 iothalamate, dx	CH	N					
A9555	Rb82 rubidium		H	1654				
A9556	Ga67 gallium		H	1671				
A9557	Tc99m bicisate		H	1672				
A9558	Xe133 xenon 10mci		N					
A9559	Co57 cyano	CH	H	0724				
A9560	Tc99m labeled rbc	CH	H	0742				
A9561	Tc99m oxidronate		N					
A9562	Tc99m mertiatide	CH	H	0743				
A9563	P32 Na phosphate		H	1675				
A9564	P32 chromic phosphate		H	1676				
A9565	In111 pentetreotide		H	1677				
A9566	Tc99m fanolesomab		H	1678				
A9567	Technetium TC–99m aerosol	CH	H	0829				
A9568	Technetium tc99m arcitumomab	NI	H	1648				
A9600	Sr89 strontium		H	0701				
A9605	Sm 153 lexidronm		H	0702				
A9698	Non-rad contrast materialNOC		N					
A9699	Radiopharm rx agent noc		N					
A9900	Supply/accessory/service	CH	Y					
B4034	Enter feed supkit syr by day	CH	Y					
B4035	Enteral feed supp pump per d	CH	Y					
B4036	Enteral feed sup kit grav by	CH	Y					
B4081	Enteral ng tubing w/ stylet	CH	Y					
B4082	Enteral ng tubing w/o stylet	CH	Y					
B4083	Enteral stomach tube levine	CH	Y					
B4086	Gastrostomy/jejunostomy tube	CH	Y					
B4102	EF adult fluids and electro	CH	Y					
B4103	EF ped fluid and electrolyte	CH	Y					
B4149	EF blenderized foods	CH	Y					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
B4150	EF complet w/intact nutrient	CH	Y					
B4152	EF calorie dense≧1.5Kcal	CH	Y					
B4153	EF hydrolyzed/amino acids	CH	Y					
B4154	EF spec metabolic noninherit	CH	Y					
B4155	EF incomplete/modular	CH	Y					
B4157	EF special metabolic inherit	CH	Y					
B4158	EF ped complete intact nut	CH	Y					
B4159	EF ped complete soy based	CH	Y					
B4160	EF ped caloric dense≧0.7kc	CH	Y					
B4161	EF ped hydrolyzed/amino acid	CH	Y					
B4162	EF ped specmetabolic inherit	CH	Y					
B4164	Parenteral 50% dextrose solu	CH	Y					
B4168	Parenteral sol amino acid 3.	CH	Y					
B4172	Parenteral sol amino acid 5.	CH	Y					
B4176	Parenteral sol amino acid 7–	CH	Y					
B4178	Parenteral sol amino acid >	CH	Y					
B4180	Parenteral sol carb > 50%	CH	Y					
B4189	Parenteral sol amino acid &	CH	Y					
B4193	Parenteral sol 52–73 gm prot	CH	Y					
B4197	Parenteral sol 74–100 gm pro	CH	Y					
B4199	Parenteral sol > 100gm prote	CH	Y					
B4216	Parenteral nutrition additiv	CH	Y					
B4220	Parenteral supply kit premix	CH	Y					
B4222	Parenteral supply kit homemi	CH	Y					
B4224	Parenteral administration ki	CH	Y					
B5000	Parenteral sol renal-amirosy	CH	Y					
B5100	Parenteral sol hepatic-fream	CH	Y					
B5200	Parenteral sol stres-brnch c	CH	Y					
B9000	Enter infusion pump w/o alrm	CH	Y					
B9002	Enteral infusion pump w/ ala	CH	Y					
B9004	Parenteral infus pump portab	CH	Y					
B9006	Parenteral infus pump statio	CH	Y					
B9998	Enteral supp not otherwise c	CH	Y					
B9999	Parenteral supp not othrws c	CH	Y					
C1178	BUSULFAN IV, 6 Mg	CH	D					
C1300	HYPERBARIC Oxygen		S	0659	1.5906	97.77		19.55
C1713	Anchor/screw bn/bn,tis/bn		N					
C1714	Cath, trans atherectomy, dir		N					
C1715	Brachytherapy needle		N					
C1716	Brachytx source, Gold 198	CH	K	1716	0.5991	36.83		7.37
C1717	Brachytx source, HDR Ir–192	CH	K	1717	2.3195	142.58		28.52
C1718	Brachytx source, Iodine 125	CH	K	1718	0.591	36.33		7.27
C1719	Brachytx sour,Non-HDR Ir-192	CH	K	1719	0.3765	23.14		4.63
C1720	Brachytx sour, Palladium 103	CH	K	1720	0.7942	48.82		9.76
C1721	AICD, dual chamber		N					
C1722	AICD, single chamber		N					
C1724	Cath, trans atherec,rotation		N					
C1725	Cath, translumin non-laser		N					
C1726	Cath, bal dil, non-vascular		N					
C1727	Cath, bal tis dis, non-vas		N					
C1728	Cath, brachytx seed adm		N					
C1729	Cath, drainage		N					
C1730	Cath, EP, 19 or few elect		N					
C1731	Cath, EP, 20 or more elec		N					
C1732	Cath, EP, diag/abl, 3D/vect		N					
C1733	Cath, EP, othr than cool-tip		N					
C1750	Cath, hemodialysis,long-term		N					
C1751	Cath, inf, per/cent/midline		N					
C1752	Cath,hemodialysis,short-term		N					
C1753	Cath, intravas ultrasound		N					
C1754	Catheter, intradiscal		N					
C1755	Catheter, intraspinal		N					
C1756	Cath, pacing, transesoph		N					
C1757	Cath, thrombectomy/embolect		N					
C1758	Catheter, ureteral		N					
C1759	Cath, intra echocardiography		N					
C1760	Closure dev, vasc		N					
C1762	Conn tiss, human(inc fascia)		N					
C1763	Conn tiss, non-human		N					
C1764	Event recorder, cardiac		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1765	Adhesion barrier		N					
C1766	Intro/sheath,strble,non-peel		N					
C1767	Generator, neuro non-recharg		N					
C1768	Graft, vascular		N					
C1769	Guide wire		N					
C1770	Imaging coil, MR, insertable		N					
C1771	Rep dev, urinary, w/sling		N					
C1772	Infusion pump, programmable		N					
C1773	Ret dev, insertable		N					
C1776	Joint device (implantable)		N					
C1777	Lead, AICD, endo single coil		N					
C1778	Lead, neurostimulator		N					
C1779	Lead, pmkr, transvenous VDD		N					
C1780	Lens, intraocular (new tech)		N					
C1781	Mesh (implantable)		N					
C1782	Morcellator		N					
C1783	Ocular imp, aqueous drain de		N					
C1784	Ocular dev, intraop, det ret		N					
C1785	Pmkr, dual, rate-resp		N					
C1786	Pmkr, single, rate-resp		N					
C1787	Patient progr, neurostim		N					
C1788	Port, indwelling, imp		N					
C1789	Prosthesis, breast, imp		N					
C1813	Prosthesis, penile, inflatab		N					
C1814	Retinal tamp, silicone oil		N					
C1815	Pros, urinary sph, imp		N					
C1816	Receiver/transmitter, neuro		N					
C1817	Septal defect imp sys		N					
C1818	Integrated keratoprosthesis		N					
C1819	Tissue localization-excision		N					
C1820	Generator neuro rechg bat sy		H	1820				
C1821	Interspinous implant	NI	H	1821				
C1874	Stent, coated/cov w/del sys		N					
C1875	Stent, coated/cov w/o del sy		N					
C1876	Stent, non-coa/non-cov w/del		N					
C1877	Stent, non-coat/cov w/o del		N					
C1878	Matrl for vocal cord		N					
C1879	Tissue marker, implantable		N					
C1880	Vena cava filter		N					
C1881	Dialysis access system		N					
C1882	AICD, other than sing/dual		N					
C1883	Adapt/ext, pacing/neuro lead		N					
C1884	Embolization Protect syst		N					
C1885	Cath, translumin angio laser		N					
C1887	Catheter, guiding		N					
C1888	Endovas non-cardiac abl cath		N					
C1891	Infusion pump,non-prog, perm		N					
C1892	Intro/sheath,fixed,peel-away		N					
C1893	Intro/sheath, fixed,non-peel		N					
C1894	Intro/sheath, non-laser		N					
C1895	Lead, AICD, endo dual coil		N					
C1896	Lead, AICD, non sing/dual		N					
C1897	Lead, neurostim test kit		N					
C1898	Lead, pmkr, other than trans		N					
C1899	Lead, pmkr/AICD combination		N					
C1900	Lead, coronary venous		N					
C2614	Probe, perc lumb disc		N					
C2615	Sealant, pulmonary, liquid		N					
C2616	Brachytx source, Yttrium-90	CH	K	2616	172.2337	10,586.86		2,117.37
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C2630	Cath, EP, cool-tip		N					
C2631	Rep dev, urinary, w/o sling		N					
C2632	Brachytx sol, I-125, per mCi	CH	D					
C2633	Brachytx source, Cesium-131	CH	K	2633	1.4779	90.84		18.17
C2634	Brachytx source, HA, I-125	CH	K	2634	0.5316	32.68		6.54
C2635	Brachytx source, HA, P-103	CH	K	2635	0.8878	54.57		10.91
C2636	Brachytx linear source,P-103	CH	K	2636	0.6427	39.51		7.90
C2637	Brachytx, Ytterbium-169	CH	B					
C8900	MRA w/cont, abd		S	0284	6.1231	376.37	148.40	75.27
C8901	MRA w/o cont, abd		S	0336	5.6745	348.80	139.51	69.76
C8902	MRA w/o fol w/cont, abd		S	0337	8.1155	498.84	199.53	99.77
C8903	MRI w/cont, breast, uni		S	0284	6.1231	376.37	148.40	75.27
C8904	MRI w/o cont, breast, uni		S	0336	5.6745	348.80	139.51	69.76
C8905	MRI w/o fol w/cont, brst, un		S	0337	8.1155	498.84	199.53	99.77
C8906	MRI w/cont, breast, bi		S	0284	6.1231	376.37	148.40	75.27
C8907	MRI w/o cont, breast, bi		S	0336	5.6745	348.80	139.51	69.76
C8908	MRI w/o fol w/cont, breast,		S	0337	8.1155	498.84	199.53	99.77
C8909	MRA w/cont, chest		S	0284	6.1231	376.37	148.40	75.27
C8910	MRA w/o cont, chest		S	0336	5.6745	348.80	139.51	69.76
C8911	MRA w/o fol w/cont, chest		S	0337	8.1155	498.84	199.53	99.77
C8912	MRA w/cont, lwr ext		S	0284	6.1231	376.37	148.40	75.27
C8913	MRA w/o cont, lwr ext		S	0336	5.6745	348.80	139.51	69.76
C8914	MRA w/o fol w/cont, lwr ext		S	0337	8.1155	498.84	199.53	99.77
C8918	MRA w/cont, pelvis		S	0284	6.1231	376.37	148.40	75.27
C8919	MRA w/o cont, pelvis		S	0336	5.6745	348.80	139.51	69.76
C8920	MRA w/o fol w/cont, pelvis		S	0337	8.1155	498.84	199.53	99.77
C8950	IV inf, tx/dx, up to 1 hr	CH	D					
C8951	IV inf, tx/dx, each addl hr	CH	D					
C8952	Tx, prophy, dx IV push	CH	D					
C8953	Chemotx adm, IV push	CH	D					
C8954	Chemotx adm, IV inf up to 1h	CH	D					
C8955	Chemotx adm, IV inf, addl hr	CH	D					
C8957	Prolonged IV inf, req pump	CH	S	0441	2.4851	152.75		30.55
C9003	Palivizumab, per 50 mg		K	9003		609.62		121.92
C9113	Inj pantoprazole sodium, via		N					
C9121	Injection, argatroban		K	9121		17.48		3.50
C9220	Sodium hyaluronate	CH	D					
C9221	Graftjacket Reg Matrix	CH	D					
C9222	Graftjacket SftTis	CH	D					
C9224	Injection, galsulfase	CH	D					
C9225	Fluocinolone acetonide	CH	D					
C9227	Injection, micafungin sodium	CH	D					
C9228	Injection, tigecycline	CH	D					
C9229	Injection ibandronate sodium	CH	D					
C9230	Injection, abatacept	CH	D					
C9231	Injection, decitabine	CH	D					
C9232	Injection, idursulfase	NI	G	9232		464.32		92.86
C9233	Injection, ranibizumab	NI	G	9233		2,067.00		413.40
C9234	Inj, alglucosidase alfa	NI	K	9234		127.20		25.44
C9235	Injection, panitumumab	NI	K	9235		84.80		16.96
C9350	Porous collagen tube per cm	NI	G	9350		494.53		98.91
C9351	Acellular derm tissue percm2	NI	G	9351		44.01		8.80
C9716	Radiofrequency energy to anu	CH	T	0150	29.6189	1,820.61	437.12	364.12
C9723	Dyn IR Perf Img		S	1502		75.00		15.00
C9724	EPS gast cardia plic		T	0422	25.7552	1,583.12	448.81	316.62
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	NI	S	1510		850.00		170.00
D0150	Comprehensve oral evaluation		S	0330	7.055	433.66		86.73
D0240	Intraoral occlusal film		S	0330	7.055	433.66		86.73
D0250	Extraoral first film		S	0330	7.055	433.66		86.73
D0260	Extraoral ea additional film		S	0330	7.055	433.66		86.73
D0270	Dental bitewing single film		S	0330	7.055	433.66		86.73
D0272	Dental bitewings two films		S	0330	7.055	433.66		86.73
D0274	Dental bitewings four films		S	0330	7.055	433.66		86.73
D0277	Vert bitewings-sev to eight		S	0330	7.055	433.66		86.73
D0460	Pulp vitality test		S	0330	7.055	433.66		86.73
D1510	Space maintainer fxd unilat		S	0330	7.055	433.66		86.73
D1515	Fixed bilat space maintainer		S	0330	7.055	433.66		86.73
D1520	Remove unilat space maintain		S	0330	7.055	433.66		86.73

