Federal Register

Tuesday,
August 3, 2010

Book 3 of 3 Books
Pages 46169–46836

Part II—Continued

Department of Health and Human Services

Centers for Medicare and Medicaid

42 CFR Parts 410, 416 and 419

Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Corrections; Final Rule, Notice, and Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 412, 413, 416, 419, 482, and 489

[CMS–1504–P]

RIN 0938–AP82

Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Proposed Changes to Payments to Hospitals for Certain Inpatient Hospital Services and for Graduate Medical Education Costs; and Proposed Changes to Physician Self-Referral Rules and Related Changes to Provider Agreement Regulations

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the Medicare hospital outpatient prospective payment system (OPPS) to implement applicable statutory requirements and changes arising from our continuing experience with this system and to implement certain provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (Affordable Care Act). In this proposed rule, we describe the proposed changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. These proposed changes would be applicable to services furnished on or after January 1, 2011.

In addition, this proposed rule would update the revised Medicare ambulatory surgical center (ASC) payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system and to implement certain provisions of the Affordable Care Act. In this proposed rule, we set forth the proposed applicable relative payment weights and amounts for services furnished in ASCs, specific HCPCS codes to which these proposed changes would apply, and other pertinent ratesetting information for the CY 2011 ASC payment system. These proposed changes would be applicable to services furnished on or after January 1, 2011.

This proposed rule also includes proposals to implement provisions of the Affordable Care Act relating to payments to hospitals for direct graduate medical education (GME) and indirect medical education (IME) costs; and new limitations on certain physician referrals to hospitals in which they have an ownership or investment interest.

DATES: To be assured consideration, comments on all sections of this proposed rule must be received at one of the addresses provided in the **ADDRESSES** section no later than 5 p.m. EST on August 31, 2010.

ADDRESSES: In commenting, please refer to file code CMS–1504–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions under the "More Search Options" tab.

2. *By regular mail.* You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1504–P, P.O. Box 8013, Baltimore, MD 21244–1850.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1504–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(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 a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call the telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

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

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document.

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

FOR FURTHER INFORMATION CONTACT:

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

Paula Smith, (410) 786–0378, Ambulatory surgical center issues.

Michele Franklin, (410) 786–4533, and Jana Lindquist, (410) 786–4533, Partial hospitalization and community mental health center issues.

James Poyer, (410) 786–2261, Reporting of quality data issues.

Tzvi Hefter, (410) 786–4487, and Ing-Jye Cheng, (410) 786–4548, Hospital preadmission services and direct graduate medical education and indirect medical education payments issues.

Jacqueline Proctor, (410) 786–8852, Physician ownership and investment in hospitals issues.

SUPPLEMENTARY INFORMATION:

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.regulations.gov*. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, on Monday through Friday of each week from 8:30

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

Electronic Access

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access,* a service of the U.S. Government Printing Office. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents' home page address is *http://www.gpoaccess.gov/index.html,* by using local WAIS client software, or by telnet to *swais.access.gpo.gov,* then login as guest (no password required). Dial-in users should use communications software and modem to call (202) 512–1661; type swais, then login as guest (no password required).

Alphabetical List of Acronyms Appearing in This Proposed Rule

ACEP American College of Emergency Physicians
AHA American Hospital Association
AHIMA American Health Information Management Association
AMA American Medical Association
AMP Average manufacturer price
AOA American Osteopathic Association
APC Ambulatory payment classification
ASC Ambulatory Surgical Center
ASP Average sales price
AWP Average wholesale price
BBA Balanced Budget Act of 1997, Public Law 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 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, Public Law 106–554
CAH Critical access hospital
CAP Competitive Acquisition Program
CBSA Core-Based Statistical Area
CCR Cost-to-charge ratio
CERT Comprehensive Error Rate Testing
CMHC Community mental health center
CMS Centers for Medicare & Medicaid Services
CoP Conditions of Participation
CORF Comprehensive outpatient rehabilitation facility
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2009, copyrighted by the American Medical Association
CY Calendar year
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DMERC Durable medical equipment regional carrier
DRA Deficit Reduction Act of 2005, Public Law 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, Public Law 92–463
FAR Federal Acquisition Regulations
FDA Food and Drug Administration
FFS Fee-for-service
FSS Federal Supply Schedule
FTE Full-time equivalent
FY Federal fiscal year
GAO Government Accountability Office
GME Graduate medical education
HCERA Health Care and Education Reconciliation Act of 2010, Public Law 111–152
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, Public Law 104–191
HOPD Hospital outpatient department
HOP QDRP Hospital Outpatient Quality Data Reporting Program
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
ICD–10–CM International Classification of Diseases, Tenth Revision, Clinical Modification
ICD–10–PCS International Classification of Diseases, Tenth Revision, Procedure Coding System
IDE Investigational device exemption
IHS Indian Health Service
IME Indirect medical education
I/OCE Integrated Outpatient Code Editor
IOL Intraocular lens
IPPE Initial preventive physical examination
IPPS [Hospital] Inpatient prospective payment system
IVIG Intravenous immune globulin
MAC Medicare Administrative Contractor
MedPAC Medicare Payment Advisory Commission
MDH Medicare-dependent, small rural hospital
MIEA–TRHCA Medicare Improvements and Extension Act under Division B, Title I of the Tax Relief Health Care Act of 2006, Public Law 109–432
MIPPA Medicare Improvements for Patients and Providers Act of 2008, Public Law 110–275
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007, Public Law 110–173
MPFS Medicare Physician Fee Schedule
MSA Metropolitan Statistical Area
NCCI National Correct Coding Initiative
NCD National Coverage Determination
NTIOL New technology intraocular lens
OIG [HHS] Office of the Inspector General
OMB Office of Management and Budget
OPD [Hospital] Outpatient department
OPPS [Hospital] Outpatient prospective payment system
PHP Partial hospitalization program
PM Program memorandum
PPACA Patient Protection and Affordable Care Act, Public Law 111–148
PPI Producer Price Index
PPPS Personalized preventive plan services
PPS Prospective payment system
PR Pulmonary rehabilitation
PRA Paperwork Reduction Act
QAPI Quality Assessment and Performance Improvement
QIO Quality Improvement Organization
RAC Recovery Audit Contractor
RFA Regulatory Flexibility Act
RHQDAPU Reporting Hospital Quality Data for Annual Payment Update [Program]
RHHI Regional home health intermediary
SBA Small Business Administration
SCH Sole community hospital
SDP Single Drug Pricer
SI Status indicator
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97–248
TOPS Transitional outpatient payments
USPDI United States Pharmacopoeia Drug Information
USPSTF United States Preventive Services Task Force
WAC Wholesale acquisition cost

In this document, we address two payment systems under the Medicare program: The hospital outpatient prospective payment system (OPPS) and the revised ambulatory surgical center (ASC) payment system. In addition, we are addressing provisions of the Affordable Care Act, relating to payments to hospitals for direct graduate medical education (GME) and indirect medical education (IME) costs; we are also addressing provisions relating to new limitations on certain physician referrals to hospitals in which they have an ownership or investment interest and proposing related changes to provider agreement regulations. The provisions relating to the OPPS are included in sections I. through XIV., XVI, and XIX. through XXII. of this proposed rule and in Addenda A, B, C (Addendum C is available on the Internet only; we refer readers to section XIX.A. of this proposed rule), D1, D2, E, L, and M to this proposed rule. The provisions related to the revised ASC payment system are included in sections XV., XVI., and XIX. through XXII. of this proposed rule and in Addenda AA, BB, DD1, DD2, and EE to this proposed rule. (Addendum EE is available on the Internet only; we refer readers to section XIX.B. of this proposed rule.) The provisions related to payments to hospitals for direct graduate medical education (GME) and indirect medical education (IME) costs are included in section XVII. of this proposed rule. The provisions relating to the new limitations on certain physician referrals to hospitals in which

they have an ownership or investment interest and proposed related changes to provider agreement regulations are included in section XVIII. of this proposed rule.

Table of Contents

I. Background and Summary of the CY 2011 OPPS/ASC Proposed Rule
A. Legislative and Regulatory Authority for the Hospital Outpatient Prospective Payment System
B. Excluded OPPS Services and Hospitals
C. Prior Rulemaking
D. The Affordable Care Act
E. Advisory Panel on Ambulatory Payment Classification (APC) Groups
1. Authority of the APC Panel
2. Establishment of the APC Panel
3. APC Panel Meetings and Organizational Structure
F. Background and Summary of This Proposed Rule
1. Proposed Updates Affecting OPPS Payments
2. Proposed OPPS Ambulatory Payment Classification (APC) Group Policies
3. Proposed OPPS Payment for Devices
4. Proposed OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals
5. Proposed Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices
6. Proposed OPPS Payment for Brachytherapy Sources
7. Proposed OPPS Payment for Drug Administration Services
8. Proposed OPPS Payment for Hospital Outpatient Visits
9. Proposed Payment for Partial Hospitalization Services
10. Proposed Procedures That Would Be Paid Only as Inpatient Procedures
11. Proposed OPPS Nonrecurring Technical and Policy Changes and Clarifications
12. Proposed OPPS Payment Status and Comment Indicators
13. OPPS Policy and Payment Recommendations
14. Proposed Updates to the Ambulatory Surgical Center (ASC) Payment System
15. Reporting Quality Data for Annual Payment Rate Updates
16. Proposed Changes Relating to Payments to Hospitals for Preadmission Services and GME and IME Costs
17. Proposed Changes to Whole Hospital and Rural Provider Exceptions to the Physician Self-Referral Prohibition and Related Changes to Provider Agreement Regulations
18. Regulatory Impact Analysis
II. Proposed Updates Affecting OPPS Payments
A. Proposed Recalibration of APC Relative Weights
1. Database Construction
a. Database Source and Methodology
b. Proposed Use of Single and Multiple Procedure Claims
c. Proposed Calculation of CCRs
(1) Development of the CCRs
(2) Charge Compression
2. Proposed Data Development Process and Calculation of Median Costs
a. Claims Preparation
b. Splitting Claims and Creation of "Pseudo" Single Procedure Claims
(1) Splitting Claims
(2) Creation of "Pseudo" Single Procedure Claims
c. Completion of Claim Records and Median Cost Calculations
d. Proposed Calculation of Single Procedure APC Criteria-Based Median Costs
(1) Device-Dependent APCs
(2) Blood and Blood Products
(3) Single Allergy Tests
(4) Hyperbaric Oxygen Therapy (APC 0659)
(5) Payment for Ancillary Outpatient Services When Patient Expires (APC 0375)
(6) Pulmonary Rehabilitation
e. Proposed Calculation of Composite APC Criteria-Based Median Costs
(1) Extended Assessment and Management Composite APCs (APCs 8002 and 8003)
(2) Low Dose Rate (LDR) Prostate Brachytherapy Composite APC (APC 8001)
(3) Cardiac Electrophysiologic Evaluation and Ablation Composite APC (APC 8000)
(4) Mental Health Services Composite APC (APC 0034)
(5) Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008)
3. Proposed Changes to Packaged Services
a. Background
b. Packaging Issues
(1) Packaged Services Addressed by the February 2010 APC Panel Recommendations
(2) Other Service-Specific Packaging Issues
4. Proposed Calculation of OPPS Scaled Payment Weights
B. Proposed Conversion Factor Update
C. Proposed Wage Index Changes
D. Proposed Statewide Average Default CCRs
E. Proposed OPPS Payment to Certain Rural and Other Hospitals
1. Hold Harmless Transitional Payment Changes Made by Pub. L. 111–148
2. Proposed Adjustment for Rural SCHs Implemented in CY 2006 Related to Public Law 108–173 (MMA)
F. Proposed OPPS Payments to Certain Cancer Hospitals Described by Section 1886(d)(1)(B)(v) of the Act
1. Background
2. Study of Cancer Hospital Costs Relative to Other Hospitals
3. Proposed Adjustment for Certain Cancer Hospitals
G. Proposed Hospital Outpatient Outlier Payments
1. Background
2. Proposed Outlier Calculation
H. Proposed Calculation of an Adjusted Medicare Payment From the National Unadjusted Medicare Payment
I. Proposed Beneficiary Copayments
1. Background
2. Proposed OPPS Copayment Policy
3. Proposed Calculation of an Adjusted Copayment Amount for an APC Group
III. Proposed OPPS Ambulatory Payment Classification (APC) Group Policies
A. Proposed OPPS Treatment of New CPT and Level II HCPCS Codes
1. Proposed Treatment of New Level II HCPCS Codes and Category I CPT Vaccine Codes and Category III CPT Codes for Which We Are Soliciting Public Comments in This Proposed Rule
2. Proposed Process for New Level II HCPCS Codes and Category I and Category III CPT Codes for Which We Are Soliciting Public Comments in the CY 2011 OPPS/ASC Final Rule With Comment Period
B. Proposed OPPS Changes—Variations Within APCs
1. Background
2. Application of the 2 Times Rule
3. Proposed Exceptions to the 2 Times Rule
C. New Technology APCs
1. Background
2. Proposed Movement of Procedures From New Technology APCs to Clinical APCs
D. Proposed OPPS APC-Specific Policy: Skin Repair (APCs 0134 and 0135)
IV. Proposed OPPS Payment for Devices
A. Proposed Pass-Through Payments for Devices
1. Expiration of Transitional Pass-Through Payments for Certain Devices
2. Proposed Provisions for Reducing Transitional Pass-Through Payments To Offset Costs Packaged Into APC Groups
a. Background
b. Proposed Policy
B. Proposed Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices
1. Background
2. Proposed APCs and Devices Subject to the Adjustment Policy
V. Proposed OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals
A. Proposed OPPS Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals, and Radiopharmaceuticals
1. Background
2. Drugs and Biologicals With Expiring Pass-Through Status in CY 2010
3. Proposed Drugs, Biologicals, and Radiopharmaceuticals With New or Continuing Pass-Through Status in CY 2011
4. Proposed Provision for Reducing Transitional Pass-Through Payments for Diagnostic Radiopharmaceuticals and Contrast Agents To Offset Costs Packaged Into APC Groups
a. Background
b. Proposed Payment Offset Policy for Diagnostic Radiopharmaceuticals
c. Proposed Payment Offset Policy for Contrast Agents
B. Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status
1. Background
2. Proposed Criteria for Packaging Payment for Drugs, Biologicals, and Radiopharmaceuticals
a. Background
b. Proposed Cost Threshold for Packaging of Payment for HCPCS Codes That Describe Certain Drugs, Nonimplantable Biologicals, and Therapeutic