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D1525	Remove bilat space maintain		S	0330	7.055	433.66		86.73
D1550	Recement space maintainer		S	0330	7.055	433.66		86.73
D2999	Dental unspec restorative pr		S	0330	7.055	433.66		86.73
D3460	Endodontic endosseous implan		S	0330	7.055	433.66		86.73
D3999	Endodontic procedure		S	0330	7.055	433.66		86.73
D4260	Osseous surgery per quadrant		S	0330	7.055	433.66		86.73
D4263	Bone replce graft first site		S	0330	7.055	433.66		86.73
D4264	Bone replce graft each add		S	0330	7.055	433.66		86.73
D4268	Surgical revision procedure		S	0330	7.055	433.66		86.73
D4270	Pedicle soft tissue graft pr		S	0330	7.055	433.66		86.73
D4271	Free soft tissue graft proc		S	0330	7.055	433.66		86.73
D4273	Subepithelial tissue graft		S	0330	7.055	433.66		86.73
D4355	Full mouth debridement		S	0330	7.055	433.66		86.73
D4381	Localized delivery antimicro		S	0330	7.055	433.66		86.73
D5911	Facial moulage sectional		S	0330	7.055	433.66		86.73
D5912	Facial moulage complete		S	0330	7.055	433.66		86.73
D5983	Radiation applicator		S	0330	7.055	433.66		86.73
D5984	Radiation shield		S	0330	7.055	433.66		86.73
D5985	Radiation cone locator		S	0330	7.055	433.66		86.73
D5987	Commissure splint		S	0330	7.055	433.66		86.73
D6920	Dental connector bar		S	0330	7.055	433.66		86.73
D7111	Extraction coronal remnants		S	0330	7.055	433.66		86.73
D7140	Extraction erupted tooth/exr		S	0330	7.055	433.66		86.73
D7210	Rem imp tooth w mucoper flp		S	0330	7.055	433.66		86.73
D7220	Impact tooth remov soft tiss		S	0330	7.055	433.66		86.73
D7230	Impact tooth remov part bony		S	0330	7.055	433.66		86.73
D7240	Impact tooth remov comp bony		S	0330	7.055	433.66		86.73
D7241	Impact tooth rem bony w/comp		S	0330	7.055	433.66		86.73
D7250	Tooth root removal		S	0330	7.055	433.66		86.73
D7260	Oral antral fistula closure		S	0330	7.055	433.66		86.73
D7261	Primary closure sinus perf		S	0330	7.055	433.66		86.73
D7291	Transseptal fiberotomy		S	0330	7.055	433.66		86.73
D7940	Reshaping bone orthognathic		S	0330	7.055	433.66		86.73
D9110	Tx dental pain minor proc		N					
D9230	Analgesia		N					
D9248	Sedation (non-iv)		N					
D9630	Other drugs/medicaments		S	0330	7.055	433.66		86.73
D9930	Treatment of complications		S	0330	7.055	433.66		86.73
D9940	Dental occlusal guard		S	0330	7.055	433.66		86.73
D9950	Occlusion analysis		S	0330	7.055	433.66		86.73
D9951	Limited occlusal adjustment		S	0330	7.055	433.66		86.73
D9952	Complete occlusal adjustment		S	0330	7.055	433.66		86.73
E0164	Commode chair mobile fixed a	CH	D					
E0166	Commode chair mobile detach	CH	D					
E0180	Press pad alternating w pump	CH	D					
E0305	Rails bed side half length	CH	D					
E0310	Rails bed side full length	CH	D					
E0616	Cardiac event recorder		N					
E0676	Inter limb compress dev NOS	NI	Y					
E0701	Helmet w face guard prefab	CH	D					
E0749	Elec osteogen stim implanted		N					
E0782	Non-programble infusion pump		N					
E0783	Programmable infusion pump		N					
E0785	Replacement impl pump cathet		N					
E0786	Implantable pump replacement		N					
E0830	Ambulatory traction device		N					
E0936	CPM device, other than knee	NI	E					
E0977	Wheelchair wedge cushion	CH	D					
E0997	Wheelchair caster w/ a fork	CH	D					
E0998	Wheelchair caster w/o a fork	CH	D					
E0999	Wheelchr pneumatic tire w/wh	CH	D					
E1399	Durable medical equipment mi	CH	Y					
E2320	Hand chin control	CH	D					
E2373	Hand/chin ctrl spec joystick	NI	Y					
E2374	Hand/chin ctrl std joystick	NI	Y					
E2375	Non-expandable controller	NI	Y					
E2376	Expandable controller, repl	NI	Y					
E2377	Expandable controller, initl	NI	Y					
E2381	Pneum drive wheel tire	NI	Y					
E2382	Tube, pneum wheel drive tire	NI	Y					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E2383	Insert, pneum wheel drive	NI	Y					
E2384	Pneumatic caster tire	NI	Y					
E2385	Tube, pneumatic caster tire	NI	Y					
E2386	Foam filled drive wheel tire	NI	Y					
E2387	Foam filled caster tire	NI	Y					
E2388	Foam drive wheel tire	NI	Y					
E2389	Foam caster tire	NI	Y					
E2390	Solid drive wheel tire	NI	Y					
E2391	Solid caster tire	NI	Y					
E2392	Solid caster tire, integrate	NI	Y					
E2393	Valve, pneumatic tire tube	NI	Y					
E2394	Drive wheel excludes tire	NI	Y					
E2395	Caster wheel excludes tire	NI	Y					
E2396	Caster fork	NI	Y					
G0008	Admin influenza virus vac	CH	S	0350	0.3945	24.25		
G0009	Admin pneumococcal vaccine	CH	S	0350	0.3945	24.25		
G0101	CA screen;pelvic/breast exam	CH	V	0604	0.8242	50.66		10.13
G0102	Prostate ca screening; dre		N					
G0104	CA screen;flexi sigmoidscope		S	0159	3.6592	224.92		56.23
G0105	Colorectal scrn; hi risk ind		T	0158	7.8492	446.00		111.50
G0106	Colon CA screen;barium enema		S	0157	2.1149	130.00		26.00
G0107	CA screen; fecal blood test	CH	D					
G0117	Glaucoma scrn hgh risk direc		S	0230	0.7898	48.55	14.97	9.71
G0118	Glaucoma scrn hgh risk direc		S	0230	0.7898	48.55	14.97	9.71
G0120	Colon ca scrn; barium enema		S	0157	2.1149	130.00		26.00
G0121	Colon ca scrn not hi rsk ind		T	0158	7.8492	446.00		111.50
G0127	Trim nail(s)		T	0009	0.7744	47.60		9.52
G0129	Partial hosp prog service		P	0033	3.8188	234.73		46.95
G0130	Single energy x-ray study		X	0260	0.7093	43.60		8.72
G0166	Extrnl counterpulse, per tx		T	0678	1.7418	107.06		21.41
G0173	Linear acc stereo radsur com	CH	S	0067	63.3759	3,895.59		779.12
G0175	OPPS Service,sched team conf	CH	V	0608	2.1794	133.96		26.79
G0176	OPPS/PHP;activity therapy		P	0033	3.8188	234.73		46.95
G0177	OPPS/PHP; train & educ serv		P	0033	3.8188	234.73		46.95
G0186	Dstry eye lesn,fdr vssl tech		T	0235	3.9333	241.77	58.93	48.35
G0237	Therapeutic procd strg endur		S	0411	0.3848	23.65		4.73
G0238	Oth resp proc, indiv		S	0411	0.3848	23.65		4.73
G0239	Oth resp proc, group		S	0411	0.3848	23.65		4.73
G0243	Multisour photon stero treat	CH	D					
G0245	Initial foot exam pt lops	CH	V	0604	0.8242	50.66		10.13
G0246	Followup eval of foot pt lop	CH	V	0605	0.984	60.48		12.10
G0247	Routine footcare pt w lops		T	0009	0.7744	47.60		9.52
G0248	Demonstrate use home inr mon	CH	X	0421	1.627	100.01		20.00
G0249	Provide test material,equipm	CH	X	0421	1.627	100.01		20.00
G0251	Linear acc based stero radio	CH	S	0065	20.3224	1,249.18		249.84
G0257	Unsched dialysis ESRD pt hos		S	0170	6.6089	406.24		81.25
G0259	Inject for sacroiliac joint		N					
G0260	Inj for sacroiliac jt anesth		T	0206	5.7253	351.92	75.55	70.38
G0267	Bone marrow or psc harvest		S	0110	3.4584	212.58		42.52
G0268	Removal of impacted wax md		X	0340	0.6102	37.51		7.50
G0269	Occlusive device in vein art		N					
G0275	Renal angio, cardiac cath		N					
G0278	Iliac art angio,cardiac cath		N					
G0288	Recon, CTA for surg plan		S	0417	3.2393	199.11		39.82
G0289	Arthro, loose body + chondro		N					
G0290	Drug-eluting stents, single		T	0656	108.3003	6,657.00		1,331.40
G0291	Drug-eluting stents,each add		T	0656	108.3003	6,657.00		1,331.40
G0293	Non-cov surg proc,clin trial	CH	X	0340	0.6102	37.51		7.50
G0294	Non-cov proc, clinical trial	CH	X	0340	0.6102	37.51		7.50
G0297	Insert single chamber/cd		T	0107	304.4894	18,716.35		3,743.27
G0298	Insert dual chamber/cd		T	0107	304.4894	18,716.35		3,743.27
G0299	Inser/repos single icd+leads		T	0108	379.7339	23,341.48		4,668.30
G0300	Insert reposit lead dual+gen		T	0108	379.7339	23,341.48		4,668.30
G0302	Pre-op service LVRS complete		S	1509		750.00		150.00
G0303	Pre-op service LVRS 10–15dos		S	1507		550.00		110.00
G0304	Pre-op service LVRS 1–9 dos		S	1504		250.00		50.00
G0305	Post op service LVRS min 6		S	1504		250.00		50.00
G0332	Preadmin IV immunoglobulin		S	1502		75.00		15.00
G0339	Robot lin-radsurg com, first	CH	S	0067	63.3759	3,895.59		779.12
G0340	Robt lin-radsurg fractx 2–5	CH	S	0066	43.0297	2,644.95		528.99

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0344	Initial preventive exam	CH	V	0605	0.984	60.48		12.10
G0364	Bone marrow aspirate &biopsy	CH	T	0002	1.0995	67.58		13.52
G0365	Vessel mapping hemo access		S	0267	2.4606	151.25	60.50	30.25
G0367	EKG tracing for initial prev		S	0099	0.3789	23.29		4.66
G0375	Smoke/tobacco counselng 3–10	CH	X	0031	0.1766	10.86		2.17
G0376	Smoke/tobacco counseling >10	CH	X	0031	0.1766	10.86		2.17
G0378	Hospital observation per hr		Q	0339	7.2039	442.81		88.56
G0379	Direct admit hospital observ	CH	Q	0604	0.8242	50.66		10.13
G0380	Lev 1 hosp type B ED visit	NF	V	0604	0.8242	50.66		10.13
G0381	Lev 2 hosp type B ED visit	NF	V	0605	0.984	60.48		12.10
G0382	Lev 3 hosp type B ED visit	NF	V	0606	1.3646	83.88		16.78
G0383	Lev 4 hosp type B ED visit	NF	V	0607	1.7096	105.09		21.02
G0384	Lev 5 hosp type B ED visit	NF	V	0608	2.1794	133.96		26.79
G0389	Ultrasound exam AAA screen	NI	S	0266	1.5607	95.93	37.80	19.19
G0390	Trauma respon w/hosp cirtica	NI	S	0618	8.0455	494.54	197.81	98.91
G0392	AV fistula or graft arterial	NI	T	0081	42.936	2,639.19		527.84
G0393	AV fistula or graft venous	NI	T	0081	42.936	2,639.19		527.84
G0394	Blood occult test, colorecta	NI	A					
G3001	Admin + supply, tositumomab	CH	S	0442	22.3666	1,374.83		274.97
G8085	ESRD pt inelig autogenous Fi	NI	M					
J0120	Tetracyclin injection		N					
J0128	Abarelix injection	CH	K	9216		71.18		14.24
J0129	Abatacept injection	NI	G	9230		18.70		3.74
J0130	Abciximab injection		K	1605		416.27		83.25
J0132	Acetylcysteine injection		K	1680		1.94		0.39
J0133	Acyclovir injection		N					
J0135	Adalimumab injection		K	1083		308.33		61.67
J0150	Injection adenosine 6 MG		K	0379		30.49		6.10
J0152	Adenosine injection		K	0917		30.49		6.10
J0170	Adrenalin epinephrin inject		N					
J0180	Agalsidase beta injection		K	9208		127.20		25.44
J0190	Inj biperiden lactate/5 mg	CH	K	3038		88.15		17.63
J0200	Alatrofloxacin mesylate		N					
J0205	Alglucerase injection		K	0900		39.22		7.84
J0207	Amifostine		K	7000		463.27		92.65
J0210	Methyldopate hcl injection		K	2210		10.01		2.00
J0215	Alefacept		K	1633		26.31		5.26
J0256	Alpha 1 proteinase inhibitor		K	0901		3.31		0.66
J0278	Amikacin sulfate injection	CH	N					
J0280	Aminophyllin 250 MG inj		N					
J0282	Amiodarone HCl		N					
J0285	Amphotericin B	CH	N					
J0287	Amphotericin b lipid complex		K	9024		11.11		2.22
J0288	Ampho b cholesteryl sulfate		K	0735		12.00		2.40
J0289	Amphotericin b liposome inj		K	0736		21.25		4.25
J0290	Ampicillin 500 MG inj		N					
J0295	Ampicillin sodium per 1.5 gm		N					
J0300	Amobarbital 125 MG inj		N					
J0330	Succinycholine chloride inj		N					
J0348	Anadulafungin injection	NI	G	0760		1.91		0.38
J0350	Injection anistreplase 30 u		K	1606		2,268.46		453.69
J0360	Hydralazine hcl injection		N					
J0364	Apomorphine hydrochloride	NI	K	0766		2.92		0.58
J0365	Aprotonin, 10,000 kiu		K	1682		2.52		0.50
J0380	Inj metaraminol bitartrate	CH	K	3039		2.62		0.52
J0390	Chloroquine injection		N					
J0395	Arbutamine HCl injection		K	9031		160.00		32.00
J0456	Azithromycin		N					
J0460	Atropine sulfate injection		N					
J0470	Dimecaprol injection	CH	N					
J0475	Baclofen 10 MG injection		K	9032		198.54		39.71
J0476	Baclofen intrathecal trial		K	1631		69.63		13.93
J0480	Basiliximab		K	1683		1,385.86		277.17
J0500	Dicyclomine injection		N					
J0515	Inj benztropine mesylate		N					
J0520	Bethanechol chloride inject		N					
J0530	Penicillin g benzathine inj		N					
J0540	Penicillin g benzathine inj		N					
J0550	Penicillin g benzathine inj		N					
J0560	Penicillin g benzathine inj		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J0570	Penicillin g benzathine inj		N					
J0580	Penicillin g benzathine inj		N					
J0583	Bivalirudin	CH	K	3041		1.75		0.35
J0585	Botulinum toxin a per unit		K	0902		5.04		1.01
J0587	Botulinum toxin type B		K	9018		8.16		1.63
J0592	Buprenorphine hydrochloride		N					
J0594	Busulfan injection	NI	K	1178		8.89		1.78
J0595	Butorphanol tartrate 1 mg		N					
J0600	Edetate calcium disodium inj		K	0892		40.19		8.04
J0610	Calcium gluconate injection		N					
J0620	Calcium glycer & lact/10 ML		N					
J0630	Calcitonin salmon injection	CH	N					
J0636	Inj calcitriol per 0.1 mcg		N					
J0637	Caspofungin acetate		K	9019		32.25		6.45
J0640	Leucovorin calcium injection		N					
J0670	Inj mepivacaine HCL/10 ml		N					
J0690	Cefazolin sodium injection		N					
J0692	Cefepime HCl for injection		N					
J0694	Cefoxitin sodium injection		N					
J0696	Ceftriaxone sodium injection		N					
J0697	Sterile cefuroxime injection		N					
J0698	Cefotaxime sodium injection		N					
J0702	Betamethasone acet&sod phosp		N					
J0704	Betamethasone sod phosp/4 MG		N					
J0706	Caffeine citrate injection		K	0876		3.54		0.71
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		66.04		13.21
J0740	Cidofovir injection		K	9033		763.15		152.63
J0743	Cilastatin sodium injection		N					
J0744	Ciprofloxacin iv		N					
J0745	Inj codeine phosphate /30 MG		N					
J0760	Colchicine injection		N					
J0770	Colistimethate sodium inj		N					
J0780	Prochlorperazine injection		N					
J0795	Corticorelin ovine triflutal		K	1684		4.17		0.83
J0800	Corticotropin injection		K	1280		116.60		23.32
J0835	Inj cosyntropin per 0.25 MG		K	0835		62.91		12.58
J0850	Cytomegalovirus imm IV /vial		K	0903		853.18		170.64
J0878	Daptomycin injection	CH	K	9124		0.33		0.07
J0881	Darbepoetin alfa, non-esrd		K	1685		2.99		0.60
J0882	Darbepoetin alfa, esrd use	CH	A					
J0885	Epoetin alfa, non-esrd		K	1686		9.36		1.87
J0886	Epoetin alfa 1000 units ESRD	CH	A					
J0894	Decitabine injection	NI	G	9231		26.50		5.30
J0895	Deferoxamine mesylate inj		K	0895		14.84		2.97
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					
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	CH	N					
J1120	Acetazolamid sodium injectio		N					
J1160	Digoxin injection		N					
J1162	Digoxin immune fab (ovine)		K	1687		533.72		106.74
J1165	Phenytoin sodium injection		N					
J1170	Hydromorphone injection		N					
J1180	Dyphylline injection	CH	N					
J1190	Dexrazoxane HCl injection		K	0726		180.13		36.03

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1200	Diphenhydramine hcl injectio		N					
J1205	Chlorothiazide sodium inj	CH	K	0747		123.84		24.77
J1212	Dimethyl sulfoxide 50% 50 ML		N					
J1230	Methadone injection		N					
J1240	Dimenhydrinate injection		N					
J1245	Dipyridamole injection		N					
J1250	Inj dobutamine HCL/250 mg		N					
J1260	Dolasetron mesylate		K	0750		6.89		1.38
J1265	Dopamine injection		N					
J1270	Injection, doxercalciferol		N					
J1320	Amitriptyline injection		N					
J1324	Enfuvirtide injection	NI	K	0767		21.82		4.36
J1325	Epoprostenol injection		N					
J1327	Eptifibatide injection		K	1607		15.37		3.07
J1330	Ergonovine maleate injection		K	1330		33.11		6.62
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		58.05		11.61
J1430	Ethanolamine oleate 100 mg		K	1688		69.60		13.92
J1435	Injection estrone per 1 MG		N					
J1436	Etidronate disodium inj		K	1436		71.41		14.28
J1438	Etanercept injection		K	1608		160.39		32.08
J1440	Filgrastim 300 mcg injection		K	0728		188.07		37.61
J1441	Filgrastim 480 mcg injection		K	7049		298.70		59.74
J1450	Fluconazole		N					
J1451	Fomepizole, 15 mg		K	1689		12.33		2.47
J1452	Intraocular Fomivirsen na		K	9040		212.00		42.40
J1455	Foscarnet sodium injection	CH	K	3042		10.49		2.10
J1457	Gallium nitrate injection	CH	N					
J1458	Galsulfase injection	NI	K	9224		1,516.12		303.22
J1460	Gamma globulin 1 CC inj	CH	K	3043		10.34		2.07
J1562	Immune globulin subcutaneous	NI	K	0804		7.08		1.42
J1565	RSV-ivig		K	0906		16.18		3.24
J1566	Immune globulin, powder		K	2731		25.27		5.05
J1567	Immune globulin, liquid		K	2732		30.33		6.07
J1570	Ganciclovir sodium injection		N					
J1580	Garamycin gentamicin inj		N					
J1590	Gatifloxacin injection		N					
J1595	Injection glatiramer acetate		N					
J1600	Gold sodium thiomaleate inj		N					
J1610	Glucagon hydrochloride/1 MG		K	9042		70.23		14.05
J1620	Gonadorelin hydroch/ 100 mcg		K	7005		189.84		37.97
J1626	Granisetron HCl injection		K	0764		7.21		1.44
J1630	Haloperidol injection		N					
J1631	Haloperidol decanoate inj		N					
J1640	Hemin, 1 mg		K	1690		6.80		1.36
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		N					
J1655	Tinzaparin sodium injection		K	1655		2.48		0.50
J1670	Tetanus immune globulin inj		K	1670		87.77		17.55
J1700	Hydrocortisone acetate inj		N					
J1710	Hydrocortisone sodium ph inj		N					
J1720	Hydrocortisone sodium succ i		N					
J1730	Diazoxide injection		K	1740		111.89		22.38
J1740	Ibandronate sodium injection	NI	G	9229		139.12		27.82
J1742	Ibutilide fumarate injection		K	9044		265.75		53.15
J1745	Infliximab injection		K	7043		53.74		10.75
J1751	Iron dextran 165 injection		K	1691		11.78		2.36
J1752	Iron dextran 267 injection		K	1692		10.38		2.08
J1756	Iron sucrose injection		K	9046		0.36		0.07
J1785	Injection imiglucerase /unit		K	0916		3.91		0.78
J1790	Droperidol injection		N					
J1800	Propranolol injection		N					
J1815	Insulin injection		N					
J1817	Insulin for insulin pump use		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1830	Interferon beta-1b / .25 MG		K	0910		90.00		18.00
J1835	Itraconazole injection		K	9047		36.45		7.29
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		23.87		4.77
J1940	Furosemide injection		N					
J1945	Lepirudin		K	1693		153.54		30.71
J1950	Leuprolide acetate /3.75 MG		K	0800		437.58		87.52
J1956	Levofloxacin injection		N					
J1960	Levorphanol tartrate inj		N					
J1980	Hyoscyamine sulfate inj		N					
J1990	Chlordiazepoxide injection		N					
J2001	Lidocaine injection		N					
J2010	Lincomycin injection		N					
J2020	Linezolid injection		K	9001		24.16		4.83
J2060	Lorazepam injection		N					
J2150	Mannitol injection		N					
J2170	Mecasermin injection	NI	K	0805		11.93		2.39
J2175	Meperidine hydrochl /100 MG		N					
J2180	Meperidine/promethazine inj		N					
J2185	Meropenem	CH	K	3045		3.68		0.74
J2210	Methylergonovin maleate inj		N					
J2248	Micafungin sodium injection	NI	G	9227		1.87		0.37
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		G	1694		6.34		1.27
J2280	Inj, moxifloxacin 100 mg		N					
J2300	Inj nalbuphine hydrochloride		N					
J2310	Inj naloxone hydrochloride		N					
J2315	Naltrexone, depot form	NI	K	0759		1.94		0.39
J2320	Nandrolone decanoate 50 MG		N					
J2321	Nandrolone decanoate 100 MG		N					
J2322	Nandrolone decanoate 200 MG		N					
J2325	Nesiritide injection		K	1695		30.13		6.03
J2353	Octreotide injection, depot		K	1207		93.35		18.67
J2354	Octreotide inj, non-depot		N					
J2355	Oprelvekin injection		K	7011		245.98		49.20
J2357	Omalizumab injection	CH	K	9300		16.61		3.32
J2360	Orphenadrine injection		N					
J2370	Phenylephrine hcl injection		N					
J2400	Chloroprocaine hcl injection		N					
J2405	Ondansetron hcl injection		K	0768		3.72		0.74
J2410	Oxymorphone hcl injection		N					
J2425	Palifermin injection		K	1696		11.43		2.29
J2430	Pamidronate disodium /30 MG		K	0730		34.80		6.96
J2440	Papaverin hcl injection		N					
J2460	Oxytetracycline injection		N					
J2469	Palonosetron HCl		K	9210		18.08		3.62
J2501	Paricalcitol		N					
J2503	Pegaptanib sodium injection		G	1697		1,107.54		221.51
J2504	Pegademase bovine, 25 iu		K	1739		177.83		35.57
J2505	Injection, pegfilgrastim 6mg		K	9119		2,163.61		432.72
J2510	Penicillin g procaine inj		N					
J2513	Pentastarch 10% solution	CH	N					
J2515	Pentobarbital sodium inj		N					
J2540	Penicillin g potassium inj		N					
J2543	Piperacillin/tazobactam		N					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2690	Procainamide hcl injection		N					
J2700	Oxacillin sodium injeciton	CH	N					
J2710	Neostigmine methylslfte inj		N					
J2720	Inj protamine sulfate/10 MG		N					
J2725	Inj protirelin per 250 mcg		N					
J2730	Pralidoxime chloride inj	CH	N					
J2760	Phentolaine mesylate inj		N					
J2765	Metoclopramide hcl injection		N					
J2770	Quinupristin/dalfopristin		K	2770		114.49		22.90
J2780	Ranitidine hydrochloride inj		N					
J2783	Rasburicase	CH	K	0738		121.26		24.25
J2788	Rho d immune globulin 50 mcg		K	9023		27.70		5.54
J2790	Rho d immune globulin inj		K	0884		80.52		16.10
J2792	Rho(D) immune globulin h, sd		K	1609		14.30		2.86
J2794	Risperidone, long acting	CH	K	9125		4.80		0.96
J2795	Ropivacaine HCl injection		N					
J2800	Methocarbamol injection		N					
J2805	Sincalide injection	CH	N					
J2810	Inj theophylline per 40 MG		N					
J2820	Sargramostim injection		K	0731		25.55		5.11
J2850	Inj secretin synthetic human		K	1700		20.31		4.06
J2910	Aurothioglucose injeciton	CH	N					
J2912	Sodium chloride injection	CH	D					
J2916	Na ferric gluconate complex		N					
J2920	Methylprednisolone injection		N					
J2930	Methylprednisolone injection		N					
J2940	Somatrem injection		K	2940		35.60		7.12
J2941	Somatropin injection		K	7034		46.80		9.36
J2950	Promazine hcl injection		N					
J2993	Reteplase injection		K	9005		902.72		180.54
J2995	Inj streptokinase /250000 IU		K	0911		79.50		15.90
J2997	Alteplase recombinant		K	7048		32.07		6.41
J3000	Streptomycin injection		N					
J3010	Fentanyl citrate injeciton		N					
J3030	Sumatriptan succinate / 6 MG		K	3030		57.40		11.48
J3070	Pentazocine injection		N					
J3100	Tenecteplase injection		K	9002		2,036.66		407.33
J3105	Terbutaline sulfate inj		N					
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		765.76		153.15
J3243	Tigecycline injection	NI	G	9228		0.91		0.18
J3246	Tirofiban HCl		K	7041		8.74		1.75
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		54.02		10.80
J3301	Triamcinolone acetonide inj		N					
J3302	Triamcinolone diacetate inj		N					
J3303	Triamcinolone hexacetonl inj		N					
J3305	Inj trimetrexate glucoronate		K	7045		145.17		29.03
J3310	Perphenazine injeciton		N					
J3315	Triptorelin pamoate		K	9122		218.53		43.71
J3320	Spectinomycn di-hcl inj	CH	K	0753		30.08		6.02
J3350	Urea injection		K	9051		37.81		7.56
J3355	Urofollitropin, 75 iu		K	1741		49.35		9.87
J3360	Diazepam injection		N					
J3364	Urokinase 5000 IU injection		N					
J3365	Urokinase 250,000 IU inj		K	7036		457.73		91.55
J3370	Vancomycin hcl injection		N					
J3396	Verteporfin injection		K	1203		8.91		1.78
J3400	Triflupromazine hcl inj		N					
J3410	Hydroxyzine hcl injection		N					
J3411	Thiamine hcl 100 mg		N					
J3415	Pyridoxine hcl 100 mg		N					
J3420	Vitamin b12 injection		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J3430	Vitamin k phytonadione inj		N					
J3465	Injection, voriconazole		K	1052		4.66		0.93
J3470	Hyaluronidase injection	CH	N					
J3471	Ovine, up to 999 USP units	CH	N					
J3472	Ovine, 1000 USP units		K	1703		137.43		27.49
J3473	Hyaluronidase recombinant	NI	G	0806		0.40		0.08
J3475	Inj magnesium sulfate		N					
J3480	Inj potassium chloride		N					
J3485	Zidovudine		N					
J3486	Ziprasidone mesylate		N					
J3487	Zoledronic acid		K	9115		204.03		40.81
J3490	Drugs unclassified injection		N					
J3530	Nasal vaccine inhalation		N					
J3590	Unclassified biologics		N					
J7030	Normal saline solution infus		N					
J7040	Normal saline solution infus		N					
J7042	5% dextrose/normal saline		N					
J7050	Normal saline solution infus		N					
J7060	5% dextrose/water		N					
J7070	D5w infusion		N					
J7100	Dextran 40 infusion		N					
J7110	Dextran 75 infusion		N					
J7120	Ringers lactate infusion		N					
J7130	Hypertonic saline solution		N					
J7187	Inj Vonwillebrand factor IU	NI	K	1704		0.88		0.18
J7188	Inj Vonwillebrand factor iu	CH	D					
J7189	Factor viia		K	1705		1.10		0.22
J7190	Factor viii		K	0925		0.69		0.14
J7191	Factor VIII (porcine)		K	0926		1.33		0.27
J7192	Factor viii recombinant		K	0927		1.06		0.21
J7193	Factor IX non-recombinant		K	0931		0.90		0.18
J7194	Factor ix complex		K	0928		0.72		0.14
J7195	Factor IX recombinant		K	0932		0.99		0.20
J7197	Antithrombin iii injection		K	0930		1.62		0.32
J7198	Anti-inhibitor		K	0929		1.36		0.27
J7308	Aminolevulinic acid hcl top		K	7308		107.72		21.54
J7310	Ganciclovir long act implant		K	0913		4,766.14		953.23
J7311	Fluocinolone acetonide implt	NI	G	9225		18,250.00		3,650.00
J7317	Sodium hyaluronate injection	CH	D					
J7319	Sodium Hyaluronate Injection	NI	K	0896		124.68		24.94
J7320	Hylan G–F 20 injection	CH	D					
J7340	Metabolic active D/E tissue		K	1632		27.89		5.58
J7341	Non-human, metabolic tissue		K	1707		1.78		0.36
J7342	Metabolically active tissue		K	9054		13.87		2.77
J7343	Nonmetabolic act d/e tissue		K	1629		18.49		3.70
J7344	Nonmetabolic active tissue		K	9156		45.02		9.00
J7345	Non-human, non-metab tissue	NI	B					
J7346	Injectable human tissue	NI	K	9222		743.96		148.79
J7350	Injectable human tissue	CH	D					
J7500	Azathioprine oral 50mg		N					
J7501	Azathioprine parenteral		K	0887		49.17		9.83
J7502	Cyclosporine oral 100 mg		K	0888		3.66		0.73
J7504	Lymphocyte immune globulin		K	0890		315.76		63.15
J7505	Monoclonal antibodies		K	7038		856.05		171.21
J7506	Prednisone oral		N					
J7507	Tacrolimus oral per 1 MG		K	0891		3.55		0.71
J7509	Methylprednisolone oral		N					
J7510	Prednisolone oral per 5 mg		N					
J7511	Antithymocyte globuln rabbit		K	9104		329.62		65.92
J7513	Daclizumab, parenteral		K	1612		328.83		65.77
J7515	Cyclosporine oral 25 mg	CH	N					
J7516	Cyclosporin parenteral 250mg		N					
J7517	Mycophenolate mofetil oral		K	9015		2.50		0.50
J7518	Mycophenolic acid	CH	K	9219		2.15		0.43
J7520	Sirolimus, oral		K	9020		7.25		1.45
J7525	Tacrolimus injection		K	9006		140.72		28.14
J7599	Immunosuppressive drug noc		N					
J7607	Levalbuterol comp con	NI	B					
J7609	Albuterol comp unit	NI	B					
J7610	Albuterol comp con	NI	B					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J7615	Levalbuterol comp unit	NI	B					
J7634	Budesonide comp con	NI	B					
J7645	Ipratropium bromide comp	NI	B					
J7647	Isoetharine comp con	NI	B					
J7650	Isoetharine comp unit	NI	B					
J7657	Isoproterenol comp con	NI	B					
J7660	Isoproterenol comp unit	NI	B					
J7667	Metaproterenol comp con	NI	B					
J7670	Metaproterenol comp unit	NI	B					
J7674	Methacholine chloride, neb		N					
J7685	Tobramycin comp unit	NI	B					
J7799	Non-inhalation drug for DME		N					
J8501	Oral aprepitant		G	0868		4.85		0.97
J8510	Oral busulfan		K	7015		2.14		0.43
J8520	Capecitabine, oral, 150 mg		K	7042		3.83		0.77
J8530	Cyclophosphamide oral 25 MG		N					
J8540	Oral dexamethasone	CH	N					
J8560	Etoposide oral 50 MG		K	0802		32.01		6.40
J8597	Antiemetic drug oral NOS		N					
J8600	Melphalan oral 2 MG		N					
J8610	Methotrexate oral 2.5 MG		N					
J8650	Nabilone oral	NI	K	0808		16.96		3.39
J8700	Temozolomide		K	1086		7.30		1.46
J9000	Doxorubic hcl 10 MG vl chemo	CH	K	3048		6.00		1.20
J9001	Doxorubicin hcl liposome inj		K	7046		379.21		75.84
J9010	Alemtuzumab injection		K	9110		531.24		106.25
J9015	Aldesleukin/single use vial		K	0807		726.69		145.34
J9017	Arsenic trioxide		K	9012		33.36		6.67
J9020	Asparaginase injection		K	0814		54.46		10.89
J9025	Azacitidine injection		K	1709		4.22		0.84
J9027	Clofarabine injection		G	1710		116.62		23.32
J9031	Bcg live intravesical vac		K	0809		113.44		22.69
J9035	Bevacizumab injection	CH	K	9214		56.88		11.38
J9040	Bleomycin sulfate injection	CH	K	0748		37.62		7.52
J9041	Bortezomib injection		K	9207		31.87		6.37
J9045	Carboplatin injection		K	0811		10.12		2.02
J9050	Carmus bischl nitro inj		K	0812		139.84		27.97
J9055	Cetuximab injection	CH	K	9215		49.86		9.97
J9060	Cisplatin 10 MG injection		N					
J9065	Inj cladribine per 1 MG		K	0858		37.87		7.57
J9070	Cyclophosphamide 100 MG inj		N					
J9093	Cyclophosphamide lyophilized	CH	K	3049		5.72		1.14
J9098	Cytarabine liposome		K	1166		396.66		79.33
J9100	Cytarabine hcl 100 MG inj		N					
J9120	Dactinomycin actinomycin d	CH	K	0752		493.43		98.69
J9130	Dacarbazine 100 mg inj	CH	K	0746		4.90		0.98
J9150	Daunorubicin		K	0820		24.56		4.91
J9151	Daunorubicin citrate liposom		K	0821		56.21		11.24
J9160	Denileukin diftitox, 300 mcg		K	1084		1,403.23		280.65
J9165	Diethylstilbestrol injection		N					
J9170	Docetaxel		K	0823		302.68		60.54
J9175	Elliotts b solution per ml		N					
J9178	Inj, epirubicin hcl, 2 mg		K	1167		24.67		4.93
J9181	Etoposide 10 MG inj		N					
J9185	Fludarabine phosphate inj		K	0842		243.82		48.76
J9190	Fluorouracil injection		N					
J9200	Floxuridine injection		K	0827		64.17		12.83
J9201	Gemcitabine HCl		K	0828		121.30		24.26
J9202	Goserelin acetate implant		K	0810		199.12		39.82
J9206	Irinotecan injection		K	0830		126.88		25.38
J9208	Ifosfomide injection		K	0831		52.39		10.48
J9209	Mesna injection		K	0732		10.10		2.02
J9211	Idarubicin hcl injection		K	0832		308.97		61.79
J9212	Interferon alfacon-1		K	0912		4.65		0.93
J9213	Interferon alfa-2a inj		K	0834		37.56		7.51
J9214	Interferon alfa-2b inj		K	0836		13.75		2.75
J9215	Interferon alfa-n3 inj		K	0865		39.48		7.90
J9216	Interferon gamma 1-b inj		K	0838		289.87		57.97
J9217	Leuprolide acetate suspnsion		K	9217		227.63		45.53
J9218	Leuprolide acetate injeciton		K	0861		11.10		2.22