Radiopharmaceuticals ("Threshold-Packaged Drugs")
c. Proposed Packaging Determination for HCPCS Codes That Describe the Same Drug or Biological But Different Dosages
d. Proposed Packaging of Payment for Diagnostic Radiopharmaceuticals, Contrast Agents, and Implantable Biologicals ("Policy-Packaged" Drugs and Devices)
3. Proposed Payment for Drugs and Biologicals Without Pass-Through Status That Are Not Packaged
a. Proposed Payment for Specified Covered Outpatient Drugs (SCODs) and Other Separately Payable and Packaged Drugs and Biologicals, Including Therapeutic Radiopharmaceuticals
b. Proposed Payment Policy
4. Proposed Payment for Blood Clotting Factors
5. Proposed Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without OPPS Hospital Claims Data
VI. Proposed Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices
A. Background
B. Proposed Estimate of Pass-Through Spending
VII. Proposed OPPS Payment for Brachytherapy Sources
A. Background
B. Proposed OPPS Payment Policy
VIII. Proposed OPPS Payment for Drug Administration Services
A. Background
B. Proposed Coding and Payment for Drug Administration Services
IX. Proposed OPPS Payment for Hospital Outpatient Visits
A. Background
B. Proposed Policies for Hospital Outpatient Visits
1. Clinic Visits: New and Established Patient Visits
2. Emergency Department Visits
3. Visit Reporting Guidelines
X. Proposed Payment for Partial Hospitalization Services
A. Background
B. Proposed PHP APC Update for CY 2011
C. Proposed Changes to Regulations To Incorporate Provisions of HCERA of 2010
D. Proposed Separate Threshold for Outlier Payments to CMHCs
XI. Proposed Procedures That Will Be Paid Only as Inpatient Procedures
A. Background
B. Proposed Changes to the Inpatient List
XII. Proposed OPPS Nonrecurring Technical and Policy Issues
A. Physician Supervision
1. Background
a. Outpatient Therapeutic Services
b. Outpatient Diagnostic Services
2. Issues Regarding the Supervision of Hospital Outpatient Services Raised by Hospitals and Other Stakeholders
3. Proposed Policies for Supervision of Outpatient Therapeutic Services in Hospital and CAHs
4. Supervision of Hospital Outpatient Diagnostic Services
B. Proposed Payment for Preventive Services
1. Definition of "Preventive Services"
2. Coinsurance and Deductible for Preventive Services
3. Extension of Waiver of Deductible to Services Furnished in Connection With or in Relation to a Colorectal Cancer Screening Test That Becomes Diagnostic or Therapeutic
C. Payment for Pulmonary Rehabilitation, Cardiac Rehabilitation, and Intensive Cardiac Rehabilitation Services Furnished to Hospital Outpatients
D. Expansion of Multiple Procedure Payment Reduction Under the Medicare Physician Fee Schedule (MPFS) to Therapy Services
XIII. Proposed OPPS Payment Status and Comment Indicators
A. Proposed OPPS Payment Status Indicator Definitions
1. Proposed Payment Status Indicators To Designate Services That Are Paid Under the OPPS
2. Proposed Payment Status Indicators To Designate Services That Are Paid Under a Payment System Other Than the OPPS
3. Proposed Payment Status Indicators To Designate Services That Are Not Recognized Under the OPPS But That May Be Recognized by Other Institutional Providers
4. Proposed Payment Status Indicators To Designate Services That Are Not Payable by Medicare on Outpatient Claims
B. Proposed Comment Indicator Definitions
XIV. OPPS Policy and Payment Recommendations
A. MedPAC Recommendations
B. APC Panel Recommendations
C. OIG Recommendations
XV. Proposed Updates to the Ambulatory Surgical Center (ASC) Payment System
A. Background
1. Legislative Authority for the ASC Payment System
2. Prior Rulemaking
3. Policies Governing Changes to the Lists of Codes and Payment Rates for ASC Covered Surgical Procedures and Covered Ancillary Services
B. Proposed Treatment of New Codes
1. Proposed Process for Recognizing New Category I and III CPT Codes and Level II HCPCS Codes
2. Proposed Treatment of New Level II HCPCS Codes and Category III CPT Codes Implemented in April and July 2010
C. Proposed Update to the List of ASC Covered Surgical Procedures and Covered Ancillary Services
1. Covered Surgical Procedures
a. Proposed Additions to the List of ASC Covered Surgical Procedures
b. Proposed Covered Surgical Procedures Designated as Office-Based
(1) Background
(2) Proposed Changes to Covered Surgical Procedures Designated as Office-Based for CY 2011
c. ASC Covered Surgical Procedures Designated as Device-Intensive
(1) Background
(2) Proposed Changes to List of Covered Surgical Procedures Designated as Device-Intensive for CY 2011
d. ASC Treatment of Surgical Procedures Proposed for Removal From the OPPS Inpatient List for CY 2011
2. Covered Ancillary Services
D. Proposed ASC Payment for Covered Surgical Procedures and Covered Ancillary Services
1. Proposed Payment for Covered Surgical Procedures
a. Background
b. Proposed Update to ASC Covered Surgical Procedure Payment Rates for CY 2011
c. Proposed Adjustment to ASC Payments for No Cost/Full Credit and Partial Credit Devices
d. Proposed Waiver of Coinsurance and Deductible for Certain Preventive Services
2. Proposed Payment for Covered Ancillary Services
a. Background
b. Proposed Payment for Covered Ancillary Services for CY 2011
E. New Technology Intraocular Lenses (NTIOLs)
1. Background
2. NTIOL Application Process for Payment Adjustment
3. Classes of NTIOLs Approved and New Requests for Payment Adjustment
a. Background
b. Request To Establish New NTIOL Class for CY 2011 and Deadline for Public Comment
4. Proposed Payment Adjustment
5. Proposed ASC Payment for Insertion of IOLs
F. Proposed ASC Payment and Comment Indicators
1. Background
2. Proposed ASC Payment and Comment Indicators
G. ASC Policy and Payment Recommendations
H. Calculation of the Proposed ASC Conversion Factor and the Proposed ASC Payment Rates
1. Background
2. Calculation of the Proposed ASC Payment Rates
a. Updating the Proposed ASC Relative Payment Weights for CY 2011 and Future Years
b. Updating the ASC Conversion Factor With Application of a Productivity Adjustment to the Update Factor
3. Display of Proposed ASC Payment Rates
XVI. Reporting Quality Data for Annual Payment Rate Updates
A. Background
1. Overview
2. Hospital Outpatient Quality Data Reporting Under Section 109(a) of Public Law 109–432
3. Reporting ASC Quality Data for Annual Payment Update
4. HOP QDRP Quality Measures for the CY 2009 Payment Determination
5. HOP QDRP Quality Measures for the CY 2010 Payment Determination
6. HOP QDRP Quality Measures, Technical Specification Updates, and Data

Publication for the CY 2011 Payment Determination
a. Quality Measures
b. Maintenance of Technical Specifications for Quality Measures
c. Publication of HOP QDRP Data
B. Proposed Expansion of HOP QDRP Quality Measures for the CY 2012, CY 2013, and CY 2014 Payment Determinations
1. Considerations in Expanding and Updating Quality Measures Under the HOP QRDP Program
2. Retirement of HOP QDRP Quality Measures
3. Proposed HOP QDRP Quality Measures for the CY 2012 Payment Determination
a. Proposed Retention of Existing HOP QDRP Measures for the CY 2012 Payment Determination
b. Proposed New Structural Measure for CY 2012 Payment Determination
c. Proposed New Claims-Based Measures for CY 2012 Payment Determination
d. Proposed New Chart-Abstracted Measures for CY 2012 Payment Determination
4. Proposed HOP QDRP Quality Measures for the CY 2013 Payment Determination
a. Proposed Retention of CY 2012 HOP QDRP Measures for the CY 2013 Payment Determination
b. Proposed New Structural Measure for the CY 2013 Payment Determination
c. Proposed New Chart-Abstracted Measures for the CY 2013 Payment Determination
5. Proposed HOP QDRP Quality Measures for the CY 2014 Payment Determination
a. Proposed Retention of CY 2013 HOP QDRP Measures for the CY 2014 Payment Determination
b. Proposed New Chart-Abstracted Measures for the CY 2014 Payment Determination
6. Possible Quality Measures Under Consideration for Future Inclusion in HOP QDRP
C. Proposed Payment Reduction for Hospitals That Fail To Meet the HOP QDRP Requirements for the CY 2011 Payment Update
1. Background
2. Proposed Reporting Ratio Application and Associated Adjustment Policy for CY 2011
D. Proposed Requirements for HOPD Quality Data Reporting for CY 2012 and Subsequent Years
1. Administrative Requirements
2. Data Collection and Submission Requirements
a. General Data Collection and Submission Requirements
b. Extraordinary Circumstance Extension or Waiver for Reporting Quality Data
3. HOP QDRP Validation Requirements for Abstracted Data: Data Validation Approach for CY 2012 and Subsequent Years
a. Background
b. Proposed Data Validation Requirements for CY 2012
c. Additional Data Validation Conditions Under Consideration for CY 2013 and Subsequent Years
E. Proposed HOP QDRP Reconsideration and Appeals Procedures
F. Reporting of ASC Quality Data
G. Electronic Health Records
XVII. Proposed Changes Relating to Payments to Hospitals for Preadmission Services and for Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) Costs
A. Proposed Changes Relating to Payments to Hospitals for Direct GME and IME Costs
1. Background
2. Counting Resident Time in Nonprovider Settings (Section 5504 of the Affordable Care Act)
a. Background and Changes Made by the Affordable Care Act
b. Elimination of the "All or Substantially All of the Costs for the Training Program in the Nonhospital Setting" Requirement and New Cost Requirements for Hospitals
c. Proposed Revision to Regulations To Allow More Than One Hospital To Incur the Costs of Training Programs at Nonhospital Settings, Either Directly or Through a Third Party
d. Proposed Changes to Regulations Regarding Recordkeeping and Comparison to a Base Year
3. Counting Resident Time for Didactic and Scholarly Activities and Other Activities (Section 5505 of the Affordable Care Act)
a. Background and Changes Made by the Affordable Care Act
b. Definition of "Nonprovider Setting That Is Primarily Engaged in Furnishing Patient Care"
c. Distinguishing Between Allowed "Nonpatient Care Activities" and Nonallowable Research Time
d. Approved Leave of Absence
4. Reductions of and Increases in Hospitals' FTE Resident Caps for GME Payment Purposes
a. General Background on Methodology for Determining the FTE Resident Count
b. Reduction of Hospitals' FTE Resident Caps Under the Provisions of Section 5503 of the Affordable Care Act
c. Hospitals Subject to the FTE Resident Cap Reduction
d. Exemption From FTE Resident Cap Reduction for Certain Rural Hospitals
e. Application of Section 5503 to Hospitals That Participate in Demonstration Projects or Voluntary Reduction Programs and Certain Other Hospitals
f. Determining the Estimated Number of FTE Resident Slots Available for Redistribution
g. Reference Cost Reports That Are Under Appeal
h. Determining the Possible Reduction to a Hospital's FTE Resident Cap
i. Application of Section 5503 to Hospitals That File Low Utilization Medicare Cost Reports
j. Treatment of Hospitals With Caps That Have Been Reduced or Increased Under Section 422 of Public Law 108–173
k. Criteria for Determining Hospitals That Will Receive Increases in Their FTE Resident Caps
l. Application Process for the Increases in Hospitals' FTE Resident Caps
m. CMS Evaluation of Applications for Increases in FTE Resident Caps
n. CMS Evaluation of Application for Increases in FTE Resident Caps
o. Exception If Positions Are Not Redistributed by July 1, 2011
p. Application of Direct GME PRAs for Primary Care and Nonprimary Care Residents and Conforming Changes for the IME Multiplier
q. Other Issues Related to a Request for Increase in the FTE Caps Under Section 5503
5. Preservation of Resident Cap Positions From Closed Hospitals (Section 5506 of the Affordable Care Act)
a. Background
b. Definition of a "Closed Hospital"
c. Priority for Hospitals in Certain Areas
d. Application Process
e. Ranking Criteria
f. Demonstrated Likelihood of Filling the Positions Within a Certain Time Period
g. No Duplication of FTE Cap Slots
h. Other Payment Issues Regarding Hospitals That Receive Slots From Closed Hospitals
i. Application—No Reopening of Settled Cost Reports
XVIII. Proposed Changes to Whole Hospital and Rural Provider Exceptions to the Physician Self-Referral Prohibition and Related Changes to Provider Agreement Regulations
A. Background
B. Changes Made by the Affordable Care Act Relating to the Whole Hospital and Rural Provider Exceptions to Ownership and Investment Prohibition
C. Proposed Changes to Physician Self-Referral Regulations
1. Physician Ownership and Provider Agreement
2. Limitation on Expansion of Facility Capacity
3. Preventing Conflicts of Interest
4. Ensuring *Bona Fide* Investment
5. Patient Safety
6. Conversion From Ambulatory Surgery Center (ASC)
7. Publication of Information Reported
8. Enforcement
D. Proposed Related Changes to Provider Agreement Regulations
XIX. Files Available to the Public via the Internet
A. Information in Addenda Related to the Proposed CY 2011 Hospital OPPS
B. Information in Addenda Related to the Proposed CY 2011 ASC Payment System
XX. Collection of Information Requirements
A. Legislative Requirements for Solicitation of Comments
B. Requirements in Regulation Text
C. Associated Information Collections Not Specified in Regulatory Text
1. Hospital Outpatient Quality Data Reporting Program (HOP QDRP)
2. Proposed HOP QDRP Quality Measures for the CY 2011 and CY 2012 Payment Determinations
3. Proposed HOP QDRP Validation Requirements
4. Proposed HOP QDRP Reconsideration and Appeals Procedures
5. Additional Topics

XXI. Response to Comments
XXII. Regulatory Impact Analysis
A. Overall Impact
1. Executive Order 12866
2. Regulatory Flexibility Act
3. Small Rural Hospitals
4. Unfunded Mandates
5. Federalism
B. Effects of OPPS Changes in This Proposed Rule
1. Alternatives Considered
2. Limitations of Our Analysis
3. Estimated Effects of This Proposed Rule on Hospitals
4. Estimated Effects of This Proposed Rule on CMHCs
5. Estimated Effects of This Proposed Rule on Beneficiaries
6. Conclusion
7. Accounting Statement
C. Effects of ASC Payment System Changes in This Proposed Rule
1. Alternatives Considered
2. Limitations of Our Analysis
3. Estimated Effects of This Proposed Rule on Payments to ASCs
4. Estimated Effects of This Proposed Rule on Beneficiaries
5. Conclusion
6. Accounting Statement
D. Effects of Proposed Requirements for Reporting of Quality Data for Annual Hospital Payment Update
E. Effects of Proposed Changes in Payments to Hospitals for Direct GME and IME Costs
F. Effects of Proposed Changes to Physician Self-Referral Regulations and Related Proposed Changes to Provider Agreement Regulations
G. Executive Order 12866

Regulation Text

Addenda

Addendum A—Proposed OPPS APCs for CY 2011
Addendum AA—Proposed ASC Covered Surgical Procedures for CY 2011 (Including Surgical Procedures for Which Payment Is Packaged)
Addendum B—Proposed OPPS Payment by HCPCS Code for CY 2011
Addendum BB—Proposed ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2011 (Including Ancillary Services for Which Payment Is Packaged)
Addendum D1—Proposed OPPS Payment Status Indicators for CY 2011
Addendum DD1—Proposed ASC Payment Indicators for CY 2011
Addendum D2—Proposed OPPS Comment Indicators for CY 2011
Addendum DD2—Proposed ASC Comment Indicators for CY 2011
Addendum E—Proposed HCPCS Codes That Would Be Paid Only as Inpatient Procedures for CY 2011
Addendum L—Proposed CY 2011 OPPS Out-Migration Adjustment
Addendum M—Proposed HCPCS Codes for Assignment to Composite APCs for CY 2011

I. Background and Summary of the CY 2011 OPPS/ASC Proposed Rule

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

When Title XVIII of the Social Security Act (the Act) was 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 Act authorizing implementation of a PPS for hospital outpatient services. 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.

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113) made major changes in the hospital outpatient prospective payment system (OPPS). The following Acts made additional changes to the OPPS: the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554); 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; the Medicare Improvements and Extension Act under Division B of Title I of the Tax Relief and Health Care Act (MIEA–TRHCA) of 2006 (Pub. L. 109–432), enacted on December 20, 2006; the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 (Pub. L. 110–173), enacted on December 29, 2007; the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (Pub. L. 110–275), enacted on July 15, 2008; and most recently the Patient Protection and Affordable Care Act (Pub. L. 111–148), enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), enacted on March 30, 2010. We refer readers to section I.D. of this proposed rule for a summary of the provisions of Public Law 111–148, as amended by Public Law 111–152, that we are proposing to implement in this proposed rule.

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC) group to which the service is assigned. We use the Healthcare Common Procedure Coding System (HCPCS) codes (which include certain Current Procedural Terminology (CPT) codes) and descriptors to identify and group the services within each APC group. The OPPS includes payment for most hospital outpatient services, except those identified in section I.B. of this proposed rule. Section 1833(t)(1)(B)(ii) of the Act provides for 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.

The OPPS rate is an unadjusted national payment amount that includes the Medicare payment and the beneficiary copayment. This rate is divided into a labor-related amount and a nonlabor-related amount. The labor-related amount is adjusted for area wage differences using the hospital inpatient wage index value for the locality in which the hospital or CMHC is located.

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

For new technology items and services, special payments under the OPPS may be made in one of two ways. Section 1833(t)(6) of the Act provides for temporary additional payments, which we refer to as "transitional pass-through payments," for at least 2 but not more than 3 years for certain drugs, biological agents, brachytherapy devices used for the treatment of cancer, and categories of other medical devices. For new technology services that are not eligible for transitional pass-through payments, and for which we lack sufficient data to appropriately assign them to a clinical APC group, we have established special APC groups based on costs, which we refer to as New Technology APCs. These New

Technology APCs are designated by cost bands which allow us to provide appropriate and consistent payment for designated new procedures that are not yet reflected in our claims data. Similar to pass-through payments, an assignment to a New Technology APC is temporary; that is, we retain a service within a New Technology APC until we acquire sufficient data to assign it to a clinically appropriate APC group.

B. Excluded OPPS Services and Hospitals

Section 1833(t)(1)(B)(i) of the Act authorizes the Secretary to designate the hospital outpatient services that are paid under the OPPS. While most hospital outpatient services are payable under the OPPS, section 1833(t)(1)(B)(iv) of the Act excludes payment for ambulance, physical and occupational therapy, and speech-language pathology services, for which payment is made under a fee schedule. It also excludes screening mammography, diagnostic mammography, and effective January 1, 2011, an annual wellness visit providing personalized prevention plan services. The Secretary exercised the authority granted under the statute to also exclude from the OPPS those services that are paid under fee schedules or other payment systems. Such excluded services include, for example, the professional services of physicians and nonphysician practitioners paid under the Medicare Physician Fee Schedule (MPFS); laboratory services paid under the clinical diagnostic laboratory fee schedule (CLFS); services for beneficiaries with end-stage renal disease (ESRD) that are paid under the ESRD composite rate; and services and procedures that require an inpatient stay that are paid under the hospital inpatient prospective payment system (IPPS). We set forth the services that are excluded from payment under the OPPS in § 419.22 of the regulations.

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

C. Prior Rulemaking

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

Since initially implementing the OPPS, we have published final rules in the **Federal Register** annually to implement statutory requirements and changes arising from our continuing experience with this system. These rules can be viewed on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/*. The CY 2010 OPPS/ASC final rule with comment period appears in the November 20, 2009 **Federal Register** (74 FR 60316). 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 2010 OPPS on the basis of claims data from January 1, 2008, through December 31, 2008, and to implement certain provisions of Public Law 110–173 and Public Law 110–275. In addition, we responded to public comments received on the provisions of the November 18, 2008 final rule with comment period (73 FR 68502) pertaining to the APC assignment of HCPCS codes identified in Addendum B to that rule with the new interim ("NI") comment indicator, and public comments received on the July 20, 2009 OPPS/ASC proposed rule for CY 2010 (74 FR 35232).

D. Provisions of the Patient Protection and Affordable Care Act (Pub. L. 111–148), as Amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152)

On March 23, 2010, the Patient Protection and Affordable Care Act, Public Law 111–148, was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. (These two public laws are collectively known as the Affordable Care Act.) A number of the provisions of the Affordable Care Act affect the OPPS and the ASC payment system and the providers and suppliers addressed in this proposed rule. Listed below are the provisions of the Affordable Care Act that we are proposing to implement in this proposed rule. We note that, due to the timing of the passage of the legislation, we were unable to address some of the provisions of the Affordable Care Act that affect the IPPS and the LTCH PPS in the FY 2011 IPPS/LTCH PPS proposed rule published in the **Federal Register** on May 4, 2010. Therefore, we also are including some proposals to implement certain provisions relating to the IPPS and LTCH PPS in this proposed rule. In addition, we note that we have issued or plan to issue separate documents in the **Federal Register** addressing other provisions of the Affordable Care Act (75 FR 30756 and 75 FR 31118).