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9219	Leuprolide acetate implant		K	7051		2,208.90		441.78
J9225	Histrelin implant		K	1711		1,741.71		348.34
J9230	Mechlorethamine hcl inj	CH	K	0751		141.61		28.32
J9245	Inj melphalan hydrochl 50 MG		K	0840		1,194.15		238.83
J9250	Methotrexate sodium inj		N					
J9261	Nelarabine injection	NI	K	0825		83.10		16.62
J9263	Oxaliplatin		K	1738		8.77		1.75
J9264	Paclitaxel protein bound		G	1712		8.73		1.75
J9265	Paclitaxel injection		K	0863		14.35		2.87
J9266	Pegaspargase/singl dose vial		K	0843		1,687.04		337.41
J9268	Pentostatin injection		K	0844		2,034.63		406.93
J9270	Plicamycin (mithramycin) inj		K	0860		61.36		12.27
J9280	Mitomycin 5 MG inj		K	0862		18.31		3.66
J9293	Mitoxantrone hydrochl / 5 MG		K	0864		223.27		44.65
J9300	Gemtuzumab ozogamicin		K	9004		2,317.16		463.43
J9305	Pemetrexed injection	CH	K	9213		42.49		8.50
J9310	Rituximab cancer treatment		K	0849		481.69		96.34
J9320	Streptozocin injection		K	0850		152.92		30.58
J9340	Thiotepa injection		K	0851		44.58		8.92
J9350	Topotecan		K	0852		813.08		162.62
J9355	Trastuzumab		K	1613		56.17		11.23
J9357	Valrubicin, 200 mg		K	9167		369.60		73.92
J9360	Vinblastine sulfate inj		N					
J9370	Vincristine sulfate 1 MG inj		N					
J9390	Vinorelbine tartrate/10 mg		K	0855		22.82		4.56
J9395	Injection, Fulvestrant		K	9120		80.66		16.13
J9600	Porfimer sodium		K	0856		2,505.40		501.08
J9999	Chemotherapy drug		N					
K0090	Rear tire power wheelchair	CH	D					
K0091	Rear tire tube power whlchr	CH	D					
K0092	Rear assem cmplt powr whlchr	CH	D					
K0093	Rear zero pressure tire tube	CH	D					
K0094	Wheel tire for power base	CH	D					
K0095	Wheel tire tube each base	CH	D					
K0096	Wheel assem powr base complt	CH	D					
K0097	Wheel zero presure tire tube	CH	D					
K0098	Drive belt power wheelchair	CH	D					
K0733	12–24hr sealed lead acid	NI	Y					
K0734	Adj skin pro w/c cus wd<22in	NI	Y					
K0735	Adj skin pro wc cus wd≧22in	NI	Y					
K0736	Adj skin pro/pos wc cus<22in	NI	Y					
K0737	Adj skin pro/pos wc cus≧22″	NI	Y					
K0738	Portable gas oxygen system	NI	Y					
K0800	POV group 1 std up to 300 lb	NI	Y					
K0801	POV group 1 hd 301–450 lbs	NI	Y					
K0802	POV group 1 vhd 451–600 lbs	NI	Y					
K0806	POV group 2 std up to 300lbs	NI	Y					
K0807	POV group 2 hd 301–450 lbs	NI	Y					
K0808	POV group 2 vhd 451–600 lbs	NI	Y					
K0812	Power operated vehicle NOC	NI	Y					
K0813	PWC gp 1 std port seat/back	NI	Y					
K0814	PWC gp 1 std port cap chair	NI	Y					
K0815	PWC gp 1 std seat/back	NI	Y					
K0816	PWC gp 1 std cap chair	NI	Y					
K0820	PWC gp 2 std port seat/back	NI	Y					
K0821	PWC gp 2 std port cap chair	NI	Y					
K0822	PWC gp 2 std seat/back	NI	Y					
K0823	PWC gp 2 std cap chair	NI	Y					
K0824	PWC gp 2 hd seat/back	NI	Y					
K0825	PWC gp 2 hd cap chair	NI	Y					
K0826	PWC gp2 vhd seat/back	NI	Y					
K0827	PWC gp 2 vhd cap chair	NI	Y					
K0828	PWC gp 2 xtra hd seat/back	NI	Y					
K0829	PWC gp 2 xtra hd cap chair	NI	Y					
K0830	PWC gp2 std seat elevate s/b	NI	Y					
K0831	PWC gp2 std seat elevate cap	NI	Y					
K0835	PWC gp2 std sing pow opt s/b	NI	Y					
K0836	PWC gp2 std sing pow opt cap	NI	Y					
K0837	PWC gp 2 hd sing pow opt s/b	NI	Y					
K0838	PWC gp 2 hd sing pow opt cap	NI	Y					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0839	PWC gp2 vhd sing pow opt s/b	NI	Y					
K0840	PWC gp2 xhd sing pow opt s/b	NI	Y					
K0841	PWC gp2 std mult pow opt s/b	NI	Y					
K0842	PWC gp2 std mult pow opt cap	NI	Y					
K0843	PWC gp2 hd mult pow opt s/b	NI	Y					
K0848	PWC gp 3 std seat/back	NI	Y					
K0849	PWC gp 3 std cap chair	NI	Y					
K0850	PWC gp 3 hd seat/back	NI	Y					
K0851	PWC gp 3 hd cap chair	NI	Y					
K0852	PWC gp 3 vhd seat/back	NI	Y					
K0853	PWC gp 3 vhd cap chair	NI	Y					
K0854	PWC gp 3 xhd seat/back	NI	Y					
K0855	PWC gp 3 xhd cap chair	NI	Y					
K0856	PWC gp3 std sing pow opt s/b	NI	Y					
K0857	PWC gp3 std sing pow opt cap	NI	Y					
K0858	PWC gp3 hd sing pow opt s/b	NI	Y					
K0859	PWC gp3 hd sing pow opt cap	NI	Y					
K0860	PWC gp3 vhd sing pow opt s/b	NI	Y					
K0861	PWC gp3 std mult pow opt s/b	NI	Y					
K0862	PWC gp3 hd mult pow opt s/b	NI	Y					
K0863	PWC gp3 vhd mult pow opt s/b	NI	Y					
K0864	PWC gp3 xhd mult pow opt s/b	NI	Y					
K0868	PWC gp 4 std seat/back	NI	Y					
K0869	PWC gp 4 std cap chair	NI	Y					
K0870	PWC gp 4 hd seat/back	NI	Y					
K0871	PWC gp 4 vhd seat/back	NI	Y					
K0877	PWC gp4 std sing pow opt s/b	NI	Y					
K0878	PWC gp4 std sing pow opt cap	NI	Y					
K0879	PWC gp4 hd sing pow opt s/b	NI	Y					
K0880	PWC gp4 vhd sing pow opt s/b	NI	Y					
K0884	PWc gp4 std mult pow opt s/b	NI	Y					
K0885	PWC gp4 std mult pow opt cap	NI	Y					
K0886	PWC gp4 hd mult pow s/b	NI	Y					
K0890	PWC gp5 ped sing pow opt s/b	NI	Y					
K0891	PWC gp5 ped mult pow opt s/b	NI	Y					
K0898	Power wheelchair NOC	NI	Y					
K0899	Pow mobility dev no sadmerc	NI	Y					
L0100	Cranial orthosis/helmet mold	CH	D					
L0110	Cranial orthosis/helmet nonm	CH	D					
L1001	CTLSO infant immobilizer	NI	A					
L3806	WHFO w/joint(s) custom fab	NI	A					
L3808	WHFO, rigid w/o joints	NI	A					
L3902	Whfo ext power compress gas	CH	D					
L3914	WHO wrist extension cock-up	CH	D					
L3915	WHO w nontor jnt(s) prefab	NI	A					
L5993	Heavy duty feature, foot	NI	A					
L5994	Heavy duty feature, knee	NI	A					
L6611	Additional switch, ext power	NI	A					
L6624	Flex/ext/rotation wrist unit	NI	A					
L6639	Heavy duty elbow feature	NI	A					
L6700	Terminal device model #3	CH	D					
L6703	Term dev, passive hand mitt	NI	A					
L6704	Term dev, sport/rec/work att	NI	A					
L6705	Terminal device model #5	CH	D					
L6706	Term dev mech hook vol open	NI	A					
L6707	Term dev mech hook vol close	NI	A					
L6708	Term dev mech hand vol open	NI	A					
L6709	Term dev mech hand vol close	NI	A					
L6710	Terminal device model #5x	CH	D					
L6715	Terminal device model #5xa	CH	D					
L6720	Terminal device model #6	CH	D					
L6725	Terminal device model #7	CH	D					
L6730	Terminal device model #7lo	CH	D					
L6735	Terminal device model #8	CH	D					
L6740	Terminal device model #8x	CH	D					
L6745	Terminal device model #88x	CH	D					
L6750	Terminal device model #10p	CH	D					
L6755	Terminal device model #10x	CH	D					
L6765	Terminal device model #12p	CH	D					
L6770	Terminal device model #99x	CH	D					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L6775	Terminal device model#555	CH	D					
L6780	Terminal device model #ss555	CH	D					
L6790	Hooks-accu hook or equal	CH	D					
L6795	Hooks-2 load or equal	CH	D					
L6800	Hooks-aprl vc or equal	CH	D					
L6806	Trs grip vc or equal	CH	D					
L6807	Term device grip1/2 or equal	CH	D					
L6808	Term device infant or child	CH	D					
L6809	Trs super sport passive	CH	D					
L6825	Hands dorrance vo	CH	D					
L6830	Hand aprl vc	CH	D					
L6835	Hand sierra vo	CH	D					
L6840	Hand becker imperial	CH	D					
L6845	Hand becker lock grip	CH	D					
L6850	Term dvc-hand becker plylite	CH	D					
L6855	Hand robin-aids vo	CH	D					
L6860	Hand robin-aids vo soft	CH	D					
L6865	Hand passive hand	CH	D					
L6867	Hand detroit infant hand	CH	D					
L6868	Passive inf hand steeper/hos	CH	D					
L6870	Hand child mitt	CH	D					
L6872	Hand nyu child hand	CH	D					
L6873	Hand mech inf steeper or equ	CH	D					
L6875	Hand bock vc	CH	D					
L6880	Hand bock vo	CH	D					
L7007	Adult electric hand	NI	A					
L7008	Pediatric electric hand	NI	A					
L7009	Adult electric hook	NI	A					
L7010	Hand otto back steeper/eq sw	CH	D					
L7015	Hand sys teknik village swit	CH	D					
L7020	Electronic greifer switch ct	CH	D					
L7025	Electron hand myoelectronic	CH	D					
L7030	Hand sys teknik vill myoelec	CH	D					
L7035	Electron greifer myoelectro	CH	D					
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					
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					
L8682	Implt neurostim radiofq rec		N					
L8690	Aud osseo dev, int/ext comp	NI	H	1032				
L8691	Aud osseo dev, int/ext comp	NI	A					
L8695	External recharg sys extern	NI	A					
L8699	Prosthetic implant NOS		N					
M0064	Visit for drug monitoring		X	0374	1.1418	70.18		14.04
P9010	Whole blood for transfusion		K	0950	2.1472	131.98		26.40
P9011	Blood split unit		K	0967	2.2323	137.22		27.44
P9012	Cryoprecipitate each unit		K	0952	0.7905	48.59		9.72
P9016	RBC leukocytes reduced		K	0954	2.859	175.74		35.15
P9017	Plasma 1 donor frz w/in 8 hr		K	9508	1.1422	70.21		14.04
P9019	Platelets, each unit		K	0957	0.959	58.95		11.79
P9020	Plaelet rich plasma unit		K	0958	3.4048	209.29		41.86
P9021	Red blood cells unit		K	0959	2.1073	129.53		25.91
P9022	Washed red blood cells unit		K	0960	3.4331	211.03		42.21
P9023	Frozen plasma, pooled, sd		K	0949	0.9346	57.45		11.49
P9031	Platelets leukocytes reduced		K	1013	1.5469	95.08		19.02
P9032	Platelets, irradiated		K	9500	2.1079	129.57		25.91
P9033	Platelets leukoreduced irrad		K	0968	2.039	125.33		25.07
P9034	Platelets, pheresis		K	9507	7.3686	452.93		90.59
P9035	Platelet pheres leukoreduced		K	9501	7.9511	488.74		97.75

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
P9036	Platelet pheresis irradiated		K	9502	6.8088	418.52		83.70
P9037	Plate pheres leukoredu irrad		K	1019	10.0443	617.40		123.48
P9038	RBC irradiated		K	9505	3.2049	197.00		39.40
P9039	RBC deglycerolized		K	9504	5.8292	358.31		71.66
P9040	RBC leukoreduced irradiated		K	0969	3.5394	217.56		43.51
P9041	Albumin (human),5%, 50ml		K	0961		29.68		5.94
P9043	Plasma protein fract,5%,50ml		K	0956	0.8339	51.26		10.25
P9044	Cryoprecipitatereducedplasma		K	1009	1.3404	82.39		16.48
P9045	Albumin (human), 5%, 250 ml		K	0963		76.81		15.36
P9046	Albumin (human), 25%, 20 ml		K	0964		28.80		5.76
P9047	Albumin (human), 25%, 50ml		K	0965		65.26		13.05
P9048	Plasmaprotein fract,5%,250ml		K	0966	3.8746	238.16		47.63
P9050	Granulocytes, pheresis unit		K	9506	12.2073	750.36		150.07
P9051	Blood, l/r, cmv-neg		K	1010	2.5493	156.70		31.34
P9052	Platelets, hla-m, l/r, unit		K	1011	10.9263	671.62		134.32
P9053	Plt, pher, l/r cmv-neg, irr		K	1020	11.4755	705.38		141.08
P9054	Blood, l/r, froz/degly/wash		K	1016	3.4335	211.05		42.21
P9055	Plt, aph/pher, l/r, cmv-neg		K	1017	6.4556	396.81		79.36
P9056	Blood, l/r, irradiated		K	1018	2.3472	144.28		28.86
P9057	RBC, frz/deg/wsh, l/r, irrad		K	1021	8.0727	496.21		99.24
P9058	RBC, l/r, cmv-neg, irrad		K	1022	4.2653	262.18		52.44
P9059	Plasma, frz between 8–24hour		K	0955	1.2489	76.77		15.35
P9060	Fr frz plasma donor retested		K	9503	1.2119	74.49		14.90
P9612	Catheterize for urine spec	CH	A					
P9615	Urine specimen collect mult		N					
Q0035	Cardiokymography		X	0100	2.5336	155.74	41.44	31.15
Q0091	Obtaining screen pap smear		T	0191	0.1468	9.02	2.55	1.80
Q0092	Set up port xray equipment		N					
Q0163	Diphenhydramine HCl 50mg		N					
Q0164	Prochlorperazine maleate 5mg		N					
Q0166	Granisetron HCl 1 mg oral		K	0765		41.18		8.24
Q0167	Dronabinol 2.5mg oral		N					
Q0169	Promethazine HCl 12.5mg oral		N					
Q0171	Chlorpromazine HCl 10mg oral		N					
Q0173	Trimethobenzamide HCl 250mg		N					
Q0174	Thiethylperazine maleate10mg		N					
Q0175	Perphenazine 4mg oral		N					
Q0177	Hydroxyzine pamoate 25mg		N					
Q0179	Ondansetron HCl 8mg oral		K	0769		36.06		7.21
Q0180	Dolasetron mesylate oral		K	0763		48.91		9.78
Q0512	Px sup fee anti-can sub pres	CH	B					
Q0515	Sermorelin acetate injection	CH	K	3050		1.75		0.35
Q1003	NTIOL category 3		N					
Q1004	Ntiol category 4		N					
Q1005	Ntiol category 5		N					
Q2004	Bladder calculi irrig sol		N					
Q2009	Fosphenytoin, 50 mg		K	7028		5.59		1.12
Q2017	Teniposide, 50 mg		K	7035		264.88		52.98
Q3025	IM inj interferon beta 1-a		K	9022		108.04		21.61
Q3031	Collagen skin test		N					
Q4079	Natalizumab injection		G	9126		7.72		1.54
Q4081	Epoetin alfa, 100 units ESRD	NI	A					
Q4082	Drug/bio NOC part B drug CAP	NI	B					
Q5001	Hospice in patient home	NI	B					
Q5002	Hospice in assisted living	NI	B					
Q5003	Hospice in LT/non-skilled NF	NI	B					
Q5004	Hospice in SNF	NI	B					
Q5005	Hospice, inpatient hospital	NI	B					
Q5006	Hospice in hospice facility	NI	B					
Q5007	Hospice in LTCH	NI	B					
Q5008	Hospice in inpatient psych	NI	B					
Q5009	Hospice care, NOS	NI	B					
Q9945	LOCM ≦149 mg/ml iodine, 1ml		K	9157		0.29		0.06
Q9946	LOCM 150–199mg/ml iodine,1ml		K	9158		1.96		0.39
Q9947	LOCM 200–249mg/ml iodine,1ml		K	9159		1.42		0.28
Q9948	LOCM 250–299mg/ml iodine,1ml		K	9160		0.27		0.05
Q9949	LOCM 300–349mg/ml iodine,1ml		K	9161		0.35		0.07
Q9950	LOCM 350–399mg/ml iodine,1ml		K	9162		0.21		0.04
Q9951	LOCM ≧ 400 mg/ml iodine,1ml		K	9163		0.30		0.06
Q9952	Inj Gad-base MR contrast,1ml		K	9164		2.87		0.57

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q9953	Inj Fe-based MR contrast,1ml		K	1713		30.41		6.08
Q9954	Oral MR contrast, 100 ml		K	9165		8.90		1.78
Q9955	Inj perflexane lip micros,ml		K	9203		7.05		1.41
Q9956	Inj octafluoropropane mic,ml		K	9202		49.61		9.92
Q9957	Inj perflutren lip micros,ml		K	9112		61.64		12.33
Q9958	HOCM ≦149 mg/ml iodine, 1ml	CH	N					
Q9959	HOCM 150–199mg/ml iodine,1ml		N					
Q9960	HOCM 200–249mg/ml iodine,1ml	CH	N					
Q9961	HOCM 250–299mg/ml iodine,1ml	CH	N					
Q9962	HOCM 300–349mg/ml iodine,1ml	CH	N					
Q9963	HOCM 350–399mg/ml iodine,1ml	CH	N					
Q9964	HOCM≧ 400mg/ml iodine, 1ml	CH	N					
V2630	Anter chamber intraocul lens		N					
V2631	Iris support intraoclr lens		N					
V2632	Post chmbr intraocular lens		N					
V2790	Amniotic membrane		N					

ADDENDUM D1.—PAYMENT STATUS INDICATORS

Indicator	Item/code/service	OPPS payment status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital • Diagnostic Mammography • Screening Mammography	Not paid under OPPS. Paid by fiscal intermediaries under a fee schedule or payment system other than OPPS.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. • May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: • That are not covered by Medicare based on statutory exclusion. • That are not covered by Medicare for reasons other than statutory exclusion. • That are not recognized by Medicare but for which an alternate code for the same item or service may be available. • For which separate payment is not provided by Medicare.	Not paid under OPPS or any other Medicare payment system.
F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines.	Not paid under OPPS. Paid at reasonable cost.
G	Pass-Through Drugs and Biologicals	Paid under OPPS; Separate APC payment includes pass through amount.
H	(1) Pass-Through Device Categories	(1) Separate cost-based pass-through payment; Not subject to coinsurance.
	(2) Radiopharmaceutical Agents	(2) Separate cost-based non-pass-through payment.
K	(1) Non-Pass-Through Drugs, Biologicals, and	(1) Paid under OPPS; Separate APC payment.
	(2) Brachytherapy Sources	(2) Paid under OPPS; Separate APC payment.
	(3) Blood and Blood Products	(3) Paid under OPPS; Separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary	Not paid under OPPS.
N	Items and Services Packaged into APC Rates	Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.

ADDENDUM D1.—PAYMENT STATUS INDICATORS—Continued

Indicator	Item/code/service	OPPS payment status
Q	Packaged Services Subject to Separate Payment Under OPPS Payment Criteria.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Separate APC payment based on OPPS payment criteria. (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; Separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.
X	Ancillary Services	Paid under OPPS; Separate APC payment.

ADDENDUM D2.—COMMENT INDICATORS

Comment indicator	Descriptor
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.
CH	Active HCPCS code in current year and next calendar year, status indicator and/or APC assignment has changed; or active HCPCS code that is discontinued at the end of the current calendar year.

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES

CPT/ HCPCS	Description	CY 2007 SI
00176	Anesth, pharyngeal surgery.	C
00192	Anesth, facial bone surgery.	C
00214	Anesth, skull drainage	C
00215	Anesth, skull repair/fract	C
00452	Anesth, surgery of shoulder.	C
00474	Anesth, surgery of rib(s)	C
00524	Anesth, chest drainage	C
00540	Anesth, chest surgery	C
00542	Anesth, release of lung	C
00546	Anesth, lung,chest wall surg.	C
00560	Anesth, heart surg w/o pump.	C
00561	Anesth, heart surg <age 1.	C
00562	Anesth, heart surg w/ pump.	C
00580	Anesth, heart/lung transplnt.	C
00604	Anesth, sitting procedure	C
00622	Anesth, removal of nerves.	C
00632	Anesth, removal of nerves.	C
00670	Anesth, spine, cord surgery.	C
00792	Anesth, hemorr/excise liver.	C
00794	Anesth, pancreas removal.	C
00796	Anesth, for liver transplant.	C
00802	Anesth, fat layer removal.	C
00844	Anesth, pelvis surgery	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
01274	Anesth, femoral embolectomy.	C
01402	Anesth, knee arthroplasty.	C
01404	Anesth, amputation at knee.	C
01442	Anesth, knee artery surg	C
01444	Anesth, knee artery repair.	C
01486	Anesth, ankle replacement.	C
01502	Anesth, lwr leg embolectomy.	C
01632	Anesth, surgery of shoulder.	C
01634	Anesth, shoulder joint amput.	C
01636	Anesth, forequarter amput.	C
01638	Anesth, shoulder replacement.	C
01652	Anesth, shoulder vessel surg.	C
01654	Anesth, shoulder vessel surg.	C
01656	Anesth, arm-leg vessel surg.	C
01756	Anesth, radical humerus surg.	C
01990	Support for organ donor	C
11004	Debride genitalia & perineum.	C
11005	Debride abdom wall	C
11006	Debride genit/per/abdom wall.	C
11008	Remove mesh from abd wall.	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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	Spinal bone allograft	C
20931	Spinal bone allograft	C
20936	Spinal bone autograft	C
20937	Spinal bone autograft	C
20938	Spinal bone autograft	C
20955	Fibula bone graft, microvasc.	C
20956	Iliac bone graft, microvasc.	C
20957	Mt bone graft, microvasc	C
20962	Other bone graft, microvasc.	C
20969	Bone/skin graft, microvasc.	C
20970	Bone/skin graft, iliac crest.	C
21045	Extensive jaw surgery	C
21141	Reconstruct midface, lefort.	C
21142	Reconstruct midface, lefort.	C
21143	Reconstruct midface, lefort.	C
21145	Reconstruct midface, lefort.	C
21146	Reconstruct midface, lefort.	C
21147	Reconstruct midface, lefort.	C
21151	Reconstruct midface, lefort.	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
21154	Reconstruct midface, lefort.	C
21155	Reconstruct midface, lefort.	C
21159	Reconstruct midface, lefort.	C
21160	Reconstruct midface, lefort.	C
21172	Reconstruct orbit/forehead.	C
21179	Reconstruct entire forehead.	C
21180	Reconstruct entire forehead.	C
21182	Reconstruct cranial bone	C
21183	Reconstruct cranial bone	C
21184	Reconstruct cranial bone	C
21188	Reconstruction of midface.	C
21193	Reconst lwr jaw w/o graft.	C
21194	Reconst lwr jaw w/graft	C
21196	Reconst lwr jaw w/fixation.	C
21247	Reconstruct lower jaw bone.	C
21255	Reconstruct lower jaw bone.	C
21256	Reconstruction of orbit	C
21268	Revise eye sockets	C
21343	Treatment of sinus fracture.	C
21344	Treatment of sinus fracture.	C
21346	Treat nose/jaw fracture	C
21347	Treat nose/jaw fracture	C
21348	Treat nose/jaw fracture	C
21360	Treat cheek bone fracture.	C
21365	Treat cheek bone fracture.	C
21366	Treat cheek bone fracture.	C
21385	Treat eye socket fracture.	C
21386	Treat eye socket fracture.	C
21387	Treat eye socket fracture.	C
21395	Treat eye socket fracture.	C
21422	Treat mouth roof fracture.	C
21423	Treat mouth roof fracture.	C
21431	Treat craniofacial fracture.	C
21432	Treat craniofacial fracture.	C
21433	Treat craniofacial fracture.	C
21435	Treat craniofacial fracture.	C
21436	Treat craniofacial fracture.	C
21510	Drainage of bone lesion	C
21615	Removal of rib	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
21616	Removal of rib and nerves.	C
21620	Partial removal of sternum.	C
21627	Sternal debridement	C
21630	Extensive sternum surgery.	C
21632	Extensive sternum surgery.	C
21705	Revision of neck muscle/rib.	C
21740	Reconstruction of sternum.	C
21750	Repair of sternum separation.	C
21810	Treatment of rib fracture(s).	C
21825	Treat sternum fracture	C
22010	I&d, p-spine, c/t/cervthor.	C
22015	I&d, p-spine, l/s/ls	C
22110	Remove part of neck vertebra.	C
22112	Remove part, thorax vertebra.	C
22114	Remove part, lumbar vertebra.	C
22116	Remove extra spine segment.	C
22210	Revision of neck spine	C
22212	Revision of thorax spine	C
22214	Revision of lumbar spine	C
22216	Revise, extra spine segment.	C
22220	Revision of neck spine	C
22224	Revision of lumbar spine	C
22226	Revise, extra spine segment.	C
22318	Treat odontoid fx w/o graft.	C
22319	Treat odontoid fx w/graft	C
22325	Treat spine fracture	C
22326	Treat neck spine fracture.	C
22327	Treat thorax spine fracture.	C
22328	Treat each add spine fx	C
22532	Lat thorax spine fusion	C
22533	Lat lumbar spine fusion	C
22534	Lat thor/lumb, 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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
22812	Fusion of spine	C
22818	Kyphectomy, 1-2 segments.	C
22819	Kyphectomy, 3 or more	C
22830	Exploration of spinal fusion.	C
22840	Insert spine fixation device.	C
22841	Insert spine fixation device.	C
22842	Insert spine fixation device.	C
22843	Insert spine fixation device.	C
22844	Insert spine fixation device.	C
22845	Insert spine fixation device.	C
22846	Insert spine fixation device.	C
22847	Insert spine fixation device.	C
22848	Insert pelv fixation device.	C
22849	Reinsert spinal fixation	C
22850	Remove spine fixation device.	C
22852	Remove spine fixation device.	C
22855	Remove spine fixation device.	C
22857	Lumbar artif diskectomy	C
22862	Revise lumbar artif disc	C
22865	Remove lumb artif disc	C
23200	Removal of collar bone	C
23210	Removal of shoulder blade.	C
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
25931	Amputation follow-up surgery.	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
27006	Incision of hip tendons	C
27025	Incision of hip/thigh fascia.	C
27030	Drainage of hip joint	C
27036	Excision of hip joint/ muscle.	C
27054	Removal of hip joint lining.	C
27070	Partial removal of hip bone.	C
27071	Partial removal of hip bone.	C
27075	Extensive hip surgery	C
27076	Extensive hip surgery	C
27077	Extensive hip surgery	C
27078	Extensive hip surgery	C
27079	Extensive hip surgery	C
27090	Removal of hip prosthesis.	C
27091	Removal of hip prosthesis.	C
27120	Reconstruction of hip socket.	C
27122	Reconstruction of hip socket.	C
27125	Partial hip replacement	C
27130	Total hip arthroplasty	C
27132	Total hip arthroplasty	C
27134	Revise hip joint replacement.	C
27137	Revise hip joint replacement.	C
27138	Revise hip joint replacement.	C
27140	Transplant femur ridge	C
27146	Incision of hip bone	C
27147	Revision of hip bone	C
27151	Incision of hip bones	C
27156	Revision of hip bones	C
27158	Revision of pelvis	C
27161	Incision of neck of femur	C
27165	Incision/fixation of femur	C
27170	Repair/graft femur head/ neck.	C
27175	Treat slipped epiphysis	C
27176	Treat slipped epiphysis	C
27177	Treat slipped epiphysis	C
27178	Treat slipped epiphysis	C
27179	Revise head/neck of femur.	C
27181	Treat slipped epiphysis	C
27185	Revision of femur epiphysis.	C
27187	Reinforce hip bones	C
27215	Treat pelvic fracture(s)	C
27217	Treat pelvic ring fracture	C
27218	Treat pelvic ring fracture	C
27222	Treat hip socket fracture	C
27226	Treat hip wall fracture	C
27227	Treat hip fracture(s)	C
27228	Treat hip fracture(s)	C
27232	Treat thigh fracture	C
27236	Treat thigh fracture	C
27240	Treat thigh fracture	C
27244	Treat thigh fracture	C
27245	Treat thigh fracture	C
27248	Treat thigh fracture	C
27253	Treat hip dislocation	C
27254	Treat hip dislocation	C
27258	Treat hip dislocation	C
27259	Treat hip dislocation	C
27280	Fusion of sacroiliac joint	C
27282	Fusion of pubic bones	C
27284	Fusion of hip joint	C
27286	Fusion of hip joint	C
27290	Amputation of leg at hip	C
27295	Amputation of leg at hip	C
27303	Drainage of bone lesion	C
27365	Extensive leg surgery	C
27445	Revision of knee joint	C
27447	Total knee arthroplasty	C
27448	Incision of thigh	C
27450	Incision of thigh	C
27454	Realignment of thigh bone.	C
27455	Realignment of knee	C
27457	Realignment of knee	C
27465	Shortening of thigh bone	C
27466	Lengthening of thigh bone.	C
27468	Shorten/lengthen thighs	C
27470	Repair of thigh	C
27472	Repair/graft of thigh	C
27477	Surgery to stop leg growth.	C
27479	Surgery to stop leg growth.	C
27485	Surgery to stop leg growth.	C
27486	Revise/replace knee joint.	C
27487	Revise/replace knee joint.	C
27488	Removal of knee prosthesis.	C
27495	Reinforce thigh	C
27506	Treatment of thigh fracture.	C
27507	Treatment of thigh fracture.	C
27511	Treatment of thigh fracture.	C
27513	Treatment of thigh fracture.	C
27514	Treatment of thigh fracture.	C
27519	Treat thigh fx growth plate.	C
27535	Treat knee fracture	C
27536	Treat knee fracture	C
27540	Treat knee fracture	C
27556	Treat knee dislocation	C
27557	Treat knee dislocation	C
27558	Treat knee dislocation	C
27580	Fusion of knee	C
27590	Amputate leg at thigh	C
27591	Amputate leg at thigh	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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
27720	Repair of tibia	C
27722	Repair/graft of tibia	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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
32124	Explore chest free adhesions.	C
32140	Removal of lung lesion(s).	C
32141	Remove/treat lung lesions.	C
32150	Removal of lung lesion(s).	C
32151	Remove lung foreign body.	C
32160	Open chest heart massage.	C
32200	Drain, open, lung lesion	C
32215	Treat chest lining	C
32220	Release of lung	C
32225	Partial release of lung	C
32310	Removal of chest lining	C
32320	Free/remove chest lining	C
32402	Open biopsy chest lining	C
32440	Removal of lung	C
32442	Sleeve pneumonectomy	C
32445	Removal of lung	C
32480	Partial removal of lung	C
32482	Bilobectomy	C
32484	Segmentectomy	C
32486	Sleeve lobectomy	C
32488	Completion pneumonectomy.	C
32491	Lung volume reduction	C
32500	Partial removal of lung	C
32501	Repair bronchus add-on	C
32503	Resect apical lung tumor	C
32504	Resect apical lung tum/chest.	C
32540	Removal of lung lesion	C
32650	Thoracoscopy, surgical	C
32651	Thoracoscopy, surgical	C
32652	Thoracoscopy, surgical	C
32653	Thoracoscopy, surgical	C
32654	Thoracoscopy, surgical	C
32655	Thoracoscopy, surgical	C
32656	Thoracoscopy, surgical	C
32657	Thoracoscopy, surgical	C
32658	Thoracoscopy, surgical	C
32659	Thoracoscopy, surgical	C
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
32900	Removal of rib(s)	C
32905	Revise & repair chest wall.	C
32906	Revise & repair chest wall.	C
32940	Revision of lung	C
32997	Total lung lavage	C
33015	Incision of heart sac	C
33020	Incision of heart sac	C
33025	Incision of heart sac	C
33030	Partial removal of heart sac.	C
33031	Partial removal of heart sac.	C
33050	Removal of heart sac lesion.	C
33120	Removal of heart lesion	C
33130	Removal of heart lesion	C
33140	Heart revascularize (tmr)	C
33141	Heart tmr w/other procedure.	C
33202	Insert epicard eltrd, open.	C
33203	Insert epicard eltrd, endo.	C
33236	Remove electrode/thoracotomy.	C
33237	Remove electrode/thoracotomy.	C
33238	Remove electrode/thoracotomy.	C
33243	Remove eltrd/thoracotomy.	C
33250	Ablate heart dysrhythm focus.	C
33251	Ablate heart dysrhythm focus.	C
33254	Ablate atria, lmtd	C
33255	Ablate atria w/o bypass, ext.	C
33256	Ablate atria w/bypass, exten.	C
33261	Ablate heart dysrhythm focus.	C
33265	Ablate atria w/bypass, endo.	C
33266	Ablate atria w/o bypass endo.	C
33300	Repair of heart wound	C
33305	Repair of heart wound	C
33310	Exploratory heart surgery.	C
33315	Exploratory heart surgery.	C
33320	Repair major blood vessel(s).	C
33321	Repair major vessel	C
33322	Repair major blood vessel(s).	C
33330	Insert major vessel graft	C
33332	Insert major vessel graft	C
33335	Insert major vessel graft	C
33400	Repair of aortic valve	C
33401	Valvuloplasty, open	C
33403	Valvuloplasty, w/cp bypass.	C
33404	Prepare heart-aorta conduit.	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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
33602	Closure of valve	C
33606	Anastomosis/artery-aorta	C
33608	Repair anomaly w/conduit.	C
33610	Repair by enlargement	C
33611	Repair double ventricle	C
33612	Repair double ventricle	C
33615	Repair, modified fontan	C
33617	Repair single ventricle	C
33619	Repair single ventricle	C
33641	Repair heart septum defect.	C
33645	Revision of heart veins	C
33647	Repair heart septum defects.	C
33660	Repair of heart defects	C
33665	Repair of heart defects	C
33670	Repair of heart chambers.	C
33675	Close mult vsd	C
33676	Close mult vsd w/resection.	C
33677	Cl mult vsd w/rem pul band.	C
33681	Repair heart septum defect.	C
33684	Repair heart septum defect.	C
33688	Repair heart septum defect.	C
33690	Reinforce pulmonary artery.	C
33692	Repair of heart defects	C
33694	Repair of heart defects	C
33697	Repair of heart defects	C
33702	Repair of heart defects	C
33710	Repair of heart defects	C
33720	Repair of heart defect	C
33722	Repair of heart defect	C
33724	Repair venous anomaly	C
33726	Repair pul venous stenosis.	C
33730	Repair heart-vein defect(s).	C
33732	Repair heart-vein defect	C
33735	Revision of heart chamber.	C
33736	Revision of heart chamber.	C
33737	Revision of heart chamber.	C
33750	Major vessel shunt	C
33755	Major vessel shunt	C
33762	Major vessel shunt	C
33764	Major vessel shunt & graft.	C
33766	Major vessel shunt	C
33767	Major vessel shunt	C
33768	Cavopulmonary shunting	C
33770	Repair great vessels defect.	C
33771	Repair great vessels defect.	C
33774	Repair great vessels defect.	C
33775	Repair great vessels defect.	C
33776	Repair great vessels defect.	C
33777	Repair great vessels defect.	C
33778	Repair great vessels defect.	C
33779	Repair great vessels defect.	C
33780	Repair great vessels defect.	C
33781	Repair great vessels defect.	C
33786	Repair arterial trunk	C
33788	Revision of pulmonary artery.	C
33800	Aortic suspension	C
33802	Repair vessel defect	C
33803	Repair vessel defect	C
33813	Repair septal defect	C
33814	Repair septal defect	C
33820	Revise major vessel	C
33822	Revise major vessel	C
33824	Revise major vessel	C
33840	Remove aorta constriction.	C
33845	Remove aorta constriction.	C
33851	Remove aorta constriction.	C
33852	Repair septal defect	C
33853	Repair septal defect	C
33860	Ascending aortic graft	C
33861	Ascending aortic graft	C
33863	Ascending aortic graft	C
33870	Transverse aortic arch graft.	C
33875	Thoracic aortic graft	C
33877	Thoracoabdominal graft	C
33880	Endovasc taa repr incl subcl.	C
33881	Endovasc taa repr w/o subcl.	C
33883	Insert endovasc prosth, taa.	C
33884	Endovasc prosth, taa, add-on.	C
33886	Endovasc prosth, delayed.	C
33889	Artery transpose/endovas taa.	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