- Section 1301 of the Affordable Care Act amended sections 1861(ff)(3)(A) and (B) of the Act to establish new additional requirements for CMHCs applicable to items or services furnished to Medicare beneficiaries on or after the first day of the first calendar quarter that begins at least 12 months after the date of enactment of Public Law 111–152 (that is, beginning April 1, 2011). The new requirements specify that a CMHC provide at least 40 percent of its services to individuals who are not eligible for Medicare benefits under Title XVIII of the Act and that a partial hospitalization program must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care "other than an individual's home or in an inpatient or residential setting." This provision is addressed in section X. of this proposed rule.
- Section 3121(a) of the Affordable Care Act amended section 1833(t)(7)(D)(i) of the Act to extend hold harmless payment adjustments (called transitional corridor payments or transitional outpatient payments (TOPS)) to rural hospitals with 100 or fewer beds and that are not sole community hospitals for covered OPD services furnished on or after January 1, 2006 and before January 1, 2011. Section 3121(b) amended section 1833(t)(7)(D)(i)(III) of the Act to provide that, for SCHs, in the case of covered OPD services furnished on or after January 1, 2010, and before January 1, 2011, the hold harmless TOPS provisions shall be applied without regard to the 100-bed limitation. These provisions are addressed in section II.E. of this proposed rule.
- Section 3138 of the Affordable Care Act amended section 1833(t) of the Act to direct the Secretary to conduct a study to determine if costs incurred by cancer hospitals (described in section 1886(d)(1)(B)(v) of the Act) for outpatient hospital services with respect to APC groups exceed those costs

incurred by other hospitals furnishing these services. In so far as the Secretary determines that such costs exceed those costs incurred by other hospitals, the Secretary shall provide for an appropriate adjustment under the authority of section 1833(t)(2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011. This provision is addressed in section II.F. of this proposed rule.

• Section 3401(i) of the Affordable Care Act amended section 1833(t)(3) of the Act by, among other things, adding new paragraphs (C)(iv)(F) and (G) to reduce the OPD fee schedule increase factor by a productivity adjustment and an additional adjustment for payments to hospital OPDs beginning in various years from CY 2010 through CY 2019 as applicable. These hospital OPD provisions are addressed in section II.B.1. of this proposed rule. Section 3401(k) of the Affordable Care Act amended section 1833(i)(2)(D) of the Act by adding a new subsection (iv) to provide for a similar productivity adjustment for payment for ASC services. This ASC provision is addressed in section XV.H.2.b. of this proposed rule.

• Section 4103(a) of the Affordable Care Act amended section 1861(s)(2) of the Act by adding a new subsection (FF) to provide Medicare coverage of "personalized prevention plan services," beginning January 1, 2011. Section 4103(b) of the Affordable Care Act amended section 1861 of the Act by adding a new subsection (hhh) to define "personalized prevention plan services" (also cited as the "annual wellness visit"). Section 4103(c) of the Affordable Care Act excludes the annual wellness visit from payment under the OPPS and provides for the elimination of beneficiary coinsurance requirements for these preventive services in outpatient hospital settings and for waiver of application of the deductible for these services. These provisions are addressed in section XII.B. of this proposed rule.

• Section 4104(a) of the Affordable Care Act amended section 1861(ddd) of the Act to define "preventive services" under Medicare to include screening and preventive services described under subsection (ww)(2) of the Act (other than services under subparagraph (M)); an initial preventive physical examination as defined in subsection (ww) of the Act; and personalized prevention plan services as defined in subsection (hhh)(1) of the Act. Section 4104(b) of the Affordable Care Act amended section 1833(a)(1) of the Act, as amended by section 4103(c)(1) of the Affordable Care Act, to provide for the elimination of coinsurance for most preventive services, and section 4104(c) amended section 1833(b) of the Act to provide for the waiver of the application of the deductible for most preventive services and, specifically, for colorectal cancer screening tests that become diagnostic and any related services performed with that diagnostic colorectal cancer screening test performed in the same clinical encounter, effective for items and services furnished on or after January 1, 2011. These provisions are addressed in section XII.B. of this proposed rule.

• Sections 5503, 5504, 5505, and 5506 of the Affordable Care Act made a number of changes to various sections of the Act relating to payment for direct GME and IME costs to hospitals.

(1) Section 5503 amended the Act to add a provision to redistribute medical residency positions that have been unfilled during a prior cost reporting period to other hospitals and to direct slots for training primary care physicians beginning July 1, 2011.

(2) Section 5504 amended sections 1886(h)(4)(E) and 1886(d)(5)(B)(iv) of the Act to allow any time spent by residents training in a nonprovider setting to count toward direct GME and IME costs if the hospital incurs the costs of residents' salaries and fringe benefits, effective for cost reporting periods beginning on or after July 1, 2010, for direct GME, and for discharges occurring on or after July 1, 2010, for IME.

(3) Section 5505 amended section 1886(h) and section 1886(d)(5)(B) of the Act to add a provision to allow hospitals to count resident time spent in certain non-patient care activities while training in certain nonhospital settings for direct GME purposes, effective for cost reporting periods beginning on or after July 1, 2009; to allow hospitals to count resident time spent in certain non-patient care activities while training in certain hospital settings for IME purposes for cost reporting periods beginning on or after January 1, 1983; and to prohibit the counting of time spent by residents in research not associated with the treatment or diagnosis of a particular patient for IME purposes effective October 1, 2001 (with certain limitations).

(4) Section 5506 amended section 1886(h)(4)(H) and section 1886(d)(5)(B)(iv) of the Act to add a provision to allow for the redistribution to other hospitals in the same or contiguous areas of FTE resident positions from a hospital that closes (on or after the date that is 2 years before the date of enactment of Pub. L. 111–148). These provisions are addressed in section XVII.B. of this proposed rule.

• Section 6001 of the Affordable Care Act amended section 1877 of the Act to add provisions under new subsection (i) relating to the prohibition against referrals to a hospital by a physician who has an ownership or investment interest in the hospital. This provision is addressed in section XVIII. of this proposed rule.

• Section 10324(b) of the Affordable Care Act amended section 1833(t) of the Act by adding a new subsection (19) to provide for a floor on the area wage adjustment factor for hospital outpatient department services furnished on or after January 1, 2011, in a State in which at least 50 percent of the counties in the State are frontier counties, that is, a county in which the population per square mile is less than 6. This provision is addressed in section II.C. of this proposed rule.

E. Advisory Panel on Ambulatory Payment Classification (APC) Groups

1. Authority of the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the APC Panel)

Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of Public Law 106–113, and redesignated by section 202(a)(2) of Public Law 106–113, 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 APC Panel, discussed under section I.E.2. of this proposed rule, fulfills these requirements. The APC Panel is not restricted to using data compiled by CMS, and it 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 (currently employed full-time, not as consultants, in their respective areas of expertise) subject to the OPPS, reviews clinical data and advises CMS about the clinical integrity of the APC groups and their payment weights. The APC Panel is technical in nature, and it is governed by the provisions of the Federal Advisory Committee Act (FACA). Since its initial chartering, the Secretary has renewed the APC Panel's charter four times: on November 1, 2002; on November 1, 2004; on November 21, 2006; and on November 2, 2008. The

current charter specifies, 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 Official (DFO); and is chaired by a Federal official designated by the Secretary.

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

3. APC Panel Meetings and Organizational Structure

The APC Panel first met on February 27 through March 1, 2001. Since the initial meeting, the APC Panel has held 17 meetings, with the last meeting taking place on February 17 and 18, 2010. Prior to each meeting, we publish a notice in the **Federal Register** to announce the meeting and, when necessary, to solicit nominations for APC Panel membership and to announce new members.

The APC Panel has established an operational structure that, in part, includes the use of three subcommittees to facilitate its required APC review process. The three current subcommittees are the Data Subcommittee, the Visits and 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 Visits and Observation Subcommittee reviews and makes recommendations to the APC Panel on all technical issues pertaining to observation services and hospital outpatient visits paid under the OPPS (for example, APC configurations and APC payment weights). The Packaging Subcommittee studies and makes recommendations on issues pertaining to services that are not separately payable under the OPPS, but whose payments are bundled or packaged into APC payments. Each of these subcommittees was established by a majority vote from the full APC Panel during a scheduled APC Panel meeting, and the APC Panel recommended that the subcommittees continue at the February 2010 APC Panel meeting. We accept those recommendations of the APC Panel. All subcommittee recommendations are discussed and voted upon by the full APC Panel.

Discussions of the other recommendations made by the APC Panel at the February 2010 meeting are included in the sections of this proposed rule that are specific to each recommendation. For discussions of earlier APC Panel meetings and recommendations, we refer readers to previously published hospital OPPS/ASC proposed and final rules, the CMS Web site mentioned earlier in this section, and the FACA database at: *http://fido.gov/facadatabase/public.asp*.

F. Summary of the Contents of This Proposed Rule

In this proposed rule, we set forth proposed changes to the Medicare hospital OPPS for CY 2011 to implement statutory requirements and changes arising from our continuing experience with the system and to implement certain provisions of Public Law 111–148, as amended by Public Law 111–152 (collectively known as the Affordable Care Act). In addition, we set forth proposed changes to the revised Medicare ASC payment system for CY 2011, including proposed updated payment weights, covered surgical procedures, and covered ancillary items and services based on the proposed OPPS update. We set forth proposed quality measures for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) for reporting quality data for annual payment rate updates for CY 2012 and subsequent calendar years, the proposed requirements for data collection and submission for the annual payment update, and a proposed reduction in the OPPS payment for hospitals that fail to meet the HOP QDRP requirements for the CY 2011 payment update, in accordance with the statutory requirement. We also set forth proposed changes to implement provisions of the Affordable Care Act relating to payments to hospitals for direct GME and IME costs and the rules relating to physician self-referrals to hospitals in which they have an ownership or investment interest. In addition, we are setting forth proposals affecting certain payments under the Medicare IPPS. The following is a summary of the major proposed changes that we are proposing to make:

1. Proposed Updates Affecting OPPS Payments

In section II. of this proposed rule, we set forth—

- The methodology used to recalibrate the proposed APC relative payment weights.
- The proposed changes to packaged services.
- The proposed update to the conversion factor used to determine payment rates under the OPPS. In this section, we set forth proposed changes in the amounts and factors for calculating the full annual update increase to the conversion factor.
- The proposed retention of our current policy to use the IPPS wage indices to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor-related cost. This proposal addresses the provisions of section 10324 of the Affordable Care Act relating to the establishment of a floor for the area wage adjustment factor for OPD services furnished in frontier States.
- The proposed update of statewide average default CCRs.
- The proposed application of hold harmless transitional outpatient payments (TOPs) for certain small rural hospitals, extended by section 3121 of the Affordable Care Act.
- The proposed payment adjustment for rural SCHs.
- The proposed calculation of the hospital outpatient outlier payment.
- The calculation of the proposed national unadjusted Medicare OPPS payment.
- The proposed beneficiary copayments for OPPS services.

2. Proposed OPPS Ambulatory Payment Classification (APC) Group Policies

In section III. of this proposed rule, we discuss—

- The proposed additions of new HCPCS codes to APCs.
- The proposed establishment of a number of new APCs.
- Our analyses of Medicare claims data and certain recommendations of the APC Panel.
- The application of the 2 times rule and proposed exceptions to it.
- The proposed changes to specific APCs.
- The proposed movement of procedures from New Technology APCs to clinical APCs.

3. Proposed OPPS Payment for Devices

In section IV. of this proposed rule, we discuss the proposed pass-through payment for specific categories of devices and the proposed adjustment for devices furnished at no cost or with partial or full credit.

4. Proposed OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

In section V. of this proposed rule, we discuss the proposed CY 2011 OPPS

payment for drugs, biologicals, and radiopharmaceuticals, including the proposed payment for drugs, biologicals, and radiopharmaceuticals with and without pass-through status.

5. Proposed Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices

In section VI. of this proposed rule, we discuss the estimate of CY 2011 OPPS transitional pass-through spending for drugs, biologicals, and devices.

6. Proposed OPPS Payment for Brachytherapy Sources

In section VII. of this proposed rule, we discuss our proposal for payment for brachytherapy sources.

7. Proposed OPPS Payment for Drug Administration Services

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

8. Proposed OPPS Payment for Hospital Outpatient Visits

In section IX. of this proposed rule, we set forth our proposed policies for the payment of clinic and emergency department visits and critical care services based on claims data.

9. Proposed Payment for Partial Hospitalization Services

In section X. of this proposed rule, we set forth our proposed payment for partial hospitalization services, including the proposed separate threshold for outlier payments for CMHCs. We also set for our proposals to implement the new requirements for CMHCs established by section 1301 of the Affordable Care Act.

10. Proposed Procedures That Would Be Paid Only as Inpatient Procedures

In section XI. of this proposed rule, we discuss the procedures that we are proposing to remove from the inpatient list and assign to APCs for payment under the OPPS.

11. Proposed OPPS Nonrecurring Technical and Policy Changes and Clarifications

In section XII. of this proposed rule, we discuss nonrecurring technical issues and proposed policy changes relating to physician supervision of OPD services in hospitals, including CAHs. We also are proposing to implement the provisions of sections 4103 and 4104 of the Affordable Care Act relating to payment for preventive services, including personalized prevention plan services, and the waiver of beneficiary coinsurance and deductibles.

12. Proposed OPPS Payment Status and Comment Indicators

In section XIII. of this proposed rule, we discuss our proposed changes to the definitions of status indicators assigned to APCs and present our proposed comment indicators for the final rule with comment period.

13. OPPS Policy and Payment Recommendations

In section XIV. of this proposed rule, we address recommendations made by the Medicare Payment Advisory Commission (MedPAC) in its March 2010 report to Congress, by the Office of Inspector General (OIG), and by the APC Panel regarding the OPPS for CY 2011.

14. Proposed Updates to the Ambulatory Surgical Center (ASC) Payment System

In section XV. of this proposed rule, we discuss the proposed updates of the revised ASC payment system and payment rates for CY 2011.

15. Reporting Quality Data for Annual Payment Rate Updates

In section XVI. of this proposed rule, we discuss the proposed quality measures for reporting hospital outpatient (HOP) quality data for the annual payment update factor for CY 2012 and subsequent calendar years; set forth the requirements for data collection and submission for the annual payment update; and discuss the reduction in the OPPS payment for hospitals that fail to meet the HOP Quality Data Reporting Program (QDRP) requirements for CY 2011.

16. Bundling of Payments for Inpatient and Outpatient Services and Payments to Hospitals for Direct GME and IME Costs

In section XVII. of this proposed rule, we discuss our proposed implementation of the provisions of section 5503, 5504, 5505, and 5506 of the Affordable Care Act relating to redistribution of FTE resident slots of closed hospitals and policy changes for the counting of FTE residents in determining payments to hospitals for direct GME and IME costs.

17. Physician Self-Referrals to Hospitals

In section XVIII. of this preamble, we discuss our proposal to implement the changes made by section 6001 of the Affordable Care Act relating to the rules governing the prohibition on referrals to a hospital by a physician who has an ownership or investment interest in the hospital.

18. Regulatory Impact Analysis

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

II. Proposed Updates Affecting OPPS Payments

A. Proposed Recalibration of APC Relative Weights

1. Database Construction

a. Database Source and Methodology

Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually. In the April 7, 2000 OPPS final rule with comment period (65 FR 18482), we explained in detail how we calculated the relative payment weights that were implemented on August 1, 2000 for each APC group.

For CY 2011, we are proposing to use the same basic methodology that we described in the November 20, 2009 OPPS final rule with comment period to recalibrate the APC relative payment weights for services furnished on or after January 1, 2011, and before January 1, 2012 (CY 2011). That is, we are proposing to recalibrate the relative payment weights for each APC based on claims and cost report data for hospital outpatient department (HOPD) services. We are proposing to use the most recent available data to construct the database for calculating APC group weights. Therefore, for the purpose of recalibrating the proposed APC relative payment weights for CY 2011, we used approximately 133 million final action claims for hospital outpatient department services furnished on or after January 1, 2009, and before January 1, 2010. (For exact counts of claims used, we refer readers to the claims accounting narrative under supporting documentation for this proposed rule on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/HORD/*.)

Of the 133 million final action claims for services provided in hospital outpatient settings used to calculate the CY 2011 OPPS payment rates for this proposed rule, approximately 102 million claims were 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 102 million claims, approximately 4 million claims were not for services paid under the OPPS or were excluded as not

appropriate for use (for example, erroneous cost-to-charge ratios (CCRs) or no HCPCS codes reported on the claim). From the remaining 98 million claims, we created approximately 95 million single records, of which approximately 64 million were "pseudo" single or "single session" claims (created from 24 million multiple procedure claims using the process we discuss later in this section). Approximately 696,000 claims were trimmed out on cost or units in excess of +/− 3 standard deviations from the geometric mean, yielding approximately 95 million single bills for median setting. As described in section II.A.2. of this proposed rule, our data development process is designed with the goal of using appropriate cost information in setting the APC relative weights. The bypass process is described in section II.A.1.b. of this proposed rule. This section discusses how we develop "pseudo" single procedure claims, with the intention of using more appropriate data from the available claims. In some cases, the bypass process allows us to use some portion of the submitted claim for cost estimation purposes, while the remaining information on the claim continues to be unusable. Consistent with the goal of using appropriate information in our data development process, we only use claims (or portions of each claim) that are appropriate for ratesetting purposes. Ultimately, we were able to use for CY 2011 ratesetting some portion of 95 percent of the CY 2009 claims containing services payable under the OPPS.

The proposed APC relative weights and payments for CY 2011 in Addenda A and B to this proposed rule were calculated using claims from CY 2009 that were processed before January 1, 2010, and continue to be based on the median hospital costs for services in the APC groups. We selected claims for services paid under the OPPS and matched these claims to the most recent cost report filed by the individual hospitals represented in our claims data. We continue to believe that it is appropriate to use the most current full calendar year claims data and the most recently submitted cost reports to calculate the median costs underpinning the APC relative payment weights and the CY 2011 payment rates.

b. Proposed Use of Single and Multiple Procedure Claims

For CY 2011, in general, we are proposing to continue to use single procedure claims to set the medians on which the APC relative payment weights would be based, with some exceptions as discussed below in this section. We generally use single procedure claims to set the median costs for APCs because we believe that the OPPS relative weights on which payment rates are based should be derived from the costs of furnishing one unit of one procedure and because, in many circumstances, we are unable to ensure that packaged costs can be appropriately allocated across multiple procedures performed on the same date of service.

We agree that, optimally, it is desirable to use the data from as many claims as possible to recalibrate the APC relative payment weights, including those claims for multiple procedures. As we have for several years, we continued to use date of service stratification and a list of codes to be bypassed to convert multiple procedure claims to "pseudo" single procedure claims. Through bypassing specified codes that we believe do not have significant packaged costs, we are able to use more data from multiple procedure claims. In many cases, this enables us to create multiple "pseudo" single procedure claims from claims that were submitted as multiple procedure claims spanning multiple dates of service, or claims that contained numerous separately paid procedures reported on the same date on one claim. We refer to these newly created single procedure claims as "pseudo" single procedure claims. The history of our use of a bypass list to generate "pseudo" single procedure claims is well documented, most recently in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60324 through 60342). In addition, for CY 2008, we increased packaging and created the first composite APCs. We have continued our packaging policies and the creation of composite APCs for CY 2009 and 2010, and we are proposing to continue them for CY 2011. This also increased the number of bills that we were able to use for median calculation by enabling us to use claims that contained multiple major procedures that previously would not have been usable. Further, for CY 2009, we expanded the composite APC model to one additional clinical area, multiple imaging services (73 FR 68559 through 68569), which also increased the number of bills we were able to use to calculate APC median costs. We have continued the composite APCs for multiple imaging services for CY 2010, and we are proposing to continue to create them for CY 2011. We refer readers to section II.A.2.e. of this proposed rule for discussion of the use of claims to establish median costs for composite APCs.

We are proposing to continue to apply these processes to enable us to use as much claims data as possible for ratesetting for the CY 2011 OPPS. This methodology enabled us to create, for this proposed rule, approximately 64 million "pseudo" single procedure claims, including multiple imaging composite "single session" bills (we refer readers to section II.A.2.e.(5) of this proposed rule for further discussion), to add to the approximately 31 million "natural" single procedure claims. For this proposed rule, "pseudo" single procedure and "single session" procedure bills represent approximately 67 percent of all single procedure bills used to calculate median costs.

For CY 2011, we are proposing to bypass 448 HCPCS codes for CY 2011 that are identified in Table 1 of this proposed rule. Since the inception of the bypass list, we have calculated the percent of "natural" single bills that contained packaging for each HCPCS code and the amount of packaging on each "natural" single bill for each code. Each year, we generally retain the codes on the previous year's bypass list and use the update year's data (for CY 2011, data available for the February 2010 APC Panel meeting from CY 2009 claims processed through September 30, 2009, and CY 2008 claims data processed through June 30, 2009, used to model the payment rates for CY 2010) to determine whether it would be appropriate to propose to add additional codes to the previous year's bypass list. For CY 2011, we are proposing to continue to bypass all of the HCPCS codes on the CY 2010 OPPS bypass list. We updated HCPCS codes on the CY 2010 bypass list that were mapped to new HCPCS codes for CY 2011 ratesetting by adding the new replacement codes and also removing the deleted codes, which are listed in Table 2. None of these deleted codes were "overlap bypass codes" (those HCPCS codes that are both on the bypass list and are members of the multiple imaging composite APCs). We also are proposing to add to the bypass list for CY 2011 all HCPCS codes not on the CY 2010 bypass list that, using both CY 2010 final rule data (CY 2008 claims) and February 2010 APC Panel data (first 9 months of CY 2009 claims), met the same previously established empirical criteria for the bypass list that are summarized below. The entire list proposed for CY 2011 (including the codes that remain on the bypass list from prior years) is open to public comment. Because we must make some assumptions about packaging in the multiple procedure claims in order to

assess a HCPCS code for addition to the bypass list, we assume that the representation of packaging on "natural" single procedure claims for any given code is comparable to packaging for that code in the multiple procedure claims. The proposed criteria for the bypass list are:

- There are 100 or more "natural" single procedure claims for the code. This number of single procedure claims ensures that observed outcomes are sufficiently representative of packaging that might occur in the multiple claims.
- Five percent or fewer of the "natural" single procedure claims for the code have packaged costs on that single procedure claim for the code. This criterion results in limiting the amount of packaging being redistributed to the separately payable procedures 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 "natural" single procedure claims is equal to or less than $50. This criterion also limits the amount of error in redistributed costs. Throughout the bypass process, we do not know the dollar value of the packaged cost that should be appropriately attributed to the other procedures on the claim. Ensuring that redistributed costs associated with a bypass code are small in amount and volume protects the validity of cost estimates for low cost services billed with the bypassed service.

In response to comments to the CY 2010 OPPS/ASC proposed rule requesting that the packaged cost threshold be updated, we noted that we would consider whether it would be appropriate to update the $50 packaged cost threshold for inflation when examining potential bypass list additions (74 FR 60328). For the CY 2011 OPPS, based on CY 2009 claims data, we are proposing to apply the final market basket of 3.6 percent published in the CY 2009 OPPS/ASC final rule with comment period (73 FR 26584) to the $50 packaged cost threshold used in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60325) that we initially established in the CY 2005 OPPS final rule based on our analysis of the data (69 FR 65731), rounded to the nearest $5 increment. This calculation would lead us to a proposed packaged cost threshold for bypass list additions of $50 ($51.80 rounded to $50). We believe that applying the market basket from the year of claims data to the packaged cost threshold, rounded to the nearest $5 increment, would appropriately account for the effects of inflation when considering additions to the bypass list because the market basket increase percentage reflects the extent to which the cost of inputs for hospital services has increased compared to the cost of inputs for hospital services in the prior year. As discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60328), the real value of this packaged cost threshold criterion has declined due to inflation, making the packaged cost threshold more restrictive over time when considering additions to the bypass list. Therefore, adjusting the threshold by the market basket would prevent continuing decline in the threshold's real value. The dollar threshold would not change for CY 2011 under this proposed policy, because when rounded to the nearest $5 increment after adjustment for the market basket increase, the threshold would for CY 2011 remain at $50. Therefore, we are not proposing to add any additional bypass codes for CY 2011 as a result of this proposed policy.

- The code is not a code for an unlisted service.

In addition, we are proposing to continue to include, on the bypass list, HCPCS codes that CMS medical advisors believe have minimal associated packaging based on their clinical assessment of the complete CY 2011 OPPS proposal. Some of these codes were identified by CMS medical advisors and some were identified in prior years by commenters with specialized knowledge of the packaging associated with specific services. We also are proposing to continue to include on the bypass list certain HCPCS codes in order to purposefully direct the assignment of packaged costs to a companion code where services always appear together and where there would otherwise be few single procedure claims available for ratesetting. For example, we have previously discussed our reasoning for adding HCPCS code G0390 (Trauma response team associated with hospital critical care service) and the CPT codes for additional hours of drug administration to the bypass list (73 FR 68513 and 71 FR 68117 through 68118).

As a result of the multiple imaging composite APCs that we established in CY 2009, the program logic for creating "pseudo" single procedure claims from bypassed codes that are also members of multiple imaging composite APCs changed. When creating the set of "pseudo" single procedure claims, claims that contain "overlap bypass codes" (those HCPCS codes that are both on the bypass list and are members of the multiple imaging composite APCs), were identified first. These HCPCS codes were then processed to create multiple imaging composite "single session" bills, that is, claims containing HCPCS codes from only one imaging family, thus suppressing the initial use of these codes as bypass codes. However, these "overlap bypass codes" were retained on the bypass list because, at the end of the "pseudo" single processing logic, we reassessed the claims without suppression of the "overlap bypass codes" under our longstanding "pseudo" single process to determine whether we could convert additional claims to "pseudo" single procedure claims. (We refer readers to section II.A.2.b. of this proposed rule for further discussion of the treatment of "overlap bypass codes.") This process also created multiple imaging composite "single session" bills that could be used for calculating composite APC median costs. "Overlap bypass codes" that are members of the proposed multiple imaging composite APCs are identified by asterisks (*) in Table 1 below.

Table 1 below includes the proposed list of bypass codes for CY 2011. The list of bypass codes contains codes that were reported on claims for services in CY 2009 and, therefore, includes codes that were in effect in 2009 and used for billing but were deleted for CY 2010. We retain these deleted bypass codes on the proposed CY 2011 bypass list because these codes existed in CY 2009 and were covered OPD services in that period. Since these bypass codes were deleted for billing in CY 2010, we will not need to retain them for the CY 2010 bypass list. Keeping these deleted bypass codes on the bypass list potentially allows us to create more "pseudo" single procedure claims for ratesetting purposes. "Overlap bypass codes" that are members of the proposed multiple imaging composite APCs are identified by asterisks (*) in the third column of Table 1 below. HCPCS codes that we are proposing to add for CY 2011 also are identified by asterisks (*) in the fourth column of Table 1. Table 2 contains the list of codes that we are proposing to remove from the CY 2011 bypass list because they were deleted from the HCPCS before CY 2009. None of these proposed deleted codes were "overlap bypass" codes.

BILLING CODE 4120–01–P

TABLE 1.—PROPOSED CY 2009 BYPASS CODES FOR CREATING "PSEUDO" SINGLE PROCEDURE CLAIMS FOR CALCULATING MEDIAN COSTS FOR CY 2011 OPPS