34808	Endovas iliac a device addon.	C
34812	Xpose for endoprosth, femorl.	C
34813	Femoral endovas graft add-on.	C
34820	Xpose for endoprosth, iliac.	C
34825	Endovasc extend prosth, init.	C
34826	Endovasc exten prosth, add?l.	C
34830	Open aortic tube prosth repr.	C
34831	Open aortoiliac prosth repr.	C
34832	Open aortofemor prosth repr.	C
34833	Xpose for endoprosth, iliac.	C
34834	Xpose, endoprosth, brachial.	C
34900	Endovasc iliac repr w/ graft.	C
35001	Repair defect of artery	C
35002	Repair artery rupture, neck.	C
35005	Repair defect of artery	C
35013	Repair artery rupture, arm.	C
35021	Repair defect of artery	C
35022	Repair artery rupture, chest.	C
35045	Repair defect of arm artery.	C
35081	Repair defect of artery	C
35082	Repair artery rupture, aorta.	C
35091	Repair defect of artery	C
35092	Repair artery rupture, aorta.	C
35102	Repair defect of artery	C
35103	Repair artery rupture, groin.	C
35111	Repair defect of artery	C
35112	Repair artery rupture,spleen.	C
35121	Repair defect of artery	C
35122	Repair artery rupture, belly.	C
35131	Repair defect of artery	C
35132	Repair artery rupture, groin.	C
35141	Repair defect of artery	C
35142	Repair artery rupture, thigh.	C
35151	Repair defect of artery	C
35152	Repair artery rupture, knee.	C
35182	Repair blood vessel lesion.	C
35189	Repair blood vessel lesion.	C
35211	Repair blood vessel lesion.	C
35216	Repair blood vessel lesion.	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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
35525	Artery bypass graft	C
35526	Artery bypass graft	C
35531	Artery bypass graft	C
35533	Artery bypass graft	C
35536	Artery bypass graft	C
35537	Artery bypass graft	C
35538	Artery bypass graft	C
35539	Artery bypass graft	C
35540	Artery bypass graft	C
35548	Artery bypass graft	C
35549	Artery bypass graft	C
35551	Artery bypass graft	C
35556	Artery bypass graft	C
35558	Artery bypass graft	C
35560	Artery bypass graft	C
35563	Artery bypass graft	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
35565	Artery bypass graft	C
35566	Artery bypass graft	C
35571	Artery bypass graft	C
35583	Vein bypass graft	C
35585	Vein bypass graft	C
35587	Vein bypass graft	C
35600	Harvest artery for cabg	C
35601	Artery bypass graft	C
35606	Artery bypass graft	C
35612	Artery bypass graft	C
35616	Artery bypass graft	C
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
37215	Transcath stent, cca w/ eps.	C
37616	Ligation of chest artery	C
37617	Ligation of abdomen artery.	C
37618	Ligation of extremity artery.	C
37660	Revision of major vein	C
37788	Revascularization, penis	C
38100	Removal of spleen, total	C
38101	Removal of spleen, partial.	C
38102	Removal of spleen, total	C
38115	Repair of ruptured spleen.	C
38380	Thoracic duct procedure	C
38381	Thoracic duct procedure	C
38382	Thoracic duct procedure	C
38562	Removal, pelvic lymph nodes.	C
38564	Removal, abdomen lymph nodes.	C
38724	Removal of lymph nodes, neck.	C
38746	Remove thoracic lymph nodes.	C
38747	Remove abdominal lymph nodes.	C
38765	Remove groin lymph nodes.	C
38770	Remove pelvis lymph nodes.	C
38780	Remove abdomen lymph nodes.	C
39000	Exploration of chest	C
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
41145	Tongue removal, neck surgery.	C
41150	Tongue, mouth, jaw surgery.	C
41153	Tongue, mouth, neck surgery.	C
41155	Tongue, jaw, & neck surgery.	C
42426	Excise parotid gland/lesion.	C
42845	Extensive surgery of throat.	C
42894	Revision of pharyngeal walls.	C
42953	Repair throat, esophagus.	C
42961	Control throat bleeding	C
42971	Control nose/throat bleeding.	C
43045	Incision of esophagus	C
43100	Excision of esophagus lesion.	C
43101	Excision of esophagus lesion.	C
43107	Removal of esophagus	C
43108	Removal of esophagus	C
43112	Removal of esophagus	C
43113	Removal of esophagus	C
43116	Partial removal of esophagus.	C
43117	Partial removal of esophagus.	C
43118	Partial removal of esophagus.	C
43121	Partial removal of esophagus.	C
43122	Partial removal of esophagus.	C
43123	Partial removal of esophagus.	C
43124	Removal of esophagus	C
43135	Removal of esophagus pouch.	C
43300	Repair of esophagus	C
43305	Repair esophagus and fistula.	C
43310	Repair of esophagus	C
43312	Repair esophagus and fistula.	C
43313	Esophagoplasty congenital.	C
43314	Tracheo-esophagoplasty cong.	C
43320	Fuse esophagus & stomach.	C
43324	Revise esophagus & stomach.	C
43325	Revise esophagus & stomach.	C
43326	Revise esophagus & stomach.	C
43330	Repair of esophagus	C
43331	Repair of esophagus	C
43340	Fuse esophagus & intestine.	C
43341	Fuse esophagus & intestine.	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
43350	Surgical opening, esophagus.	C
43351	Surgical opening, esophagus.	C
43352	Surgical opening, esophagus.	C
43360	Gastrointestinal repair	C
43361	Gastrointestinal repair	C
43400	Ligate esophagus veins	C
43401	Esophagus surgery for veins.	C
43405	Ligate/staple esophagus	C
43410	Repair esophagus wound.	C
43415	Repair esophagus wound.	C
43420	Repair esophagus opening.	C
43425	Repair esophagus opening.	C
43460	Pressure treatment esophagus.	C
43496	Free jejunum flap, microvasc.	C
43500	Surgical opening of stomach.	C
43501	Surgical repair of stomach.	C
43502	Surgical repair of stomach.	C
43520	Incision of pyloric muscle.	C
43605	Biopsy of stomach	C
43610	Excision of stomach lesion.	C
43611	Excision of stomach lesion.	C
43620	Removal of stomach	C
43621	Removal of stomach	C
43622	Removal of stomach	C
43631	Removal of stomach, partial.	C
43632	Removal of stomach, partial.	C
43633	Removal of stomach, partial.	C
43634	Removal of stomach, partial.	C
43635	Removal of stomach, partial.	C
43640	Vagotomy & pylorus repair.	C
43641	Vagotomy & pylorus repair.	C
43644	Lap gastric bypass/roux-en-y.	C
43645	Lap gastr bypass incl smll i.	C
43770	Lap, place gastr adjust band.	C
43771	Lap, revise adjust gast band.	C
43772	Lap, remove adjust gast band.	C
43773	Lap, change adjust gast band.	C
43774	Lap remov adj gast band/port.	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
43800	Reconstruction of pylorus.	C
43810	Fusion of stomach and bowel.	C
43820	Fusion of stomach and bowel.	C
43825	Fusion of stomach and bowel.	C
43832	Place gastrostomy tube	C
43840	Repair of stomach lesion	C
43843	Gastroplasty w/o v-band	C
43845	Gastroplasty duodenal switch.	C
43846	Gastric bypass for obesity.	C
43847	Gastric bypass incl small i.	C
43848	Revision gastroplasty	C
43850	Revise stomach-bowel fusion.	C
43855	Revise stomach-bowel fusion.	C
43860	Revise stomach-bowel fusion.	C
43865	Revise stomach-bowel fusion.	C
43880	Repair stomach-bowel fistula.	C
43881	Impl/redo electrd, antrum.	C
43882	Revise/remove electrd antrum.	C
44005	Freeing of bowel adhesion.	C
44010	Incision of small bowel	C
44015	Insert needle cath bowel	C
44020	Explore small intestine	C
44021	Decompress small bowel.	C
44025	Incision of large bowel	C
44050	Reduce bowel obstruction.	C
44055	Correct malrotation of bowel.	C
44110	Excise intestine lesion(s)	C
44111	Excision of bowel lesion(s).	C
44120	Removal of small intestine.	C
44121	Removal of small intestine.	C
44125	Removal of small intestine.	C
44126	Enterectomy w/o taper, cong.	C
44127	Enterectomy w/taper, cong.	C
44128	Enterectomy cong, add-on.	C
44130	Bowel to bowel fusion	C
44132	Enterectomy, cadaver donor.	C
44133	Enterectomy, live donor	C
44135	Intestine transplnt, cadaver.	C
44136	Intestine transplant, live	C
44137	Remove intestinal allograft.	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
44139	Mobilization of colon	C
44140	Partial removal of colon	C
44141	Partial removal of colon	C
44143	Partial removal of colon	C
44144	Partial removal of colon	C
44145	Partial removal of colon	C
44146	Partial removal of colon	C
44147	Partial removal of colon	C
44150	Removal of colon	C
44151	Removal of colon/ileostomy.	C
44155	Removal of colon/ileostomy.	C
44156	Removal of colon/ileostomy.	C
44157	Colectomy w/ileoanal anast.	C
44158	Colectomy w/neo-rectum pouch.	C
44160	Removal of colon	C
44187	Lap, ileo/jejuno-stomy	C
44188	Lap, colostomy	C
44202	Lap, enterectomy	C
44203	Lap resect s/intestine, addl.	C
44204	Laparo partial colectomy	C
44205	Lap colectomy part w/ ileum.	C
44210	Laparo total proctocolectomy.	C
44211	Lap colectomy w/ proctectomy.	C
44212	Laparo total proctocolectomy.	C
44227	Lap, close enterostomy	C
44300	Open bowel to skin	C
44310	Ileostomy/jejunostomy	C
44314	Revision of ileostomy	C
44316	Devise bowel pouch	C
44320	Colostomy	C
44322	Colostomy with biopsies	C
44345	Revision of colostomy	C
44346	Revision of colostomy	C
44602	Suture, small intestine	C
44603	Suture, small intestine	C
44604	Suture, large intestine	C
44605	Repair of bowel lesion	C
44615	Intestinal stricturoplasty	C
44620	Repair bowel opening	C
44625	Repair bowel opening	C
44626	Repair bowel opening	C
44640	Repair bowel-skin fistula	C
44650	Repair bowel fistula	C
44660	Repair bowel-bladder fistula.	C
44661	Repair bowel-bladder fistula.	C
44680	Surgical revision, intestine.	C
44700	Suspend bowel w/prosthesis.	C
44715	Prepare donor intestine	C
44720	Prep donor intestine/venous.	C
44721	Prep donor intestine/artery.	C
44800	Excision of bowel pouch	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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 proctopexy	C
45402	Lap proctopexy w/sig resect.	C
45540	Correct rectal prolapse	C
45550	Repair rectum/remove sigmoid.	C
45562	Exploration/repair of rectum.	C
45563	Exploration/repair of rectum.	C
45800	Repair rect/bladder fistula.	C
45805	Repair fistula w/colostomy.	C
45820	Repair rectourethral fistula.	C
45825	Repair fistula w/colostomy.	C
46705	Repair of anal stricture	C
46710	Repr per/vag pouch sngl proc.	C
46712	Repr per/vag pouch dbl proc.	C
46715	Rep perf anoper fistu	C
46716	Rep perf anoper/vestib fistu.	C
46730	Construction of absent anus.	C
46735	Construction of absent anus.	C
46740	Construction of absent anus.	C
46742	Repair of imperforated anus.	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
46744	Repair of cloacal anomaly.	C
46746	Repair of cloacal anomaly.	C
46748	Repair of cloacal anomaly.	C
46751	Repair of anal sphincter	C
47010	Open drainage, liver lesion.	C
47015	Inject/aspirate liver cyst	C
47100	Wedge biopsy of liver	C
47120	Partial removal of liver	C
47122	Extensive removal of liver.	C
47125	Partial removal of liver	C
47130	Partial removal of liver	C
47133	Removal of donor liver	C
47135	Transplantation of liver	C
47136	Transplantation of liver	C
47140	Partial removal, donor liver.	C
47141	Partial removal, donor liver.	C
47142	Partial removal, donor liver.	C
47143	Prep donor liver, whole	C
47144	Prep donor liver, 3-segment.	C
47145	Prep donor liver, lobe split.	C
47146	Prep donor liver/venous	C
47147	Prep donor liver/arterial	C
47300	Surgery for liver lesion	C
47350	Repair liver wound	C
47360	Repair liver wound	C
47361	Repair liver wound	C
47362	Repair liver wound	C
47380	Open ablate liver tumor rf.	C
47381	Open ablate liver tumor cryo.	C
47400	Incision of liver duct	C
47420	Incision of bile duct	C
47425	Incision of bile duct	C
47460	Incise bile duct sphincter	C
47480	Incision of gallbladder	C
47550	Bile duct endoscopy add-on.	C
47570	Laparo cholecystoenterostomy.	C
47600	Removal of gallbladder	C
47605	Removal of gallbladder	C
47610	Removal of gallbladder	C
47612	Removal of gallbladder	C
47620	Removal of gallbladder	C
47700	Exploration of bile ducts	C
47701	Bile duct revision	C
47711	Excision of bile duct tumor.	C
47712	Excision of bile duct tumor.	C
47715	Excision of bile duct cyst	C
47719	Fusion of bile duct cyst	C
47720	Fuse gallbladder & bowel.	C
47721	Fuse upper gi structures	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
49040	Drain, open, abdom abscess.	C
49060	Drain, open, retrop abscess.	C
49062	Drain to peritoneal cavity	C
49201	Remove abdom lesion, complex.	C
49215	Excise sacral spine tumor.	C
49220	Multiple surgery, abdomen.	C
49255	Removal of omentum	C
49425	Insert abdomen-venous drain.	C
49428	Ligation of shunt	C
49605	Repair umbilical lesion	C
49606	Repair umbilical lesion	C
49610	Repair umbilical lesion	C
49611	Repair umbilical lesion	C
49900	Repair of abdominal wall	C
49904	Omental flap, extra-abdom.	C
49905	Omental flap, intra-abdom.	C
49906	Free omental flap, microvasc.	C
50010	Exploration of kidney	C
50040	Drainage of kidney	C
50045	Exploration of kidney	C
50060	Removal of kidney stone	C
50065	Incision of kidney	C
50070	Incision of kidney	C
50075	Removal of kidney stone	C
50100	Revise kidney blood vessels.	C
50120	Exploration of kidney	C
50125	Explore and drain kidney	C
50130	Removal of kidney stone	C
50135	Exploration of kidney	C
50205	Biopsy of kidney	C
50220	Remove kidney, open	C
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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
50580	Kidney endoscopy & treatment.	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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
51060	Removal of ureter stone	C
51525	Removal of bladder lesion.	C
51530	Removal of bladder lesion.	C
51535	Repair of ureter 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
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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
58805	Drainage of ovarian cyst(s).	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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
60254	Extensive thyroid surgery.	C
60270	Removal of thyroid	C
60271	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
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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
61770	Incise skull for treatment	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
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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
69970	Remove inner ear lesion	C
75900	Intravascular cath exchange.	C
75952	Endovasc repair abdom aorta.	C
75953	Abdom aneurysm endovas rpr.	C
75954	Iliac aneurysm endovas rpr.	C
75956	Xray, endovasc thor ao repr.	C
75957	Xray, endovasc thor ao repr.	C
75958	Xray, place prox ext thor ao.	C
75959	Xray, place dist ext thor ao.	C
92970	Cardioassist, internal	C
92971	Cardioassist, external	C
92975	Dissolve clot, heart vessel.	C
92992	Revision of heart chamber.	C
92993	Revision of heart chamber.	C
99190	Special pump services	C
99191	Special pump services	C
99192	Special pump services	C
99251	Inpatient consultation	C
99252	Inpatient consultation	C
99253	Inpatient consultation	C
99254	Inpatient consultation	C
99255	Inpatient consultation	C
99293	Ped critical care, initial	C
99294	Ped critical care, subseq	C
99295	Neonate crit care, initial	C
99296	Neonate critical care subseq.	C
99298	Ic for lbw infant <1500 gm.	C
99299	Ic, lbw infant 1500-2500 gm.	C
99356	Prolonged service, inpatient.	C
99357	Prolonged service, inpatient.	C
99433	Normal newborn care/ hospital.	C
0024T	Transcath cardiac reduction.	C
0048T	Implant ventricular device.	C
0049T	External circulation assist.	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Description	CY 2007 SI
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
0092T	Artific disc addl	C
0093T	Cervical artific diskectomy.	C
0095T	Artific diskectomy addl	C
0096T	Rev cervical artific disc	C
0098T	Rev artific disc addl	C
0153T	Tcath sensor aneurysm sac.	C
0157T	Open impl gast curve electrd.	C
0158T	Open remv gast curve electrd.	C
0163T	Lumb artif diskectomy addl.	C
0164T	Remove lumb artif disc addl.	C
0165T	Revise lumb artif disc addl.	C
0166T	Tcath vsd close w/o bypass.	C
0167T	Tcath vsd close w bypass.	C
0169T	Place stereo cath brain	C
G0341	Percutaneous islet celltrans.	C
G0342	Laparoscopy islet cell trans.	C
G0343	Laparotomy islet cell transp.	C