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
11056	Trim skin lesions, 2 to 4		
11057	Trim skin lesions, over 4		
11300	Shave skin lesion		
11301	Shave skin lesion		
11719	Trim nail(s)		
11720	Debride nail, 1-5		
11721	Debride nail, 6 or more		
11954	Therapy for contour defects		
17000	Destruct premalg lesion		
17003	Destruct premalg les, 2-14		
23600	Treat humerus fracture		*
29220	Strapping of low back		
29530	Strapping of knee		*
31231	Nasal endoscopy, dx		
31579	Diagnostic laryngoscopy		
51798	Us urine capacity measure		
53661	Dilation of urethra		
54240	Penis study		
56820	Exam of vulva w/scope		
57150	Treat vagina infection		
57452	Exam of cervix w/scope		*
57454	Bx/curett of cervix w/scope		*
67820	Revise eyelashes		
69210	Remove impacted ear wax		
69220	Clean out mastoid cavity		
70030	X-ray eye for foreign body		
70100	X-ray exam of jaw		
70110	X-ray exam of jaw		
70120	X-ray exam of mastoids		
70130	X-ray exam of mastoids		
70140	X-ray exam of facial bones		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
70150	X-ray exam of facial bones		
70160	X-ray exam of nasal bones		
70200	X-ray exam of eye sockets		
70210	X-ray exam of sinuses		
70220	X-ray exam of sinuses		
70240	X-ray exam, pituitary saddle		*
70250	X-ray exam of skull		
70260	X-ray exam of skull		
70320	Full mouth x-ray of teeth		*
70328	X-ray exam of jaw joint		
70330	X-ray exam of jaw joints		
70336	Magnetic image, jaw joint	*	
70355	Panoramic x-ray of jaws		
70360	X-ray exam of neck		
70370	Throat x-ray & fluoroscopy		
70371	Speech evaluation, complex		
70450	Ct head/brain w/o dye	*	
70480	Ct orbit/ear/fossa w/o dye	*	
70486	Ct maxillofacial w/o dye	*	
70490	Ct soft tissue neck w/o dye	*	
70544	Mr angiography head w/o dye	*	
70547	Mr angiography neck w/o dye	*	*
70551	Mri brain w/o dye	*	
71010	Chest x-ray		
71015	Chest x-ray		
71020	Chest x-ray		
71021	Chest x-ray		
71022	Chest x-ray		
71023	Chest x-ray and fluoroscopy		
71030	Chest x-ray		
71034	Chest x-ray and fluoroscopy		
71035	Chest x-ray		
71100	X-ray exam of ribs		
71101	X-ray exam of ribs/chest		
71110	X-ray exam of ribs		
71111	X-ray exam of ribs/chest		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
71120	X-ray exam of breastbone		
71130	X-ray exam of breastbone		
71250	Ct thorax w/o dye	*	
72010	X-ray exam of spine		
72020	X-ray exam of spine		
72040	X-ray exam of neck spine		
72050	X-ray exam of neck spine		
72052	X-ray exam of neck spine		
72069	X-ray exam of trunk spine		
72070	X-ray exam of thoracic spine		
72072	X-ray exam of thoracic spine		
72074	X-ray exam of thoracic spine		
72080	X-ray exam of trunk spine		
72090	X-ray exam of trunk spine		
72100	X-ray exam of lower spine		
72110	X-ray exam of lower spine		
72114	X-ray exam of lower spine		
72120	X-ray exam of lower spine		
72125	Ct neck spine w/o dye	*	
72128	Ct chest spine w/o dye	*	
72131	Ct lumbar spine w/o dye	*	
72141	Mri neck spine w/o dye	*	
72146	Mri chest spine w/o dye	*	
72148	Mri lumbar spine w/o dye	*	
72170	X-ray exam of pelvis		
72190	X-ray exam of pelvis		
72192	Ct pelvis w/o dye	*	
72202	X-ray exam sacroiliac joints		
72220	X-ray exam of tailbone		
73000	X-ray exam of collar bone		
73010	X-ray exam of shoulder blade		
73020	X-ray exam of shoulder		
73030	X-ray exam of shoulder		
73050	X-ray exam of shoulders		
73060	X-ray exam of humerus		
73070	X-ray exam of elbow		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
73080	X-ray exam of elbow		
73090	X-ray exam of forearm		
73100	X-ray exam of wrist		
73110	X-ray exam of wrist		
73120	X-ray exam of hand		
73130	X-ray exam of hand		
73140	X-ray exam of finger(s)		
73200	Ct upper extremity w/o dye	*	
73218	Mri upper extremity w/o dye	*	
73221	Mri joint upr extrem w/o dye	*	
73510	X-ray exam of hip		
73520	X-ray exam of hips		
73540	X-ray exam of pelvis & hips		
73550	X-ray exam of thigh		
73560	X-ray exam of knee, 1 or 2		
73562	X-ray exam of knee, 3		
73564	X-ray exam, knee, 4 or more		
73565	X-ray exam of knees		
73590	X-ray exam of lower leg		
73600	X-ray exam of ankle		
73610	X-ray exam of ankle		
73620	X-ray exam of foot		
73630	X-ray exam of foot		
73650	X-ray exam of heel		
73660	X-ray exam of toe(s)		
73700	Ct lower extremity w/o dye	*	
73718	Mri lower extremity w/o dye	*	
73721	Mri jnt of lwr extre w/o dye	*	
74000	X-ray exam of abdomen		
74010	X-ray exam of abdomen		
74020	X-ray exam of abdomen		
74022	X-ray exam series, abdomen		
74150	Ct abdomen w/o dye	*	
74210	Contrst x-ray exam of throat		
74220	Contrast x-ray, esophagus		
74230	Cine/vid x-ray, throat/esoph		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
74246	Contrst x-ray uppr gi tract		
74247	Contrst x-ray uppr gi tract		
74249	Contrst x-ray uppr gi tract		
76100	X-ray exam of body section		
76510	Ophth us, b & quant a		
76511	Ophth us, quant a only		
76512	Ophth us, b w/non-quant a		
76513	Echo exam of eye, water bath		
76514	Echo exam of eye, thickness		
76516	Echo exam of eye		
76519	Echo exam of eye		
76536	Us exam of head and neck		
76645	Us exam, breast(s)		
76700	Us exam, abdom, complete	*	
76705	Echo exam of abdomen	*	
76770	Us exam abdo back wall, comp	*	
76775	Us exam abdo back wall, lim	*	
76776	Us exam k transpl w/Doppler	*	
76801	Ob us < 14 wks, single fetus		
76805	Ob us >/= 14 wks, sngl fetus		
76811	Ob us, detailed, sngl fetus		
76816	Ob us, follow-up, per fetus		
76817	Transvaginal us, obstetric		
76830	Transvaginal us, non-ob		
76856	Us exam, pelvic, complete	*	
76857	Us exam, pelvic, limited	*	
76870	Us exam, scrotum	*	
76880	Us exam, extremity		
76970	Ultrasound exam follow-up		
76977	Us bone density measure		
77072	X-rays for bone age		
77073	X-rays, bone length studies		
77074	X-rays, bone survey, limited		
77075	X-rays, bone survey complete		
77076	X-rays, bone survey, infant		
77077	Joint survey, single view		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
77078	Ct bone density, axial		
77079	Ct bone density, peripheral		
77080	Dxa bone density, axial		
77081	Dxa bone density/peripheral		
77082	Dxa bone density, vert fx		
77083	Radiographic absorptiometry		
77084	Magnetic image, bone marrow		
77300	Radiation therapy dose plan		
77301	Radiotherapy dose plan, imrt		
77315	Teletx isodose plan complex		
77327	Brachytx isodose calc interm		
77331	Special radiation dosimetry		
77336	Radiation physics consult		
77370	Radiation physics consult		
77401	Radiation treatment delivery		
77600	Hyperthermia treatment		
77605	Hyperthermia treatment		
77610	Hyperthermia treatment		
78350	Bone mineral, single photon		*
80500	Lab pathology consultation		
80502	Lab pathology consultation		
85097	Bone marrow interpretation		
86510	Histoplasmosis skin test		
86850	RBC antibody screen		
86870	RBC antibody identification		
86880	Coombs test, direct		
86885	Coombs test, indirect, qual		
86886	Coombs test, indirect, titer		
86890	Autologous blood process		
86900	Blood typing, ABO		
86901	Blood typing, Rh (D)		
86903	Blood typing, antigen screen		
86904	Blood typing, patient serum		
86905	Blood typing, RBC antigens		
86906	Blood typing, Rh phenotype		
86930	Frozen blood prep		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
86970	RBC pretreatment		
86977	RBC pretreatment, serum		
88104	Cytopath fl nongyn, smears		
88106	Cytopath fl nongyn, filter		
88107	Cytopath fl nongyn, sm/fltr		
88108	Cytopath, concentrate tech		
88112	Cytopath, cell enhance tech		
88160	Cytopath smear, other source		
88161	Cytopath smear, other source		
88162	Cytopath smear, other source		
88172	Cytopathology eval of fna		
88173	Cytopath eval, fna, report		
88182	Cell marker study		
88184	Flowcytometry/ tc, 1 marker		
88185	Flowcytometry/tc, add-on		
88300	Surgical path, gross		
88302	Tissue exam by pathologist		
88304	Tissue exam by pathologist		
88305	Tissue exam by pathologist		
88307	Tissue exam by pathologist		
88311	Decalcify tissue		
88312	Special stains group 1		
88313	Special stains group 2		
88314	Histochemical stain add-on		*
88321	Microslide consultation		
88323	Microslide consultation		
88325	Comprehensive review of data		
88331	Path consult intraop, 1 bloc		
88342	Immunohistochemistry		
88346	Immunofluorescent study		
88347	Immunofluorescent study		
88348	Electron microscopy		
88358	Analysis, tumor		
88360	Tumor immunohistochem/manual		
88361	Tumor immunohistochem/comput		
88365	Insitu hybridization (fish)		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
88368	Insitu hybridization, manual		
89049	Chct for mal hyperthermia		
89230	Collect sweat for test		
89240	Pathology lab procedure		
90472	Immunization admin, each add		
90474	Immune admin oral/nasal addl		
90801	Psy dx interview		
90802	Intac psy dx interview		
90804	Psytx, office, 20-30 min		
90805	Psytx, off, 20-30 min w/e&m		
90806	Psytx, off, 45-50 min		
90807	Psytx, off, 45-50 min w/e&m		
90808	Psytx, office, 75-80 min		
90809	Psytx, off, 75-80 min, w/e&m		
90810	Intac psytx, off, 20-30 min		
90811	Intac psytx, 20-30 min, w/e&m		
90812	Intac psytx, off, 45-50 min		
90816	Psytx, hosp, 20-30 min		
90818	Psytx, hosp, 45-50 min		
90826	Intac psytx, hosp, 45-50 min		
90845	Psychoanalysis		
90846	Family psytx w/o patient		
90847	Family psytx w/patient		
90853	Group psychotherapy		
90857	Intac group psytx		
90862	Medication management		
92002	Eye exam, new patient		
92004	Eye exam, new patient		
92012	Eye exam established pat		
92014	Eye exam & treatment		
92020	Special eye evaluation		
92025	Corneal topography		
92060	Special eye evaluation		*
92081	Visual field examination(s)		
92082	Visual field examination(s)		
92083	Visual field examination(s)		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
92135	Ophth dx imaging post seg		
92136	Ophthalmic biometry		
92225	Special eye exam, initial		
92226	Special eye exam, subsequent		
92230	Eye exam with photos		
92240	Icg angiography		
92250	Eye exam with photos		
92275	Electroretinography		
92285	Eye photography		
92286	Internal eye photography		
92520	Laryngeal function studies		
92541	Spontaneous nystagmus test		
92542	Positional nystagmus test		*
92546	Sinusoidal rotational test		
92548	Posturography		
92552	Pure tone audiometry, air		
92553	Audiometry, air & bone		
92555	Speech threshold audiometry		
92556	Speech audiometry, complete		
92557	Comprehensive hearing test		
92567	Tympanometry		
92582	Conditioning play audiometry		
92585	Auditor evoke potent, compre		
92603	Cochlear implt f/up exam 7 >		
92604	Reprogram cochlear implt 7 >		
92626	Eval aud rehab status		
93005	Electrocardiogram, tracing		
93017	Cardiovascular stress test		
93225	ECG monitor/record, 24 hrs		
93226	ECG monitor/report, 24 hrs		
93231	Ecg monitor/record, 24 hrs		
93232	ECG monitor/report, 24 hrs		
93236	ECG monitor/report, 24 hrs		
93270	ECG recording		
93271	Ecg/monitoring and analysis		
93278	ECG/signal-averaged		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
93279	Pm device progr eval, sngl		*
93280	Pm device progr eval, dual		*
93281	Pm device progr eval, multi		*
93282	Icd device progr eval, 1 sngl		*
93283	Icd device progr eval, dual		*
93284	Icd device progr eval, mult		*
93285	Ilr device eval progr		*
93288	Pm device eval in person		*
93289	Icd device interrogate		*
93290	Icm device eval		*
93291	Ilr device interrogate		*
93292	Wcd device interrogate		*
93293	Pm phone r-strip device eval		*
93296	Pm/icd remote tech serv		*
93306	Tte w/doppler, complete		*
93307	Tte w/o doppler, complete		*
93786	Ambulatory BP recording		
93788	Ambulatory BP analysis		
93797	Cardiac rehab		
93798	Cardiac rehab/monitor		
93875	Extracranial study		
93880	Extracranial study		
93882	Extracranial study		
93886	Intracranial study		
93888	Intracranial study		
93922	Extremity study		
93923	Extremity study		
93924	Extremity study		
93925	Lower extremity study		
93926	Lower extremity study		
93930	Upper extremity study		
93931	Upper extremity study		
93965	Extremity study		
93970	Extremity study		
93971	Extremity study		
93975	Vascular study		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
93976	Vascular study		
93978	Vascular study		
93979	Vascular study		
93990	Doppler flow testing		
94015	Patient recorded spirometry		
94690	Exhaled air analysis		
95115	Immunotherapy, one injection		
95117	Immunotherapy injections		
95165	Antigen therapy services		
95250	Glucose monitoring, cont		
95805	Multiple sleep latency test		
95806	Sleep study unatt&resp efft		
95807	Sleep study, attended		
95808	Polysomnography, 1-3		
95812	Eeg, 41-60 minutes		
95813	Eeg, over 1 hour		
95816	Eeg, awake and drowsy		
95819	Eeg, awake and asleep		
95822	Eeg, coma or sleep only		
95869	Muscle test, thor paraspinal		
95872	Muscle test, one fiber		
95900	Motor nerve conduction test		
95921	Autonomic nerv function test		
95925	Somatosensory testing		
95926	Somatosensory testing		
95930	Visual evoked potential test		
95950	Ambulatory eeg monitoring		
95953	EEG monitoring/computer		
95970	Analyze neurostim, no prog		
95972	Analyze neurostim, complex		
95974	Cranial neurostim, complex		
95978	Analyze neurostim brain/1h		
96000	Motion analysis, video/3d		
96101	Psycho testing by psych/phys		
96111	Developmental test, extend		
96116	Neurobehavioral status exam		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
96118	Neuropsych tst by psych/phys		
96119	Neuropsych testing by tec		
96150	Assess hlth/behave, init		
96151	Assess hlth/behave, subseq		
96152	Intervene hlth/behave, indiv		
96153	Intervene hlth/behave, group		
96361	Hydrate iv infusion, add-on		*
96366	Ther/proph/diag iv inf addon		*
96367	Tx/proph/dg addl seq iv inf		*
96370	Sc ther infusion, addl hr		*
96371	Sc ther infusion, reset pump		*
96375	Tx/pro/dx inj new drug addon		*
96402	Chemo hormon antineopl sq/im		
96411	Chemo, iv push, addl drug		
96415	Chemo, iv infusion, addl hr		
96417	Chemo iv infus each addl seq		
96423	Chemo ia infuse each addl hr		
96900	Ultraviolet light therapy		
96910	Photochemotherapy with UV-B		
96912	Photochemotherapy with UV-A		
96913	Photochemotherapy, UV-A or B		
96920	Laser tx, skin < 250 sq cm		
98925	Osteopathic manipulation		
98926	Osteopathic manipulation		
98927	Osteopathic manipulation		
98940	Chiropractic manipulation		
98941	Chiropractic manipulation		
98942	Chiropractic manipulation		
99203	Office/outpatient visit, new		*
99204	Office/outpatient visit, new		
99212	Office/outpatient visit, est		
99213	Office/outpatient visit, est		
99214	Office/outpatient visit, est		
99241	Office consultation		
99242	Office consultation		
99243	Office consultation		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
99244	Office consultation		
99245	Office consultation		
99406	Behav chng smoking 3-10 min		*
99407	Behav chng smoking > 10 min		*
0144T	CT heart wo dye; qual calc		
G0008	Admin influenza virus vac		
G0101	CA screen;pelvic/breast exam		
G0127	Trim nail(s)		
G0130	Single energy x-ray study		
G0166	Extrnl counterpulse, per tx		
G0175	OPPS Service,sched team conf		
G0248	Demonstrate use home inr mon		*
G0249	Provide INR test mater/equip		*
G0340	Robt lin-radsurg fractx 2-5		
G0365	Vessel mapping hemo access		
G0389	Ultrasound exam AAA screen		
G0390	Trauma Respons w/hosp criti		
G0402	Initial preventive exam		*
G0404	EKG tracing for initial prev		*
M0064	Visit for drug monitoring		
Q0091	Obtaining screen pap smear		

TABLE 2.—HCPCS CODES PROPOSED TO BE REMOVED FROM THE CY 2011 BYPASS LIST BECAUSE THEY WERE DELETED PRIOR TO CY 2009

HCPCS Code	HCPCS Short Descriptor
90761	Hydrate iv infusion, add-on
90766	Ther/proph/dg iv inf, add-on
90767	Tx/proph/dg addl seq iv inf
90770	Sc ther infusion, addl hr
90771	Sc ther infusion, reset pump
90775	Tx/pro/dx inj new drug addon
93727	Analyze ilr system
93731	Analyze pacemaker system
93732	Analyze pacemaker system
93733	Telephone analy, pacemaker
93734	Analyze pacemaker system
93735	Analyze pacemaker system
93736	Telephonic analy, pacemaker
93741	Analyze ht pace device sngl
93742	Analyze ht pace device sngl
93743	Analyze ht pace device dual
93744	Analyze ht pace device dual
G0344	Initial preventive exam
G0367	EKG tracing for initial prev
G0376	Smoke/tobacco counseling >10

BILLING CODE 4120–01–C

c. Proposed Calculation and Use of Cost-to-Charge Ratios (CCRs)

For CY 2011, we are proposing to continue to use the hospital-specific overall ancillary and departmental CCRs to convert charges to estimated costs through application of a revenue code-to-cost center crosswalk. To calculate the APC median costs on which the proposed CY 2011 APC payment rates are based, we calculated hospital-specific overall ancillary CCRs and hospital-specific departmental CCRs for each hospital for which we had CY 2009 claims data from the most recent available hospital cost reports, in most cases, cost reports beginning in CY 2008. For the CY 2011 OPPS proposed rates, we used the set of claims processed during CY 2009. We applied the hospital-specific CCR to the hospital's charges at the most detailed level possible, based on a revenue code-to-cost center crosswalk that contains a hierarchy of CCRs used to estimate costs from charges for each revenue code. That crosswalk is available for review and continuous comment on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage.*

To ensure the completeness of the revenue code-to-cost center crosswalk, we reviewed changes to the list of revenue codes for CY 2009 (the year of the claims data we are using to calculate the CY 2011 OPPS proposed payment rates). For CY 2009, there were several changes to these revenue codes. The National Uniform Billing Committee (NUBC) is the organization that is responsible for the data specifications for the Uniform Bill (currently the UB–04). For CY 2009, the NUBC changed the title of revenue code series 076X from "Specialty Room—Treatment/Observation Room" to "Specialty Services" and changed the title of subclassification revenue code 0762 from "Observation Room" to "Observation Hours". We are not proposing to change the revenue code-to-cost center crosswalk as a result of this change because we believe that hospitals have historically reported charges for observation based on hours of care and that this change reflects existing practices. In addition, for CY 2009, NUBC removed a note that indicated that subcategory revenue codes 0912, Behavioral Health Treatment/Services (also see 091X, an extension of 090X), and 0913, Behavioral Health Treatment/Services—Extension of 090X, were designed as zero-billed revenue codes (that is, no dollar in the amount field). This change has no impact on the revenue code-to-cost center crosswalk. We note that the addition of revenue codes with effective dates in CY 2010 is not relevant to this process because the revenue codes were not applicable to claims for services furnished during CY 2009.

We calculated CCRs for the standard and nonstandard cost centers accepted by the electronic cost report database. In general, the most detailed level at which we calculated CCRs was the hospital-specific departmental level. For a discussion of the hospital-specific overall ancillary CCR calculation, we

refer readers to the CY 2007 OPPS/ASC final rule with comment period (71 FR 67983 through 67985). One longstanding exception to this general methodology for calculation of CCRs used for converting charges to costs on each claim is the calculation of median blood costs, as discussed in section II.A.2.d.(2) of this proposed rule and which has been our standard policy since the CY 2005 OPPS.

For the CCR calculation process, we used the same general approach that we used in developing the final APC rates for CY 2007 and thereafter, using the revised CCR calculation that excluded the costs of paramedical education programs and weighted the outpatient charges by the volume of outpatient services furnished by the hospital. We refer readers to the CY 2007 OPPS/ASC final rule with comment period for more information (71 FR 67983 through 67985). We first limited the population of cost reports to only those for hospitals that filed outpatient claims in CY 2009 before determining whether the CCRs for such hospitals were valid.

We then calculated the CCRs for each cost center and the overall ancillary CCR for each hospital for which we had claims data. We did this using hospital-specific data from the Hospital Cost Report Information System (HCRIS). We used the most recent available cost report data, in most cases, cost reports with cost reporting periods beginning in CY 2007. For this proposed rule, we used the most recently submitted cost reports to calculate the CCRs to be used to calculate median costs for the proposed CY 2011 OPPS payment rates. If the most recent available cost report was submitted but not settled, we looked at the last settled cost report to determine the ratio of submitted to settled cost using the overall ancillary CCR, and we then adjusted the most recent available submitted but not settled cost report using that ratio. We then calculated both an overall ancillary CCR and cost center-specific CCRs for each hospital. We used the overall ancillary CCR referenced in section II.A.1.c. of this proposed rule for all purposes that require use of an overall ancillary CCR.

Since the implementation of the OPPS, some commenters have raised concerns about potential bias in the OPPS cost-based weights due to "charge compression," which is the practice of applying a lower charge markup to higher-cost services and a higher charge markup to lower-cost services. As a result, the cost-based weights may reflect some aggregation bias, undervaluing high-cost items and overvaluing low-cost items when an estimate of average markup, embodied in a single CCR, is applied to items of widely varying costs in the same cost center.

To explore this issue, in August 2006 we awarded a contract to RTI International (RTI) to study the effects of charge compression in calculating the IPPS cost-based relative weights, particularly with regard to the impact on inpatient diagnosis-related group (DRG) payments, and to consider methods to better capture the variation in cost and charges for individual services when calculating costs for the IPPS relative weights across services in the same cost center. RTI issued a report in March 2007 with its findings on charge compression, which is available on the CMS Web site at: *http://www.cms.gov/reports/downloads/Dalton.pdf.* Although this report was focused largely on charge compression in the context of the IPPS cost-based relative weights, because several of the findings were relevant to the OPPS, we discussed that report in the CY 2008 OPPS/ASC proposed rule (72 FR 42641 through 42643) and reiterated them in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66599 through 66602).

In August 2007, we contracted with RTI to evaluate the cost estimation process for the OPPS relative weights because its 2007 report had concentrated on IPPS DRG cost-based relative weights. The results of RTI's analyses had implications for both the OPPS APC cost-based relative weights and the IPPS MS–DRG (Medicare severity) cost-based relative weights. The RTI final report can be found on RTI's Web site at: *http://www.rti.org/reports/cms/HHSM-500-2005-0029I/PDF/Refining_Cost_to_Charge_Ratios_200807_Final.pdf.* For a complete discussion of the RTI recommendations, public comments, and our responses, we refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68519 through 68527).

We addressed the RTI finding that there was aggregation bias in both the IPPS and the OPPS cost estimation of expensive and inexpensive medical supplies in the FY 2009 IPPS final rule. Specifically, we finalized our proposal for both the OPPS and IPPS to create one cost center for "Medical Supplies Charged to Patients" and one cost center for "Implantable Devices Charged to Patients," essentially splitting the then current CCR for "Medical Supplies and Equipment" into one CCR for low-cost medical supplies and another CCR for high-cost implantable devices in order to mitigate some of the effects of charge compression. Accordingly, in Transmittal 20 of the Provider Reimbursement Manual, Part II (PRM–II), Chapter 36, Form CMS–2552–96, which was issued in July 2009, we created a new subscripted Line 55.01 on Worksheet A for the "Implantable Devices Charged to Patients" cost center. This new subscripted cost center, placed under the standard line for "Medical Supplies Charged to Patients," is available for use for cost reporting periods beginning on or after May 1, 2009. A subscripted cost center is the addition of a separate new cost center line and description which bears a logical relationship to the standard cost center line and is located immediately following a standard cost center line. Subscripting a cost center line adds flexibility and cost center expansion capability to the cost report. For example, Line 55 of Worksheet A on Form CMS 2552–96 (the Medicare hospital cost report) is "Medical Supplies Charged to Patients." The additional cost center, which isolates the costs of "Implantable Medical Supplies Charged to Patients", was created by adding subscripted Line 55.01 to Worksheet A.

Because there is approximately a 3-year lag in the availability of cost report data for IPPS and OPPS ratesetting purposes in a given calendar year, we believe we will be able to use data from the revised cost report form to estimate costs from charges for implantable devices for the CY 2013 OPPS relative weights. For a complete discussion of the rationale for the creation of the new cost center for "Implantable Devices Charged to Patients," public comments, and our responses, we refer readers to the FY 2009 IPPS final rule (73 FR 48458 through 45467).

In the CY 2009 OPPS/ASC final rule with comment period, we indicated that we would be making some OPPS-specific changes in response to the RTI report recommendations. Specifically, these changes included modifications to the cost reporting software and the addition of three new nonstandard cost centers. With regard to modifying the cost reporting preparation software in order to offer additional descriptions for nonstandard cost centers to improve the accuracy of reporting for nonstandard cost centers, we indicated that the change would be made for the next release of the cost report software. These changes have been made to the cost reporting software with the implementation of CMS Transmittal 21, under Chapter 36 of the Provider Reimbursement Manual—Part II, available online at *http://www.cms.hhs.gov/Manuals/PBM/,* which is effective for cost reporting

periods ending on or after October 1, 2009.

We also indicated that we intended to add new nonstandard cost centers for Cardiac Rehabilitation, Hyperbaric Oxygen Therapy, and Lithotripsy. We note that in January 2010, CMS issued Transmittal 21 which updated the PRM–II, Chapter 36, Form CMS–2552–96. One of the updates in this transmittal established nonstandard cost centers for Cardiac Rehabilitation, Hyperbaric Oxygen Therapy, and Lithotripsy for use on Worksheet A. These three new nonstandard cost centers are now available for cost reporting periods ending on or after October 1, 2009.

Furthermore, we noted in the FY 2010 IPPS/LTCH PPS final rule (74 FR 43781 through 43782) that we were updating the cost report form to eliminate outdated requirements, in conjunction with the Paperwork Reduction Act (PRA), and that we had proposed actual changes to the cost reporting form, the attending cost reporting software, and the cost report instructions in Chapters 36 and 40 of the PRM–II. The new draft hospital cost report Form CMS–2552–10 was published in the **Federal Register** on July 2, 2009, and was subject to a 60-day review and comment period, which ended on August 31, 2009. We received numerous comments on the draft hospital cost report Form CMS–2552–10, specifically regarding the creation of new cost centers from which data might be used in the OPPS cost-based relative weights calculation. We had proposed to create new standard cost centers for Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and Cardiac Catheterization in Form CMS–2552–10. If these standard cost centers are finalized, when the data become available, we would analyze the cost and charge data to determine if it is appropriate to use those data to create distinct CCRs from these cost centers in setting the relative weights. For a discussion of these cost centers, we refer readers to the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23878 through 23880). Comments will be addressed in detail in the **Federal Register** notice that will finalize Form CMS–2552–10. The revised draft of hospital cost report Form CMS–2552–10 went on public display on April 23, 2010, and appeared in the **Federal Register** on April 30, 2010 (75 FR 22810) with a 30-day public comment period. The public comment period ended on June 1, 2010.

We believe that improved cost report software, the incorporation of new standard and nonstandard cost centers, and the elimination of outdated requirements will improve the accuracy of the cost data contained in the electronic cost report data files and, therefore, the accuracy of our cost estimation processes for the OPPS relative weights. We will continue our standard practice of examining ways in which we can improve the accuracy of our cost estimation processes.

2. Proposed Data Development Process and Calculation of Median Costs

In this section of this proposed rule, we discuss the use of claims to calculate proposed OPPS payment rates for CY 2011. The hospital OPPS page on the CMS Web site on which this proposed rule is posted provides an accounting of claims used in the development of the proposed payment rates at: *http://www.cms.gov/HospitalOutpatientPPS*. The accounting of claims used in the development of this proposed rule is included on the CMS Web site under supplemental materials for the CY 2011 OPPS/ASC proposed rule. That accounting provides additional detail regarding the number of claims derived at each stage of the process. In addition, below in this section, we discuss the file of claims that comprises the data set that is available for purchase under a CMS data use agreement. Our CMS Web site, *http://www.cms.gov/HospitalOutpatientPPS*, includes information about purchasing the "OPPS Limited Data Set," which now includes the additional variables previously available only in the OPPS Identifiable Data Set, including ICD–9–CM diagnosis codes and revenue code payment amounts. This file is derived from the CY 2009 claims that were used to calculate the proposed payment rates for the CY 2011 OPPS.

We used the methodology described in sections II.A.2.a. through II.A.2.e. of this proposed rule to calculate the median costs we use to establish the relative weights used in calculating the proposed OPPS payment rates for CY 2011 shown in Addenda A and B to this proposed rule. We refer readers to section II.A.4. of this proposed rule for a discussion of the conversion of APC median costs to scaled payment weights.

a. Claims Preparation

We used the CY 2009 hospital outpatient claims processed before January 1, 2010 to calculate the median costs of APCs that underpin the proposed relative weights for CY 2011. To begin the calculation of the relative weights for CY 2011, we pulled all claims for outpatient services furnished in CY 2009 from the national claims history file. This is not the population of claims paid under the OPPS, but all outpatient claims (including, for example, critical access hospital (CAH) claims and hospital claims for clinical laboratory services for persons who are neither inpatients nor outpatients of the hospital).

We then excluded claims with condition codes 04, 20, 21, and 77. These are claims that providers submitted to Medicare knowing that no payment would be made. For example, providers submit claims with a condition code 21 to elicit an official denial notice from Medicare and document that a service is not covered. We then excluded claims for services furnished in Maryland, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands because hospitals in those geographic areas are not paid under the OPPS.

We divided the remaining claims into the three groups shown below. Groups 2 and 3 comprise the 102 million claims that contain hospital bill types paid under the OPPS.

1. Claims that were not bill types 12X, 13X (hospital bill types), 14X (laboratory specimen 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. Claims with bill types 12X and 13X are hospital outpatient claims. Claims with bill type 14X are laboratory specimen claims, of which we use a subset for the limited number of services in these claims that are paid under the OPPS.

3. Claims that were bill type 76X (CMHC).

To convert charges on the claims to estimated cost, we multiplied the charges on each claim by the appropriate hospital specific CCR associated with the revenue code for the charge as discussed in section II.A.1.c. of this proposed rule. We then flagged and excluded CAH claims (which are not paid under the OPPS) and claims from hospitals with invalid CCRs. The latter included claims from hospitals without a CCR; those from hospitals paid an all-inclusive rate; those from hospitals with obviously erroneous CCRs (greater than 90 or less than .0001); and those from hospitals with overall ancillary CCRs that were identified as outliers (3 standard deviations from the geometric mean after removing error CCRs). In addition, we trimmed the CCRs at the cost center (that is, departmental) level by removing the CCRs for each cost center as outliers if they exceeded +/− 3 standard deviations from the geometric mean. We used a four-tiered hierarchy of cost

center CCRs, which is the revenue code-to-cost center crosswalk, to match a cost center to every possible revenue code appearing in the outpatient claims that is relevant to OPPS services, with the top tier being the most common cost center and the last tier being the default CCR. If a hospital's cost center CCR was deleted by trimming, we set the CCR for that cost center to "missing" so that another cost center CCR in the revenue center hierarchy could apply. If no other cost center CCR could apply to the revenue code on the claim, we used the hospital's overall ancillary CCR for the revenue code in question as the default CCR. 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 ancillary CCR to the clinic revenue code. The revenue code-to-cost center crosswalk is available for inspection and comment on the CMS Web site: *http://www.cms.gov/HospitalOutpatientPPS*. Revenue codes that we do not use to set medians or to model impacts are identified with an "N" in the revenue code-to-cost center crosswalk.

At the February 17–18, 2010 APC Panel Meeting, the Panel recommended that CMS present to the Data Subcommittee an analysis of the effect of using a different lower-level threshold in the overall CCR error trim as part of the standard methodology. The Panel members were concerned that our current CCR trimming policy (excluding providers with an overall ancillary CCR greater than 90 or less than .0001 or above and then excluding remaining providers with overall ancillary CCRs beyond +/− 3 standard deviations from the geometric mean) could result in the exclusion of claims from providers that could otherwise be used for ratesetting and modeling. We are accepting this recommendation. We will study the issue and provide the relevant data to the Data Subcommittee at an upcoming meeting.

We applied CCRs as described above to claims with bill type 12X, 13X, or 14X, excluding all claims from CAHs and hospitals in Maryland, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands and claims from all hospitals for which CCRs were flagged as invalid.

We identified claims with condition code 41 as partial hospitalization services of hospitals and moved them to another file. We note that the separate file containing partial hospitalization claims is included in the files that are available for purchase as discussed above.

We then excluded claims without a HCPCS code. We moved to another file claims that contained nothing but influenza and pneumococcal pneumonia (PPV) vaccines. Influenza and PPV vaccines are paid at reasonable cost and, therefore, these claims are not used to set OPPS rates.

We next copied line-item costs for drugs, blood, and brachytherapy sources (the lines stay on the claim, but are copied onto another file) to a separate file. No claims were deleted when we copied these lines onto another file. These line-items are used to calculate a per unit mean and median cost and a per day mean and median cost for drugs and nonimplantable biologicals, therapeutic radiopharmaceutical agents, and brachytherapy sources, as well as other information used to set payment rates, such as a unit-to-day ratio for drugs.

To implement our proposed policy to redistribute some portion of total cost for packaged drugs and biologicals to the separately payable drugs and biologicals as acquisition and pharmacy overhead and handling costs discussed in section V.B.3. of this proposed rule, we used the line-item cost data for drugs and biologicals for which we had a HCPCS code with ASP pricing information to calculate the ASP+X values, first for all drugs and biologicals, and then for separately payable drugs and biologicals and for packaged drugs and biologicals, respectively, by taking the ratio of total claim cost for each group relative to total ASP dollars (per unit of each drug or biological HCPCS code's April 2010 ASP amount multiplied by total units for each drug or biological in the CY 2009 claims data). These values are ASP+14 percent (for all drugs and biologicals with HCPCS codes, whether separately paid or packaged), ASP+0 percent (for drugs and biologicals that are separately paid), and ASP+283 percent (for drugs and biologicals that have HCPCS codes and that are packaged), respectively. As we discuss in section V.B.3. of this proposed rule, we are proposing a policy to redistribute $150 million of the total cost in our claims data for packaged drugs and biologicals that have an associated ASP from packaged drugs with an ASP to separately payable drugs and biologicals. We also are proposing a policy to redistribute an additional $50 million of the total cost in our claims data for drugs and biologicals lacking an ASP, largely for estimated costs associated with uncoded charges billed under pharmacy revenue code series 025X (Pharmacy (also see 063X, an extension of 025X)), 026X (IV Therapy), and 063X (Pharmacy—Extension of 025X). We observe about $623 million for drugs lacking an ASP in our CY 2009 claims data. This total excludes the cost of diagnostic and therapeutic radiopharmaceuticals because they are not reported under pharmacy revenue codes or under the pharmacy cost center on the hospital cost report.

Removing a total of $150 million in pharmacy overhead cost from packaged drugs and biologicals reduces the $593 million to $443 million, approximately a 25 percent reduction. Removing $50 million from the cost of drugs lacking an ASP reduces the $623 million to $573 million, approximately an 8 percent reduction. To implement our proposed CY 2011 policy to redistribute $150 million in claim cost from packaged drugs and biologicals with an ASP to separately payable drugs and biologicals and $50 million in claim cost from packaged drugs and biologicals lacking an ASP, including uncoded pharmacy revenue code charges, we multiplied the cost of each packaged drug or biological with a HCPCS code and ASP pricing information in our CY 2009 claims data by 0.75, and we multiplied all other packaged drug costs in our CY 2009 claims data, excluding those for diagnostic radiopharmaceuticals, by 0.92. We also added the redistributed $200 million to the total cost of separately payable drugs and biologicals in our CY 2009 claims data, which increased the relationship between the total cost for separately payable drugs and biologicals and ASP dollars for the same drugs and biologicals from ASP+0 percent to ASP+6 percent. We refer readers to section V.B.3. of this proposed rule for a complete discussion of our proposal to pay for separately paid drugs and biologicals and pharmacy overhead for CY 2011.

We then removed line-items that were not paid during claim processing, presumably for a line-item rejection or denial. We added this process to our median cost calculation methodology for the CY 2010 OPPS, as discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60359). The number of edits for valid OPPS payment in the Integrated Outpatient Code Editor (I/OCE) and elsewhere has grown significantly in the past few years, especially with the implementation of the full spectrum of National Correct Coding Initiative (NCCI) edits. To ensure that we are using valid claims that represent the cost of payable services to set payment rates, we removed line-items with an OPPS status indicator for the claim year and a status indicator of "S," "T," "V," or "X" when separately paid under the prospective

year's payment system. This logic preserves charges for services that would not have been paid in the claim year but for which some estimate of cost is needed for the prospective year, such as services newly proposed to come off the inpatient list for CY 2010 that were assigned status indicator "C" in the claim year.

For CY 2011, we are proposing to expand the application of this trim to exclude line-item data for pass-through drugs and biologicals (status indicator "G" for CY 2009) and nonpass-through drugs and biologicals (status indicator "K" for CY 2009) where the charges reported on the claim for the line were either denied or rejected during claims processing. Removing lines that were eligible for payment but were not paid ensures that we are using appropriate data. The trim avoids using cost data on lines that we believe were defective or invalid because those rejected or denied lines did not meet the Medicare requirements for payment. For example, edits may reject a line for a separately paid drug because the number of units billed exceeded the number of units that would be reasonable and, therefore, is likely a billing error (for example, a line reporting 55 units of a drug for which 5 units is known to be a fatal dose). For approximately 90 percent of the codes with status indicators "G" and "K" in their claims year, to which the expansion of the trim would apply, between 0 and 10 percent of lines would be removed due to receiving zero payment. As with our trimming in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60359) of line items with a status indicator of "S," "T," "V," or "X", we believe that unpaid line-items represent services that are invalidly reported and, therefore, should not be used for ratesetting. We believe that removing lines with valid status indicators that were edited and not paid during claims processing increases the accuracy of the single bills used to determine the mean unit costs for use in the ASP+X calculation described in section V.B.3. of this proposed rule.

b. Splitting Claims and Creation of "Pseudo" Single Procedure Claims

(1) Splitting Claims

We then split the remaining claims into five groups: Single majors; multiple majors; single minors; multiple minors; and other claims. (Specific definitions of these groups follow below.) For CY 2011, we are proposing to continue our current policy of defining major procedures as any HCPCS code having a status indicator of "S," "T," "V," or "X;" defining minor procedures as any code having a status indicator of "F," "G," "H," "K," "L," "R," "U," or "N," and classifying "other" procedures as any code having a status indicator other than one that we have classified as major or minor. For CY 2011, we are proposing to continue assigning status indicator "R" to blood and blood products; status indicator "U" to brachytherapy sources; status indicator "Q1" to all "STVX-packaged codes;" status indicator "Q2" to all "T-packaged codes;" and status indicator "Q3" to all codes that may be paid through a composite APC based on composite-specific criteria or paid separately through single code APCs when the criteria are not met. As discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68709), we established status indicators "Q1," "Q2," and "Q3" to facilitate identification of the different categories of codes. We are proposing to treat these codes in the same manner for data purposes for CY 2011 as we have treated them since CY 2008. Specifically, we are proposing to continue to evaluate whether the criteria for separate payment of codes with status indicator "Q1" or "Q2" are met in determining whether they are treated as major or minor codes. Codes with status indicator "Q1" or "Q2" are carried through the data either with status indicator "N" as packaged or, if they meet the criteria for separate payment, they are given the status indicator of the APC to which they are assigned and are considered as "pseudo" single procedure claims for major codes. Codes assigned status indicator "Q3" are paid under individual APCs unless they occur in the combinations that qualify for payment as composite APCs and, therefore, they carry the status indicator of the individual APC to which they are assigned through the data process and are treated as major codes during both the split and "pseudo" single creation process. The calculation of the median costs for composite APCs from multiple procedure major claims is discussed in section II.A.2.e. of this proposed rule.

Specifically, we divided the remaining claims into the following five groups:

1. *Single Procedure Major Claims:* Claims with a single separately payable procedure (that is, status indicator "S," "T," "V," or "X," which includes codes with status indicator "Q3"); claims with one unit of a status indicator "Q1" code ("STVX-packaged") where there was no code with status indicator "S," "T," "V," or "X" on the same claim on the same date; or claims with one unit of a status indicator "Q2" code ("T-packaged") where there was no code with a status indicator "T" on the same claim on the same date.