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT

Provider No.	Out-migration adjustment	Qualifying county name
010005	0.0259	MARSHALL
010008	0.0212	CRENSHAW
010009	0.0092	MORGAN
010010	0.0259	MARSHALL
010012	0.0205	DE KALB
010022	0.0714	CHEROKEE
010025	0.0235	CHAMBERS
010029	0.0107	LEE
010035	0.0375	CULLMAN
010038	0.0062	CALHOUN

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
010045	0.0160	FAYETTE
010047	0.0155	BUTLER
010052	0.0103	TALLAPOOSA
010054	0.0092	MORGAN
010061	0.0506	JACKSON
010065	0.0103	TALLAPOOSA
010078	0.0062	CALHOUN
010083	0.0121	BALDWIN
010085	0.0092	MORGAN
010100	0.0121	BALDWIN
010101	0.0310	TALLADEGA
010109	0.0451	PICKENS
010129	0.0121	BALDWIN
010143	0.0375	CULLMAN
010146	0.0062	CALHOUN
010150	0.0155	BUTLER
010158	0.0093	FRANKLIN
010164	0.0310	TALLADEGA
013027	0.0121	BALDWIN
014008	0.0121	BALDWIN
014009	0.0092	MORGAN
040014	0.0159	WHITE
040019	0.0697	ST. FRANCIS
040047	0.0090	RANDOLPH
040069	0.0140	MISSISSIPPI
040071	0.0026	JEFFERSON
040076	0.1075	HOT SPRING
040100	0.0159	WHITE
042007	0.0026	JEFFERSON
050008	0.0026	SAN FRANCISCO
050009	0.0478	NAPA
050013	0.0478	NAPA
050014	0.0131	AMADOR
050016	0.0103	SAN LUIS OBISPO
050042	0.0219	TEHAMA
050046	0.0156	VENTURA
050047	0.0026	SAN FRANCISCO
050055	0.0026	SAN FRANCISCO
050065	0.0029	ORANGE
050069	0.0029	ORANGE
050073	0.0269	SOLANO
050076	0.0026	SAN FRANCISCO
050082	0.0156	VENTURA
050084	0.0555	SAN JOAQUIN
050089	0.0152	SAN BERNARDINO
050090	0.0308	SONOMA
050099	0.0152	SAN BERNARDINO
050101	0.0269	SOLANO
050117	0.0463	MERCED
050118	0.0555	SAN JOAQUIN
050122	0.0555	SAN JOAQUIN
050129	0.0152	SAN BERNARDINO
050133	0.0170	YUBA
050136	0.0308	SONOMA
050140	0.0152	SAN BERNARDINO
050150	0.0316	NEVADA
050152	0.0026	SAN FRANCISCO
050159	0.0156	VENTURA
050167	0.0555	SAN JOAQUIN
050168	0.0029	ORANGE
050173	0.0029	ORANGE
050174	0.0308	SONOMA
050193	0.0029	ORANGE
050194	0.0052	SANTA CRUZ
050224	0.0029	ORANGE
050226	0.0029	ORANGE
050228	0.0026	SAN FRANCISCO
050230	0.0029	ORANGE
050232	0.0103	SAN LUIS OBISPO

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
050236	0.0156	VENTURA
050242	0.0052	SANTA CRUZ
050245	0.0152	SAN BERNARDINO
050272	0.0152	SAN BERNARDINO
050279	0.0152	SAN BERNARDINO
050291	0.0308	SONOMA
050298	0.0152	SAN BERNARDINO
050300	0.0152	SAN BERNARDINO
050313	0.0555	SAN JOAQUIN
050325	0.0176	TUOLUMNE
050327	0.0152	SAN BERNARDINO
050335	0.0176	TUOLUMNE
050336	0.0555	SAN JOAQUIN
050348	0.0029	ORANGE
050367	0.0269	SOLANO
050385	0.0308	SONOMA
050394	0.0156	VENTURA
050407	0.0026	SAN FRANCISCO
050426	0.0029	ORANGE
050444	0.0463	MERCED
050454	0.0026	SAN FRANCISCO
050457	0.0026	SAN FRANCISCO
050469	0.0152	SAN BERNARDINO
050476	0.0257	LAKE
050494	0.0316	NEVADA
050506	0.0103	SAN LUIS OBISPO
050517	0.0152	SAN BERNARDINO
050526	0.0029	ORANGE
050528	0.0463	MERCED
050535	0.0029	ORANGE
050543	0.0029	ORANGE
050547	0.0308	SONOMA
050548	0.0029	ORANGE
050549	0.0156	VENTURA
050550	0.0029	ORANGE
050551	0.0029	ORANGE
050567	0.0029	ORANGE
050568	0.0062	MADERA
050570	0.0029	ORANGE
050580	0.0029	ORANGE
050584	0.0152	SAN BERNARDINO
050585	0.0029	ORANGE
050586	0.0152	SAN BERNARDINO
050589	0.0029	ORANGE
050592	0.0029	ORANGE
050594	0.0029	ORANGE
050603	0.0029	ORANGE
050609	0.0029	ORANGE
050616	0.0156	VENTURA
050618	0.0152	SAN BERNARDINO
050633	0.0103	SAN LUIS OBISPO
050667	0.0478	NAPA
050668	0.0026	SAN FRANCISCO
050678	0.0029	ORANGE
050680	0.0269	SOLANO
050690	0.0308	SONOMA
050693	0.0029	ORANGE
050695	0.0555	SAN JOAQUIN
050714	0.0052	SANTA CRUZ
050720	0.0029	ORANGE
050728	0.0308	SONOMA
050744	0.0029	ORANGE
050745	0.0029	ORANGE
050746	0.0029	ORANGE
050747	0.0029	ORANGE
050749	0.0156	VENTURA
052035	0.0029	ORANGE
052037	0.0152	SAN BERNARDINO
052039	0.0029	ORANGE

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
053034 ...	0.0029	ORANGE
053037 ...	0.0152	SAN BERNARDINO
053304 ...	0.0029	ORANGE
053306 ...	0.0029	ORANGE
053308 ...	0.0029	ORANGE
054074 ...	0.0269	SOLANO
054077 ...	0.0156	VENTURA
054089 ...	0.0026	SAN FRANCISCO
054093 ...	0.0152	SAN BERNARDINO
054111 ...	0.0152	SAN BERNARDINO
054122 ...	0.0478	NAPA
054123 ...	0.0555	SAN JOAQUIN
054135 ...	0.0029	ORANGE
054141 ...	0.0269	SOLANO
054144 ...	0.0026	SAN FRANCISCO
060001 ...	0.0294	WELD
060003 ...	0.0203	BOULDER
060010 ...	0.0153	LARIMER
060027 ...	0.0203	BOULDER
060030 ...	0.0153	LARIMER
060103 ...	0.0203	BOULDER
060116 ...	0.0203	BOULDER
063033 ...	0.0153	LARIMER
064007 ...	0.0203	BOULDER
070003 ...	0.0009	WINDHAM
070006 ...	0.0047	FAIRFIELD
070010 ...	0.0047	FAIRFIELD
070018 ...	0.0047	FAIRFIELD
070020 ...	0.0073	MIDDLESEX
070021 ...	0.0009	WINDHAM
070028 ...	0.0047	FAIRFIELD
070033 ...	0.0047	FAIRFIELD
070034 ...	0.0047	FAIRFIELD
074000 ...	0.0047	FAIRFIELD
074003 ...	0.0073	MIDDLESEX
074012 ...	0.0047	FAIRFIELD
074014 ...	0.0047	FAIRFIELD
080001 ...	0.0063	NEW CASTLE
080003 ...	0.0063	NEW CASTLE
082000 ...	0.0063	NEW CASTLE
083300 ...	0.0063	NEW CASTLE
084001 ...	0.0063	NEW CASTLE
084002 ...	0.0063	NEW CASTLE
084003 ...	0.0063	NEW CASTLE
100014 ...	0.0118	VOLUSIA
100017 ...	0.0118	VOLUSIA
100045 ...	0.0118	VOLUSIA
100047 ...	0.0021	CHARLOTTE
100062 ...	0.0060	MARION
100068 ...	0.0118	VOLUSIA
100072 ...	0.0118	VOLUSIA
100077 ...	0.0021	CHARLOTTE
100102 ...	0.0125	COLUMBIA
100118 ...	0.0398	FLAGLER
100156 ...	0.0125	COLUMBIA
100175 ...	0.0231	DE SOTO
100212 ...	0.0060	MARION
100232 ...	0.0347	PUTNAM
100236 ...	0.0021	CHARLOTTE
100252 ...	0.0233	OKEECHOBEE
100290 ...	0.0582	SUMTER
110023 ...	0.0500	GORDON
110027 ...	0.0387	FRANKLIN
110029 ...	0.0063	HALL
110041 ...	0.0777	HABERSHAM
110069 ...	0.0474	HOUSTON
110124 ...	0.0428	WAYNE
110146 ...	0.0805	CAMDEN
110150 ...	0.0261	BALDWIN

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
110153 ...	0.0474	HOUSTON
110187 ...	0.1172	LUMPKIN
110189 ...	0.0031	FANNIN
110190 ...	0.0182	MACON
110205 ...	0.0779	GILMER
114018 ...	0.0261	BALDWIN
130003 ...	0.0095	NEZ PERCE
130024 ...	0.0275	BONNER
130049 ...	0.0349	KOOTENAI
130066 ...	0.0349	KOOTENAI
140012 ...	0.0220	LEE
140026 ...	0.0346	LA SALLE
140033 ...	0.0147	LAKE
140043 ...	0.0046	WHITESIDE
140058 ...	0.0081	MORGAN
140084 ...	0.0147	LAKE
140100 ...	0.0147	LAKE
140110 ...	0.0346	LA SALLE
140130 ...	0.0147	LAKE
140155 ...	0.0027	KANKAKEE
140160 ...	0.0286	STEPHENSON
140161 ...	0.0138	LIVINGSTON
140186 ...	0.0027	KANKAKEE
140202 ...	0.0147	LAKE
140205 ...	0.0163	BOONE
140234 ...	0.0346	LA SALLE
140291 ...	0.0147	LAKE
150006 ...	0.0113	LA PORTE
150015 ...	0.0113	LA PORTE
150022 ...	0.0249	MONTGOMERY
150030 ...	0.0201	HENRY
150035 ...	0.0083	PORTER
150045 ...	0.0416	DE KALB
150065 ...	0.0139	JACKSON
150076 ...	0.0189	MARSHALL
150088 ...	0.0196	MADISON
150091 ...	0.0573	HUNTINGTON
150102 ...	0.0160	STARKE
150113 ...	0.0196	MADISON
150122 ...	0.0199	RIPLEY
150146 ...	0.0319	NOBLE
154047 ...	0.0189	MARSHALL
154050 ...	0.0416	DE KALB
160013 ...	0.0218	MUSCATINE
160030 ...	0.0040	STORY
160032 ...	0.0272	JASPER
160080 ...	0.0049	CLINTON
170137 ...	0.0336	DOUGLAS
180012 ...	0.0083	HARDIN
180066 ...	0.0567	LOGAN
180127 ...	0.0352	FRANKLIN
180128 ...	0.0282	LAWRENCE
183028 ...	0.0083	HARDIN
184012 ...	0.0083	HARDIN
190001 ...	0.0645	WASHINGTON
190003 ...	0.0107	IBERIA
190015 ...	0.0401	TANGIPAHOA
190017 ...	0.0235	ST. LANDRY
190054 ...	0.0107	IBERIA
190078 ...	0.0235	ST. LANDRY
190088 ...	0.0705	WEBSTER
190099 ...	0.0390	AVOYELLES
190106 ...	0.0238	ALLEN
190133 ...	0.0238	ALLEN
190144 ...	0.0705	WEBSTER
190184 ...	0.0161	CALDWELL
190190 ...	0.0161	CALDWELL
190191 ...	0.0235	ST. LANDRY
190246 ...	0.0161	CALDWELL

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
192034 ...	0.0235	ST. LANDRY
192036 ...	0.0401	TANGIPAHOA
192040 ...	0.0401	TANGIPAHOA
192046 ...	0.0645	WASHINGTON
193044 ...	0.0401	TANGIPAHOA
193079 ...	0.0401	TANGIPAHOA
193091 ...	0.0107	IBERIA
194080 ...	0.0645	WASHINGTON
200002 ...	0.0129	LINCOLN
200024 ...	0.0071	ANDROSCOGGIN
200032 ...	0.0466	OXFORD
200034 ...	0.0071	ANDROSCOGGIN
200050 ...	0.0140	HANCOCK
210001 ...	0.0129	WASHINGTON
210004 ...	0.0040	MONTGOMERY
210016 ...	0.0040	MONTGOMERY
210018 ...	0.0040	MONTGOMERY
210022 ...	0.0040	MONTGOMERY
210023 ...	0.0209	ANNE ARUNDEL
210028 ...	0.0512	ST. MARYS
210043 ...	0.0209	ANNE ARUNDEL
210048 ...	0.0287	HOWARD
210057 ...	0.0040	MONTGOMERY
212002 ...	0.0129	WASHINGTON
213029 ...	0.004	MONTGOMERY
214003 ...	0.0129	WASHINGTON
214013 ...	0.004	MONTGOMERY
220001 ...	0.0056	WORCESTER
220002 ...	0.0249	MIDDLESEX
220010 ...	0.0306	ESSEX
220011 ...	0.0249	MIDDLESEX
220019 ...	0.0056	WORCESTER
220025 ...	0.0056	WORCESTER
220028 ...	0.0056	WORCESTER
220029 ...	0.0306	ESSEX
220033 ...	0.0306	ESSEX
220035 ...	0.0306	ESSEX
220049 ...	0.0249	MIDDLESEX
220058 ...	0.0056	WORCESTER
220062 ...	0.0056	WORCESTER
220063 ...	0.0249	MIDDLESEX
220070 ...	0.0249	MIDDLESEX
220080 ...	0.0306	ESSEX
220082 ...	0.0249	MIDDLESEX
220084 ...	0.0249	MIDDLESEX
220089 ...	0.0249	MIDDLESEX
220090 ...	0.0056	WORCESTER
220095 ...	0.0056	WORCESTER
220098 ...	0.0249	MIDDLESEX
220101 ...	0.0249	MIDDLESEX
220105 ...	0.0249	MIDDLESEX
220163 ...	0.0056	WORCESTER
220171 ...	0.0249	MIDDLESEX
220174 ...	0.0306	ESSEX
220176 ...	0.0056	WORCESTER
222000 ...	0.0249	MIDDLESEX
222003 ...	0.0249	MIDDLESEX
222026 ...	0.0306	ESSEX
222044 ...	0.0306	ESSEX
222047 ...	0.0306	ESSEX
222048 ...	0.0056	WORCESTER
223026 ...	0.0249	MIDDLESEX
223028 ...	0.0306	ESSEX
223029 ...	0.0056	WORCESTER
223033 ...	0.0056	WORCESTER
224007 ...	0.0249	MIDDLESEX
224022 ...	0.0249	MIDDLESEX
224026 ...	0.0056	WORCESTER
224032 ...	0.0056	WORCESTER