2. *Multiple Procedure Major Claims:* Claims with more than one separately payable procedure (that is, status indicator "S," "T," "V," or "X," which includes codes with status indicator "Q3"), or multiple units of one payable procedure. These claims include those codes with a status indicator "Q2" code ("T-packaged") where there was no procedure with a status indicator "T" on the same claim on the same date of service but where there was another separately paid procedure on the same claim with the same date of service (that is, another code with status indicator "S," "V," or "X"). We also include, in this set, claims that contained one unit of one code when the bilateral modifier was appended to the code and the code was conditionally or independently bilateral. In these cases, the claims represented more than one unit of the service described by the code, notwithstanding that only one unit was billed.

3. *Single Procedure Minor Claims:* Claims with a single HCPCS code that was assigned status indicator "F," "G," "H," "K," "L," "R," "U," or "N" and not status indicator "Q1" ("STVX-packaged") or status indicator "Q2" ("T-packaged") code.

4. *Multiple Procedure Minor Claims:* Claims with multiple HCPCS codes that are assigned status indicator "F," "G," "H," "K," "L," "R," "U," or "N;" claims that contain more than one code with status indicator "Q1" ("STVX-packaged") or more than one unit of a code with status indicator "Q1" but no codes with status indicator "S," "T," "V," or "X" on the same date of service; or claims that contain more than one code with status indicator "Q2" (T-packaged), or "Q2" and "Q1," or more than one unit of a code with status indicator "Q2" but no code with status indicator "T" on the same date of service.

5. *Non-OPPS Claims:* Claims that contain no services payable under the OPPS (that is, all status indicators other than those listed for major or minor status). These claims were excluded from the files used for the OPPS. Non-OPPS claims have codes paid under other fee schedules, for example, durable medical equipment or clinical laboratory tests, and do not contain a code for a separately payable or packaged OPPS service. Non-OPPS claims include claims for therapy services paid sometimes under the OPPS but billed, in these non-OPPS cases, with revenue codes indicating that the therapy services would be paid under the Medicare Physician Fee Schedule (MPFS).

The claims listed in numbers 1, 2, 3, and 4 above are included in the data file that can be purchased as described above. Claims that contain codes to which we have assigned status indicators "Q1" ("STVX-packaged") and "Q2" ("T-packaged") appear in the data for the single major file, the multiple major file, and the multiple minor file used in this proposed rule. Claims that contain codes to which we have assigned status indicator "Q3" (composite APC members) appear in both the data of the single and multiple major files used in this proposed rule, depending on the specific composite calculation.

(2) Creation of "Pseudo" Single Procedure Claims

To develop "pseudo" single procedure claims for this proposed rule, we examined both the multiple procedure major claims and the multiple procedure minor claims. We first examined the multiple major procedure claims for dates of service to determine if we could break them into "pseudo" single procedure claims using the dates of service for all lines on the claim. If we could create claims with single major procedures by using dates of service, we created a single procedure claim record for each separately payable procedure on a different date of service (that is, a "pseudo" single).

We also used the bypass codes listed earlier in Table 1 and discussed in section II.A.1.b. of this proposed rule to remove separately payable procedures that we determined contained limited or no packaged costs or that were otherwise suitable for inclusion on the bypass list from a multiple procedure bill. As discussed above, we ignore the "overlap bypass codes," that is, those HCPCS codes that are both on the bypass list and are members of the multiple imaging composite APCs, in this initial assessment for "pseudo" single procedure claims. The proposed CY 2011 "overlap bypass codes" are listed in Table 1 in section II.A.1.b. of this proposed rule. When one of the two separately payable procedures on a multiple procedure claim was on the bypass list, we split the claim into two "pseudo" single procedure claim records. The single procedure claim record that contained the bypass code did not retain packaged services. The single procedure claim record that contained the other separately payable procedure (but no bypass code) retained the packaged revenue code charges and the packaged HCPCS code charges. We also removed lines that contained multiple units of codes on the bypass list and treated them as "pseudo" single procedure claims by dividing the cost for the multiple units by the number of units on the line. Where one unit of a single, separately payable procedure code remained on the claim after removal of the multiple units of the bypass code, we created a "pseudo" single procedure 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 then assessed the claims to determine if the criteria for the multiple imaging composite APCs, discussed in section II.A.2.e.(5) of this proposed rule, were met. Where the criteria for the imaging composite APCs were met, we created a "single session" claim for the applicable imaging composite service and determined whether we could use the claim in ratesetting. For HCPCS codes that are both conditionally packaged and are members of a multiple imaging composite APC, we first assessed whether the code would be packaged and, if so, the code ceased to be available for further assessment as part of the composite APC. Because the packaged code would not be a separately payable procedure, we considered it to be unavailable for use in setting the composite APC median cost. Having identified "single session" claims for the imaging composite APCs, we reassessed the claim to determine if, after removal of all lines for bypass codes, including the "overlap bypass codes," a single unit of a single separately payable code remained on the claim. If so, we attributed the packaged costs on the claim to the single unit of the single remaining separately payable code other than the bypass code to create a "pseudo" single procedure claim. We also identified line-items of overlap bypass codes as a "pseudo" single procedure claim. This allowed us to use more claims data for ratesetting purposes.

We also examined the multiple procedure minor claims to determine whether we could create "pseudo" single procedure claims. Specifically, where the claim contained multiple codes with status indicator "Q1" ("STVX-packaged") on the same date of service or contained multiple units of a single code with status indicator "Q1," we selected the status indicator "Q1" HCPCS code that had the highest CY 2010 relative weight, set the units to one on that HCPCS code to reflect our policy of paying only one unit of a code with a status indicator of "Q1." We then packaged all costs for the following into a single cost for the "Q1" HCPCS code that had the highest CY 2010 relative weight to create a "pseudo" single procedure claim for that code: Additional units of the status indicator "Q1" HCPCS code with the highest CY 2010 relative weight; other codes with status indicator "Q1"; and all other packaged HCPCS codes and packaged revenue code costs. We changed the status indicator for selected codes from the data status indicator of "N" to the status indicator of the APC to which the selected procedure was assigned for further data processing and considered this claim as a major procedure claim. We used this claim in the calculation of the APC median cost for the status indicator "Q1" HCPCS code.

Similarly, where a multiple procedure minor claim contained multiple codes with status indicator "Q2" ("T-packaged") or multiple units of a single code with status indicator "Q2," we selected the status indicator "Q2" HCPCS code that had the highest CY 2010 relative weight, set the units to one on that HCPCS code to reflect our policy of paying only one unit of a code with a status indicator of "Q2." We then packaged all costs for the following into a single cost for the "Q2" HCPCS code that had the highest CY 2010 relative weight to create a "pseudo" single procedure claim for that code: Additional units of the status indicator "Q2" HCPCS code with the highest CY 2010 relative weight; other codes with status indicator "Q2;" and other packaged HCPCS codes and packaged revenue code costs. We changed the status indicator for the selected code from a data status indicator of "N" to the status indicator of the APC to which the selected code was assigned, and we considered this claim as a major procedure claim.

Lastly, where a multiple procedure minor claim contained multiple codes with status indicator "Q2" ("T-packaged") and status indicator "Q1" ("STVX-packaged"), we selected the status indicator "Q2" HCPCS code ("T-packaged") that had the highest relative weight for CY 2010 and set the units to one on that HCPCS code to reflect our policy of paying only one unit of a code with a status indicator of "Q2." We then packaged all costs for the following into a single cost for the selected ("T packaged") HCPCS code to create a "pseudo" single procedure claim for that code: Additional units of the status indicator "Q2" HCPCS code with the highest CY 2010 relative weight; other codes with status indicator "Q2;" codes with status indicator "Q1" ("STVX-packaged"); and other packaged HCPCS codes and packaged revenue code costs. We favor status indicator "Q2" over "Q1"

HCPCS codes because "Q2" HCPCS codes have higher CY 2010 relative weights. If a status indicator "Q1" HCPCS code had a higher CY 2010 relative weight, it would become the primary code for the simulated single bill process. We changed the status indicator for the selected status indicator "Q2" ("T-packaged") code from a data status indicator of "N" to the status indicator of the APC to which the selected code was assigned and we considered this claim as a major procedure claim.

In public comments received on the CY 2010 OPPS/ASC proposed rule, a public commenter suggested that CMS could use more claims data to develop medians for these conditionally packaged codes if CMS applied the "pseudo" single creation process to the conditionally packaged codes in the multiple major claims that still contained unusable data. We agree and, for this CY 2011 OPPS/ASC proposed rule, we are proposing to use the otherwise unusable multiple procedure claims data that remain after the standard pseudo single creation process is applied to them, in order to create more pseudo single procedure claims. We would do this by treating the conditionally packaged codes that do not meet the criteria for packaging as if they were separately payable major codes and applying the pseudo single process to the claims data to create single procedure claims from them if they meet the criteria for single procedure claims. Conditionally packaged codes are identified using status indicators "Q1" and "Q2," and are described in section XIII.A.1. of this proposed rule. Using the February 2010 APC Panel data, we estimate that the impact of adding this proposed additional step to the pseudo single creation process would result in a small increase in the number of claims usable for ratesetting in most cases, but with more significant increases of between 5 to 10 percent of claims for a few codes. For most of the codes affected by adding this proposed additional step to the "pseudo" single creation process, we found no significant changes to the APC medians. Some HCPCS codes do experience some fluctuations, with the impact of additional claims causing their APC median to decrease. We believe that this change is consistent with our goal of using more available data from within the existing set of claims information and results in a more accurate estimation of the APC median cost for conditionally packaged services.

We excluded those claims that we were not able to convert to single procedure claims even after applying all of the techniques for creation of "pseudo" single procedure claims to multiple procedure major and to multiple procedure minor claims. As has been our practice in recent years, we also excluded claims that contained codes that were viewed as independently or conditionally bilateral and that contained the bilateral modifier (Modifier 50 (Bilateral procedure)) because the line-item cost for the code represented the cost of two units of the procedure, notwithstanding that hospitals billed the code with a unit of one.

c. Completion of Claim Records and Median Cost Calculations

We then packaged the costs of packaged HCPCS codes (codes with status indicator "N" listed in Addendum B to this proposed rule and the costs of those lines for codes with status indicator "Q1" or "Q2" when they are not separately paid), and the costs of the services reported under packaged revenue codes in Table 3 that appeared on the claim without a HCPCS code into the cost of the single major procedure remaining on the claim.

As noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66606), for the CY 2008 OPPS, we adopted an APC Panel recommendation that CMS should review the final list of packaged revenue codes for consistency with OPPS policy and ensure that future versions of the I/OCE edit accordingly. As we have in the past, we will continue to compare the final list of packaged revenue codes that we adopt for CY 2011 to the revenue codes that the I/OCE will package for CY 2011 to ensure consistency.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68531), we replaced the NUBC standard abbreviations for the revenue codes listed in Table 2 of the CY 2009 OPPS/ASC proposed rule with the most current NUBC descriptions of the revenue code categories and subcategories to better articulate the meanings of the revenue codes without changing the proposed list of revenue codes. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60362 through 60363), we finalized changes to the packaged revenue code list based on our examination of the updated NUBC codes and public comment to the CY 2010 proposed list of packaged revenue codes. For this CY 2011 OPPS proposed rule, we reviewed the changes to revenue codes that were effective during CY 2009 for purposes of determining the charges reported with revenue codes but without HCPCS codes that we would propose to package for the CY 2011 OPPS. As we discuss in the context of the revenue code-to-cost center crosswalk in section II.A.1.c. of this proposed rule, for CY 2009, the NUBC changed the title of revenue code series 076x from "Specialty Room—Treatment/Observation Room" to "Specialty Services" and changed the title of subclassification revenue code 0762 from "Observation Room" to "Observation Hours". In addition, the NUBC deleted an explanatory note following revenue code 0913, "Behavioral Health Treatment Services—Extension of 090x." We are proposing to revise the title for revenue code 076x, Observation Hours, in Table 3 to comport to the CY 2009 revenue code title for revenue code 076x. There is no need to revise the table as a result of the deletion of the explanatory note. We believe that the charges reported under the revenue codes listed in Table 3 continue to reflect ancillary and supportive services for which hospitals report charges without HCPCS codes. Therefore, we are proposing to continue to package the costs that we derive from the charges reported under the revenue codes displayed in Table 3 below for purposes of calculating the median costs on which the CY 2011 OPPS would be based.

BILLING CODE 4120–01–P

TABLE 3.—PROPOSED CY 2011 PACKAGED REVENUE CODES

Revenue Code	Description
0250	Pharmacy; General Classification
0251	Pharmacy; Generic Drugs
0252	Pharmacy; Non-Generic Drugs
0254	Pharmacy; Drugs Incident to Other Diagnostic Services
0255	Pharmacy; Drugs Incident to Radiology
0257	Pharmacy; Non-Prescription
0258	Pharmacy; IV Solutions
0259	Pharmacy; Other Pharmacy
0260	IV Therapy; General Classification
0261	IV Therapy; Infusion Pump
0262	IV Therapy; IV Therapy/Pharmacy Svcs
0263	IV Therapy; IV Therapy/Drug/Supply Delivery
0264	IV Therapy; IV Therapy/Supplies
0269	IV Therapy; Other IV Therapy
0270	Medical/Surgical Supplies and Devices; General Classification
0271	Medical/Surgical Supplies and Devices; Non-sterile Supply
0272	Medical/Surgical Supplies and Devices; Sterile Supply
0275	Medical/Surgical Supplies and Devices; Pacemaker
0276	Medical/Surgical Supplies and Devices; Intraocular Lens
0278	Medical/Surgical Supplies and Devices; Other Implants
0279	Medical/Surgical Supplies and Devices; Other Supplies/Devices
0280	Oncology; General Classification
0289	Oncology; Other Oncology
0343	Nuclear Medicine; Diagnostic Radiopharmaceuticals
0344	Nuclear Medicine; Therapeutic Radiopharmaceuticals
0370	Anesthesia; General Classification
0371	Anesthesia; Anesthesia Incident to Radiology
0372	Anesthesia; Anesthesia Incident to Other DX Services
0379	Anesthesia; Other Anesthesia
0390	Administration, Processing and Storage for Blood and Blood Components; General Classification
0392	Administration, Processing and Storage for Blood and Blood Components; Processing and Storage
0399	Administration, Processing and Storage for Blood and Blood Components; Other Blood Handling
0621	Medical Surgical Supplies – Extension of 027X; Supplies Incident to Radiology
0622	Medical Surgical Supplies – Extension of 027X; Supplies Incident to Other DX Services
0623	Medical Supplies – Extension of 027X, Surgical Dressings
0624	Medical Surgical Supplies – Extension of 027X; FDA Investigational Devices

Revenue Code	Description
0630	Pharmacy – Extension of 025X; Reserved
0631	Pharmacy – Extension of 025X; Single Source Drug
0632	Pharmacy – Extension of 025X; Multiple Source Drug
0633	Pharmacy – Extension of 025X; Restrictive Prescription
0681	Trauma Response; Level I Trauma
0682	Trauma Response; Level II Trauma
0683	Trauma Response; Level III Trauma
0684	Trauma Response; Level IV Trauma
0689	Trauma Response; Other
0700	Cast Room; General Classification
0710	Recovery Room; General Classification
0720	Labor Room/Delivery; General Classification
0721	Labor Room/Delivery; Labor
0732	EKG/ECG (Electrocardiogram); Telemetry
0762	Specialty services; Observation Hours
0801	Inpatient Renal Dialysis; Inpatient Hemodialysis
0802	Inpatient Renal Dialysis; Inpatient Peritoneal Dialysis (Non-CAPD)
0803	Inpatient Renal Dialysis; Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)
0804	Inpatient Renal Dialysis; Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)
0809	Inpatient Renal Dialysis; Other Inpatient Dialysis
0810	Acquisition of Body Components; General Classification
0819	Inpatient Renal Dialysis; Other Donor
0821	Hemodialysis-Outpatient or Home; Hemodialysis Composite or Other Rate
0824	Hemodialysis-Outpatient or Home; Maintenance – 100%
0825	Hemodialysis-Outpatient or Home; Support Services
0829	Hemodialysis-Outpatient or Home; Other OP Hemodialysis
0942	Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training
0943	Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation
0948	Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation

BILLING CODE 4120–01–C

In accordance with our longstanding policy, we are proposing to continue to exclude: (1) Claims that had zero costs after summing all costs on the claim; and (2) claims containing packaging flag number 3. Effective for services furnished on or after July 1, 2004, the I/OCE assigned packaging flag number 3 to claims on which hospitals submitted token charges less than $1.01 for a service with status indicator "S" or "T" (a major separately payable service under the OPPS) for which the fiscal intermediary or MAC was required to allocate the sum of charges for services with a status indicator equaling "S" or "T" based on the relative weight of the APC to which each code was assigned. We do not believe that these charges, which were token charges as submitted by the hospital, are valid reflections of hospital resources. Therefore, we deleted these claims. We also deleted claims for which the charges equaled the revenue center payment (that is, the Medicare payment) on the assumption that where the charge equaled the payment, to apply a CCR to the charge would not yield a valid estimate of relative provider cost. We are proposing to continue these processes for the CY 2011 OPPS.

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

In accordance with our longstanding practice, we also excluded single and pseudo single procedure claims for

which the total cost on the claim was outside 3 standard deviations from the geometric mean of units for each HCPCS code on the bypass list (because, as discussed above, we used claims that contain multiple units of the bypass codes).

After removing claims for hospitals with error CCRs, claims without HCPCS codes, claims for immunizations not covered under the OPPS, and claims for services not paid under the OPPS, approximately 98 million claims were left. Using these 98 million claims, we created approximately 96 million single and "pseudo" single procedure claims, of which we used 95 million single bills (after trimming out approximately 696,000 claims as discussed above in this section) in the proposed CY 2011 median development and ratesetting.