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
224033 ...	0.0306	ESSEX
224038 ...	0.0249	MIDDLESEX
230003 ...	0.0035	OTTAWA
230013 ...	0.0091	OAKLAND
230015 ...	0.0359	ST. JOSEPH
230019 ...	0.0091	OAKLAND
230021 ...	0.0136	BERRIEN
230022 ...	0.0113	BRANCH
230029 ...	0.0091	OAKLAND
230037 ...	0.0178	HILLSDALE
230041 ...	0.0099	BAY
230047 ...	0.0082	MACOMB
230069 ...	0.0487	LIVINGSTON
230071 ...	0.0091	OAKLAND
230072 ...	0.0035	OTTAWA
230075 ...	0.0145	CALHOUN
230078 ...	0.0136	BERRIEN
230092 ...	0.0389	JACKSON
230093 ...	0.0079	MECOSTA
230096 ...	0.0359	ST. JOSEPH
230099 ...	0.0339	MONROE
230106 ...	0.0030	NEWAYGO
230121 ...	0.0691	SHIAWASSEE
230130 ...	0.0091	OAKLAND
230151 ...	0.0091	OAKLAND
230174 ...	0.0035	OTTAWA
230195 ...	0.0082	MACOMB
230204 ...	0.0082	MACOMB
230207 ...	0.0091	OAKLAND
230217 ...	0.0145	CALHOUN
230222 ...	0.0228	MIDLAND
230223 ...	0.0091	OAKLAND
230227 ...	0.0082	MACOMB
230254 ...	0.0091	OAKLAND
230257 ...	0.0082	MACOMB
230264 ...	0.0082	MACOMB
230269 ...	0.0091	OAKLAND
230277 ...	0.0091	OAKLAND
230279 ...	0.0487	LIVINGSTON
232020 ...	0.0099	BAY
232023 ...	0.0082	MACOMB
232025 ...	0.0136	BERRIEN
232028 ...	0.0145	CALHOUN
232036 ...	0.0389	JACKSON
233025 ...	0.0145	CALHOUN
233028 ...	0.0091	OAKLAND
234011 ...	0.0091	OAKLAND
234021 ...	0.0082	MACOMB
234023 ...	0.0091	OAKLAND
234039 ...	0.0082	MACOMB
240018 ...	0.1196	GOODHUE
240044 ...	0.0868	WINONA
240064 ...	0.0138	ITASCA
240069 ...	0.0419	STEELE
240071 ...	0.0454	RICE
240187 ...	0.0506	MC LEOD
240211 ...	0.0705	PINE
250040 ...	0.0294	JACKSON
254009 ...	0.0294	JACKSON
260011 ...	0.0007	COLE
260047 ...	0.0007	COLE
260074 ...	0.0158	RANDOLPH
260097 ...	0.0425	JOHNSON
280077 ...	0.0089	DODGE
280123 ...	0.0137	GAGE
290019 ...	0.0026	CARSON CITY
290049 ...	0.0026	CARSON CITY
290051 ...	0.0026	CARSON CITY
293029 ...	0.0026	CARSON CITY

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
300011 ...	0.0069	HILLSBOROUGH
300012 ...	0.0069	HILLSBOROUGH
300017 ...	0.0361	ROCKINGHAM
300020 ...	0.0069	HILLSBOROUGH
300023 ...	0.0361	ROCKINGHAM
300029 ...	0.0361	ROCKINGHAM
300034 ...	0.0069	HILLSBOROUGH
303026 ...	0.0361	ROCKINGHAM
304001 ...	0.0361	ROCKINGHAM
310002 ...	0.0351	ESSEX
310009 ...	0.0351	ESSEX
310010 ...	0.0092	MERCER
310011 ...	0.0115	CAPE MAY
310013 ...	0.0351	ESSEX
310018 ...	0.0351	ESSEX
310021 ...	0.0092	MERCER
310038 ...	0.0350	MIDDLESEX
310039 ...	0.0350	MIDDLESEX
310044 ...	0.0092	MERCER
310054 ...	0.0351	ESSEX
310070 ...	0.0350	MIDDLESEX
310076 ...	0.0351	ESSEX
310083 ...	0.0351	ESSEX
310092 ...	0.0092	MERCER
310093 ...	0.0351	ESSEX
310096 ...	0.0351	ESSEX
310108 ...	0.0350	MIDDLESEX
310110 ...	0.0092	MERCER
310119 ...	0.0351	ESSEX
310123 ...	0.0351	ESSEX
310124 ...	0.0350	MIDDLESEX
312018 ...	0.035	MIDDLESEX
312019 ...	0.0351	ESSEX
313025 ...	0.0351	ESSEX
313027 ...	0.0092	MERCER
314010 ...	0.0351	ESSEX
314011 ...	0.035	MIDDLESEX
314013 ...	0.0092	MERCER
314020 ...	0.0351	ESSEX
320003 ...	0.0629	SAN MIGUEL
320011 ...	0.0442	RIO ARRIBA
320018 ...	0.0063	DONA ANA
320085 ...	0.0063	DONA ANA
323032 ...	0.0063	DONA ANA
324010 ...	0.0063	DONA ANA
324012 ...	0.0063	DONA ANA
330004 ...	0.0959	ULSTER
330008 ...	0.0470	WYOMING
330027 ...	0.0137	NASSAU
330094 ...	0.0778	COLUMBIA
330106 ...	0.0137	NASSAU
330126 ...	0.0560	ORANGE
330135 ...	0.0560	ORANGE
330167 ...	0.0137	NASSAU
330181 ...	0.0137	NASSAU
330182 ...	0.0137	NASSAU
330191 ...	0.0026	WARREN
330198 ...	0.0137	NASSAU
330205 ...	0.0560	ORANGE
330224 ...	0.0959	ULSTER
330225 ...	0.0137	NASSAU
330235 ...	0.0270	CAYUGA
330259 ...	0.0137	NASSAU
330264 ...	0.0560	ORANGE
330276 ...	0.0063	FULTON
330331 ...	0.0137	NASSAU
330332 ...	0.0137	NASSAU
330372 ...	0.0137	NASSAU
330386 ...	0.1139	SULLIVAN

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
334017 ...	0.056	ORANGE
334061 ...	0.056	ORANGE
340015 ...	0.0267	ROWAN
340020 ...	0.0207	LEE
340021 ...	0.0216	CLEVELAND
340037 ...	0.0216	CLEVELAND
340039 ...	0.0144	IREDELL
340069 ...	0.0053	WAKE
340070 ...	0.0448	ALAMANCE
340073 ...	0.0053	WAKE
340085 ...	0.0377	DAVIDSON
340096 ...	0.0377	DAVIDSON
340104 ...	0.0216	CLEVELAND
340114 ...	0.0053	WAKE
340126 ...	0.0161	WILSON
340127 ...	0.0961	GRANVILLE
340129 ...	0.0144	IREDELL
340133 ...	0.0308	MARTIN
340138 ...	0.0053	WAKE
340144 ...	0.0144	IREDELL
340145 ...	0.0563	LINCOLN
340173 ...	0.0053	WAKE
344001 ...	0.0053	WAKE
344004 ...	0.0961	GRANVILLE
344014 ...	0.0053	WAKE
360013 ...	0.0166	SHELBY
360025 ...	0.0087	ERIE
360036 ...	0.0263	WAYNE
360065 ...	0.0141	HURON
360070 ...	0.0028	STARK
360078 ...	0.0159	PORTAGE
360084 ...	0.0028	STARK
360086 ...	0.0168	CLARK
360095 ...	0.0087	HANCOCK
360100 ...	0.0028	STARK
360107 ...	0.0213	SANDUSKY
360131 ...	0.0028	STARK
360151 ...	0.0028	STARK
360156 ...	0.0213	SANDUSKY
360175 ...	0.0159	CLINTON
360187 ...	0.0168	CLARK
360197 ...	0.0092	LOGAN
360270 ...	0.0120	DEFIANCE
362007 ...	0.0213	SANDUSKY
362032 ...	0.0028	STARK
364031 ...	0.0028	STARK
364040 ...	0.0168	CLARK
370004 ...	0.0193	OTTAWA
370014 ...	0.0831	BRYAN
370015 ...	0.0463	MAYES
370023 ...	0.0084	STEPHENS
370065 ...	0.0121	CRAIG
370113 ...	0.0205	DELAWARE
370149 ...	0.0356	POTTAWATOMIE
370219 ...	0.0356	POTTAWATOMIE
372019 ...	0.0356	POTTAWATOMIE
374017 ...	0.0193	OTTAWA
380002 ...	0.0130	JOSEPHINE
380022 ...	0.0201	LINN
380029 ...	0.0075	MARION
380051 ...	0.0075	MARION
380056 ...	0.0075	MARION
384008 ...	0.0075	MARION
390011 ...	0.0012	CAMBRIA
390030 ...	0.0284	SCHUYLKILL
390031 ...	0.0284	SCHUYLKILL
390044 ...	0.0200	BERKS
390046 ...	0.0098	YORK
390056 ...	0.0042	HUNTINGDON

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
390065 ...	0.0501	ADAMS
390066 ...	0.0259	LEBANON
390096 ...	0.0200	BERKS
390101 ...	0.0098	YORK
390110 ...	0.0012	CAMBRIA
390130 ...	0.0012	CAMBRIA
390138 ...	0.0325	FRANKLIN
390146 ...	0.0053	WARREN
390150 ...	0.0206	GREENE
390151 ...	0.0325	FRANKLIN
390162 ...	0.0200	NORTHAMPTON
390181 ...	0.0284	SCHUYLKILL
390183 ...	0.0284	SCHUYLKILL
390201 ...	0.1127	MONROE
390233 ...	0.0098	YORK
392031 ...	0.0012	CAMBRIA
392034 ...	0.02	NORTHAMPTON
393026 ...	0.02	BERKS
393037 ...	0.0098	YORK
394014 ...	0.02	BERKS
394016 ...	0.0053	WARREN
394020 ...	0.0259	LEBANON
420007 ...	0.0001	SPARTANBURG
420009 ...	0.0113	OCONEE
420020 ...	0.0035	GEORGETOWN
420027 ...	0.0210	ANDERSON
420030 ...	0.0103	COLLETON
420039 ...	0.0153	UNION
420043 ...	0.0177	CHEROKEE
420062 ...	0.0109	CHESTERFIELD
420068 ...	0.0097	ORANGEBURG
420070 ...	0.0101	SUMTER
420083 ...	0.0001	SPARTANBURG
420098 ...	0.0035	GEORGETOWN
423029 ...	0.021	ANDERSON
424011 ...	0.021	ANDERSON
440008 ...	0.0663	HENDERSON
440024 ...	0.0387	BRADLEY
440030 ...	0.0056	HAMBLEN
440035 ...	0.0441	MONTGOMERY
440047 ...	0.0499	GIBSON
440056 ...	0.0321	JEFFERSON
440060 ...	0.0499	GIBSON
440063 ...	0.0011	WASHINGTON
440067 ...	0.0056	HAMBLEN
440073 ...	0.0513	MAURY
440105 ...	0.0011	WASHINGTON
440115 ...	0.0499	GIBSON
440148 ...	0.0568	DE KALB
440153 ...	0.0007	COCKE
440174 ...	0.0372	HAYWOOD
440181 ...	0.0407	HARDEMAN
440184 ...	0.0011	WASHINGTON

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
440185 ...	0.0387	BRADLEY
444008 ...	0.0407	HARDEMAN
450032 ...	0.0416	HARRISON
450039 ...	0.0097	TARRANT
450059 ...	0.0073	COMAL
450064 ...	0.0097	TARRANT
450087 ...	0.0097	TARRANT
450099 ...	0.0180	GRAY
450121 ...	0.0097	TARRANT
450135 ...	0.0097	TARRANT
450137 ...	0.0097	TARRANT
450144 ...	0.0573	ANDREWS
450163 ...	0.0134	KLEBERG
450187 ...	0.0264	WASHINGTON
450194 ...	0.0328	CHEROKEE
450214 ...	0.0368	WHARTON
450224 ...	0.0411	WOOD
450324 ...	0.0132	GRAYSON
450347 ...	0.0427	WALKER
450370 ...	0.0258	COLORADO
450389 ...	0.0881	HENDERSON
450393 ...	0.0132	GRAYSON
450395 ...	0.0484	POLK
450419 ...	0.0097	TARRANT
450438 ...	0.0258	COLORADO
450447 ...	0.0358	NAVARRO
450451 ...	0.0551	SOMERVELL
450465 ...	0.0435	MATAGORDA
450469 ...	0.0132	GRAYSON
450547 ...	0.0411	WOOD
450563 ...	0.0097	TARRANT
450565 ...	0.0486	PALO PINTO
450596 ...	0.0808	HOOD
450597 ...	0.0077	DE WITT
450639 ...	0.0097	TARRANT
450672 ...	0.0097	TARRANT
450675 ...	0.0097	TARRANT
450677 ...	0.0097	TARRANT
450694 ...	0.0368	WHARTON
450747 ...	0.0195	ANDERSON
450755 ...	0.0484	HOCKLEY
450779 ...	0.0097	TARRANT
450813 ...	0.0195	ANDERSON
450872 ...	0.0097	TARRANT
450880 ...	0.0097	TARRANT
450886 ...	0.0097	TARRANT
450888 ...	0.0097	TARRANT
452018 ...	0.0097	TARRANT
452019 ...	0.0097	TARRANT
452028 ...	0.0097	TARRANT
452041 ...	0.0132	GRAYSON
452088 ...	0.0097	TARRANT
453040 ...	0.0097	TARRANT

ADDENDUM L.—OUT-MIGRATION ADJUSTMENT—Continued

Provider No.	Out-migration adjustment	Qualifying county name
453041 ...	0.0097	TARRANT
453042 ...	0.0097	TARRANT
453089 ...	0.0195	ANDERSON
453094 ...	0.0097	TARRANT
453300 ...	0.0097	TARRANT
454009 ...	0.0328	CHEROKEE
454012 ...	0.0097	TARRANT
460017 ...	0.0392	BOX ELDER
460039 ...	0.0392	BOX ELDER
490019 ...	0.1240	CULPEPER
490038 ...	0.0022	SMYTH
490084 ...	0.0167	ESSEX
490105 ...	0.0022	SMYTH
490110 ...	0.0082	MONTGOMERY
494029 ...	0.0022	SMYTH
500003 ...	0.0208	SKAGIT
500007 ...	0.0208	SKAGIT
500019 ...	0.0213	LEWIS
500021 ...	0.0055	PIERCE
500024 ...	0.0023	THURSTON
500039 ...	0.0174	KITSAP
500041 ...	0.0118	COWLITZ
500079 ...	0.0055	PIERCE
500108 ...	0.0055	PIERCE
500129 ...	0.0055	PIERCE
500139 ...	0.0023	THURSTON
500143 ...	0.0023	THURSTON
503301 ...	0.0055	PIERCE
504003 ...	0.0055	PIERCE
510018 ...	0.0209	JACKSON
510039 ...	0.0112	OHIO
510047 ...	0.0275	MARION
510050 ...	0.0112	OHIO
510077 ...	0.0021	MINGO
513025 ...	0.0112	OHIO
520028 ...	0.0157	GREEN
520035 ...	0.0077	SHEBOYGAN
520044 ...	0.0077	SHEBOYGAN
520057 ...	0.0118	SAUK
520059 ...	0.0200	RACINE
520071 ...	0.0239	JEFFERSON
520095 ...	0.0118	SAUK
520096 ...	0.0200	RACINE
520102 ...	0.0298	WALWORTH
520116 ...	0.0239	JEFFERSON
520132 ...	0.0077	SHEBOYGAN
522005 ...	0.02	RACINE

[FR Doc. 06–9079 Filed 11–1–06; 4:00 pm]

BILLING CODE 4120–01–P