We used these claims to calculate the proposed CY 2011 median costs for each separately payable HCPCS code and each APC. The comparison of HCPCS code-specific and APC medians determines the applicability of the 2 times rule. Section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (the 2 times rule). Finally, we reviewed the median costs for the services for which we are proposing to pay separately under this proposed rule, and we reassigned HCPCS codes to different APCs where it was necessary to ensure clinical and resource homogeneity within the APCs. Section III. of this proposed rule includes a discussion of many of the HCPCS code assignment changes that resulted from examination of the median costs and for other reasons. The APC medians were recalculated after we reassigned the affected HCPCS codes. Both the HCPCS code-specific 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 procedure claims.

As we discuss in sections II.A.2 d. and II.A.2.e. and in section X.B. of this proposed rule, in some cases, APC median costs are calculated using variations of the process outlined above. Specifically, section II.A.2.d. of this proposed rule addresses the proposed calculation of single APC criteria-based median costs. Section II.A.2.e. of this proposed rule discusses the proposed calculation of composite APC criteria-based median costs. Section X.B. of this proposed rule addresses the methodology for calculating the proposed median cost for partial hospitalization services.

At the February 2010 APC Panel Meeting, we provided the APC Panel a list of all APCs decreasing by more than 5 percent and increasing by more than 15 percent when comparing the proposed CY 2011 median costs based on data available for the February 2010 APC Panel meeting from CY 2009 claims processed through September 30, 2009, to those based on CY 2010 OPPS/ASC final rule data (CY 2008 claims). The APC Panel reviewed these fluctuations in the APC median costs but did not express particular concerns with the median cost changes.

As we stated earlier, at the February 2010 APC Panel Meeting, the APC Panel also recommended that the Data Subcommittee continue its work. We are proposing to accept that recommendation.

d. Proposed Calculation of Single Procedure APC Criteria-Based Median Costs

(1) Device-Dependent APCs

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 a full history of how we have calculated payment rates for device-dependent APCs in previous years and a detailed discussion of how we developed the standard device-dependent APC ratesetting methodology, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66739 through 66742). Overviews of the procedure-to-device edits and device-to-procedure edits used in ratesetting for device-dependent APCs are available in the CY 2005 OPPS final rule with comment period (69 FR 65761 through 65763) and the CY 2007 OPPS/ASC final rule with comment period (71 FR 68070 through 68071).

For CY 2011, we are proposing to continue to use the standard methodology for calculating median costs for device-dependent APCs that was finalized in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60365). This methodology utilizes claims data that generally represent the full cost of the required device. Specifically, we are proposing to calculate the median costs for device-dependent APCs for CY 2011 using only the subset of single procedure claims from CY 2009 claims data that pass the procedure-to-device and device-to-procedure edits; do not contain token charges (less than $1.01) for devices; do not contain the "FB" modifier signifying that the device was furnished without cost to the provider, supplier, or practitioner, or where a full credit was received; and do not contain the "FC" modifier signifying that the hospital received partial credit for the device. The "FC" modifier became effective January 1, 2008, and was present for the first time on claims that were used in OPPS ratesetting for CY 2010. We continue to believe the standard methodology for calculating median costs for device-dependent APCs gives us the most appropriate proposed median costs for device-dependent APCs in which the hospital incurs the full cost of the device.

The median costs for the majority of device-dependent APCs that are calculated using the CY 2011 proposed rule claims data are generally stable, with most median costs increasing moderately compared to the median costs upon which the CY 2010 OPPS payment rates were based. However, the median costs for APC 0225 (Implantation of Neurostimulator Electrodes, Cranial Nerve) and APC 0418 (Insertion of Left Ventricular Pacing Electrode) demonstrate significant fluctuation. Specifically, the proposed CY 2011 median cost for APC 0225 increased approximately 40 percent compared to its final CY 2010 median cost, while the proposed CY 2011 median cost for APC 0418, which had increased approximately 53 percent from CY 2009 to CY 2010, showed a decrease of approximately 27 percent based on the claims data available for this CY 2011 proposed rule. We believe the fluctuations in median costs for these two APCs are a consequence of the small number of single bills upon which the median costs are based and the small number of providers of these services. As we have stated in the past, some fluctuation in relative costs from year to year is to be expected in a prospective payment system for low volume device-dependent APCs, particularly where there are small numbers of single bills from a small number of providers. The additional single bills available for ratesetting in the CY 2011 final rule data and updated cost report data may result in less fluctuation in the median costs for these APCs for CY 2011.

Table 4 below lists the APCs for which we are proposing to use our standard device-dependent APC ratesetting methodology for CY 2011. We refer readers to Addendum A to this proposed rule for the proposed payment rates for these APCs.

TABLE 4.—PROPOSED CY 2011 DEVICE-DEPENDENT APCs

Proposed CY 2011 APC	Proposed CY 2011 Status Indicator	Proposed CY 2011 APC Title
0039	S	Level I Implantation of Neurostimulator Generator
0040	S	Percutaneous Implantation of Neurostimulator Electrodes
0061	S	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes
0082	T	Coronary or Non-Coronary Atherectomy
0083	T	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty
0084	S	Level I Electrophysiologic Procedures
0085	T	Level II Electrophysiologic Procedures
0086	T	Level III Electrophysiologic Procedures
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes
0090	T	Insertion/Replacement of Pacemaker Pulse Generator
0104	T	Transcatheter Placement of Intracoronary Stents
0106	T	Insertion/Replacement of Pacemaker Leads and/or Electrodes
0107	T	Insertion of Cardioverter-Defibrillator
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads
0115	T	Cannula/Access Device Procedures
0202	T	Level VII Female Reproductive Procedures
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve
0227	T	Implantation of Drug Infusion Device
0229	T	Transcatheter Placement of Intravascular Shunts
0259	T	Level VII ENT Procedures
0293	T	Level V Anterior Segment Eye Procedures
0315	S	Level II Implantation of Neurostimulator Generator
0384	T	GI Procedures with Stents
0385	S	Level I Prosthetic Urological Procedures
0386	S	Level II Prosthetic Urological Procedures
0418	T	Insertion of Left Ventricular Pacing Electrode
0425	T	Level II Arthroplasty or Implantation with Prosthesis
0427	T	Level II Tube or Catheter Changes or Repositioning
0622	T	Level II Vascular Access Procedures
0623	T	Level III Vascular Access Procedures
0648	T	Level IV Breast Surgery
0652	T	Insertion of Intraperitoneal and Pleural Catheters
0653	T	Vascular Reconstruction/Fistula Repair with Device
0654	T	Insertion/Replacement of a Permanent Dual Chamber Pacemaker
0655	T	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker
0656	T	Transcatheter Placement of Intracoronary Drug-Eluting Stents
0674	T	Prostate Cryoablation
0680	S	Insertion of Patient Activated Event Recorders

BILLING CODE 4120–01–C

(2) Blood and Blood Products

Since the implementation of the OPPS in August 2000, we have made separate payments for blood and blood products through APCs rather than packaging payment for them into payments for the procedures with which they are administered. Hospital payments for the costs of blood and blood products, as well as for the costs of collecting, processing, and storing blood and blood products, are made through the OPPS payments for specific blood product APCs.

For CY 2011, we are proposing to continue to establish payment rates for blood and blood products using our blood-specific CCR methodology, which utilizes actual or simulated CCRs from the most recently available hospital cost reports to convert hospital charges for blood and blood products to costs. This methodology has been our standard ratesetting methodology for blood and blood products since CY 2005. It was developed in response to data analysis indicating that there was a significant difference in CCRs for those hospitals with and without blood-specific cost centers, and past comments indicating that the former OPPS policy of defaulting to the overall hospital CCR for hospitals not reporting a blood-specific cost center often resulted in an underestimation of the true hospital costs for blood and blood products. Specifically, in order to address the differences in CCRs and to better reflect hospitals' costs, we are proposing to continue to simulate blood CCRs for each hospital that does not report a blood cost center by calculating the ratio of the blood-specific CCRs to hospitals' overall CCRs for those hospitals that do report costs and charges for blood cost centers. We would then apply this mean ratio to the overall CCRs of hospitals not reporting costs and charges for blood cost centers on their cost reports in order to simulate blood-specific CCRs for those hospitals. We calculated the median costs upon which the proposed CY 2011 payment rates for blood and blood products are based using the actual blood-specific CCR for hospitals that reported costs and charges for a blood cost center and a hospital-specific simulated blood-specific CCR for hospitals that did not report costs and charges for a blood cost center.

We continue to believe the hospital-specific, blood-specific CCR methodology better responds to the absence of a blood-specific CCR for a hospital than alternative methodologies, such as defaulting to the overall hospital CCR or applying an average blood-specific CCR across hospitals. Because this methodology takes into account the unique charging and cost accounting structure of each provider, we believe that it yields more accurate estimated costs for these products. We believe that continuing with this methodology in CY 2011 would result in median costs for blood and blood products that appropriately reflect the relative estimated costs of these products for hospitals without blood cost centers and, therefore, for these blood products in general.

We refer readers to Addendum B to this proposed rule for the proposed CY 2011 payment rates for blood and blood products, which are identified with status indicator "R." For more detailed discussion of the blood-specific CCR methodology, we refer readers to the CY 2005 OPPS proposed rule (69 FR 50524 through 50525). For a full history of OPPS payment for blood and blood products, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66807 through 66810).

(3) Single Allergy Tests

We are proposing to continue with our methodology of differentiating single allergy tests ("per test") from multiple allergy tests ("per visit") by assigning these services to two different APCs to provide accurate payments for these tests in CY 2011. Multiple allergy tests are currently assigned to APC 0370 (Allergy Tests), with a median cost calculated based on the standard OPPS methodology. We provided billing guidance in CY 2006 in Transmittal 804 (issued on January 3, 2006) specifically clarifying that hospitals should report charges for the CPT codes that describe single allergy tests to reflect charges "per test" rather than "per visit" and should bill the appropriate number of units (as defined in the CPT code descriptor) of these CPT codes to describe all of the tests provided. Our CY 2009 claims data available for this proposed rule for APC 0381 do not reflect improved and more consistent hospital billing practices of "per test" for single allergy tests. The median cost of APC 0381, calculated for this proposed rule according to the standard single claims OPPS methodology, is approximately $52, significantly higher than the CY 2010 median cost of APC 0381 of approximately $29 calculated according to the "per unit" methodology, and greater than we would expect for these procedures that are to be reported "per test" with the appropriate number of units. Some claims for single allergy tests still appear to provide charges that represent a "per visit" charge, rather than a "per test" charge. Therefore, consistent with our payment policy for single allergy tests since CY 2006, we are proposing to calculate a "per unit" median cost for APC 0381, based upon 595 claims containing multiple units or multiple occurrences of a single CPT code. The proposed CY 2011 median cost for APC 0381 using the "per unit" methodology is approximately $29. For a full discussion of this methodology, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66737).

(4) Hyperbaric Oxygen Therapy (APC 0659)

Since the implementation of OPPS in August 2000, the OPPS has recognized HCPCS code C1300 (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval) for hyperbaric oxygen therapy (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 or other departmental cost centers. The public comments on the CY 2005 OPPS proposed rule effectively demonstrated that hospitals report the costs and charges for HBOT in a wide variety of cost centers. Since CY 2005, we have used this methodology to estimate the median cost for HBOT. The median costs of HBOT using this methodology have been relatively stable for the last 5 years. For CY 2011, we are proposing to continue using the same methodology to estimate a "per unit" median cost for HCPCS code C1300. This methodology results in a proposed APC median cost of approximately $109 using 328,960 claims with multiple units or multiple occurrences for HCPCS code C1300 for CY 2011.

(5) Payment for Ancillary Outpatient Services When Patient Expires (APC 0375)

In the November 1, 2002 final rule with comment period (67 FR 66798), we discussed the creation of the 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. HCPCS modifier –CA is defined as a procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission. In Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of this modifier. For a complete description of the history of the policy and the development of the payment methodology for these services, we refer readers to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68157 through 68158).

For CY 2011, we are proposing to continue to use our established ratesetting methodology for calculating the median cost of APC 0375 (Ancillary Outpatient Services When Patient Expires) and to continue to make one payment under APC 0375 for the services that meet the specific conditions for using HCPCS modifier –CA. We are proposing to calculate the relative payment weight for APC 0375 by using all claims reporting a status indicator "C" (inpatient procedures) appended with HCPCS modifier –CA, using estimated costs from claims data for line-items with a HCPCS code assigned to status indicators "G," "H," "K," "N," "Q1," "Q2," "Q3," "R," "S," "T," "U," "V," and "X" and charges for packaged revenue codes without a HCPCS code (we refer readers to section XIII.A.1. of this proposed rule for a complete listing of status indicators). We continue to believe that this methodology results in the most appropriate aggregate median cost for the ancillary services provided in these unusual clinical situations.

We believe that hospitals are reporting the HCPCS modifier –CA according to the policy initially established in CY 2003. We note that the claims frequency for APC 0375 has been relatively stable over the past few years. Although the median cost for APC 0375 has increased, the median in the CY 2009 OPPS claims data used for development of proposed rates for CY 2011 was only slightly higher than that for CY 2010. Variation in the median cost for APC 0375 is expected because of the small number of claims and because the specific cases are grouped by the presence of the HCPCS modifier –CA appended to an inpatient procedure and not according to the standard APC criteria of clinical and resource homogeneity. Cost variation for APC 0375 from year to year is anticipated and acceptable as long as hospitals continue judicious reporting of the HCPCS modifier –CA. Table 5 below shows the number of claims and the final median costs for APC 0375 for CYs 2007, 2008, 2009, and 2010. For CY 2011, we are proposing a median cost of approximately $6,566 for APC 0375 based on 117 claims.

TABLE 5.--CLAIMS FOR ANCILLARY OUTPATIENT SERVICES WHEN PATIENT EXPIRES (–CA MODIFIER) FOR CYs 2007 THROUGH 2010

Prospective Payment Year	Number of Claims	APC Median Cost
CY 2007	260	$3,549
CY 2008	183	$4,945
CY 2009	168	$5,545
CY 2010	182	$5,911

(6) Pulmonary Rehabilitation

Section 144(a)(1) of Public Law 110–275 (MIPPA) added section 1861(fff) to the Act to provide Medicare Part B coverage and payment for a comprehensive program of pulmonary rehabilitation services furnished to beneficiaries with chronic obstructive pulmonary disease, effective January 1, 2010. Accordingly, in the CY 2010 OPPS/ASC final rule with comment period, we established a policy to pay for pulmonary rehabilitation (PR) services furnished as a part of the comprehensive PR program benefit (74 FR 60567). We created new HCPCS code G0424 (Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day) and assigned it to new APC 0102 (Level II Pulmonary Treatment).

For CY 2011, we are proposing to continue to require hospitals to report PR services provided under the comprehensive PR benefit in section 1861(fff) of the Act using HCPCS code G0424. We also are proposing to continue to use the methodology described in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60567 through 60570) to calculate the median cost on which the proposed payment rate for CY 2011 is based. Specifically, we are proposing to continue to assign HCPCS code G0424 to APC 0102 and to calculate a median "per session" cost simulated from historical hospital claims data for similar pulmonary therapy services for the CY 2011 OPPS.

To simulate the proposed "per session" median cost of HCPCS code G0424 from claims data for existing services, we used only claims that contained at least one unit of HCPCS code G0239 (Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)), the group code that is without limitation on time duration, and one unit of HCPCS code G0237 (Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)) or G0238 (Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)), the individual, face-to-face codes that report 15 minutes of service on the same date of service. We continue to believe that patients in a PR program would typically receive individual and group services in each session of

approximately 1 hour in duration. This proposal is consistent with public comments on the CY 2010 OPPS/ASC proposed rule that were addressed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60569) that suggested that PR is often provided in group sessions in the HOPD, although patients commonly require additional one-on-one care in order to fully participate in the program. We note that our use of "per session" claims reporting one unit of HCPCS code G0237 or G0238 and one unit of HCPCS code G0239 in this simulation methodology is also consistent with our overall finding of approximately 2.4 service units of the HCPCS G-codes per day on a single date of service, usually consisting of both individual and group services, for patients receiving pulmonary therapy services in the HOPD based upon CY 2008 claims used for CY 2010 OPPS final rule ratesetting. We continue to believe that the typical session of PR is 1 hour based on public comments that indicated that a session of PR is typically 1 hour and based on our findings that the most commonly reported HCPCS code for pulmonary treatment is HCPCS code G0239, which has no time definition for this group service.

In the calculation of the proposed median cost for APC 0102, we included all costs of the related tests and assessment services, including CPT codes 94620 (Pulmonary stress testing, simple (e.g. 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)), 94664 (Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device), and 94667 (Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation and all the costs of all CPT codes for established patient clinic visits) on the same date of service as the HCPCS codes in the claims we used to simulate the median cost for HCPCS code G0424, which is the only HCPCS code in APC 0102. After identifying these "per session" claims, which we believe represent 1 hour of care, we summed the costs and calculated the median cost for the set of selected claims. In light of the cost and clinical similarities of PR and the existing services described by HCPCS codes G0237, G0238, and G0239 and the CPT codes for related assessments and tests, and the significant number of "per session" hospital claims we found, we are confident that the proposed simulated median cost for HCPCS code G0424 and APC 0102 of approximately $68 is a valid estimate of the expected hospital cost of a PR session. We note that this proposed median cost is higher than the CY 2010 final rule median cost for HCPCs code G0424 and APC 0102 of approximately $50 on which the CY 2010 payment is based.

e. Proposed Calculation of Composite APC Criteria-Based Median Costs

As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66613), we believe it is important that the OPPS enhance incentives for hospitals to provide only necessary, high quality care and to provide that care as efficiently as possible. For CY 2008, we developed composite APCs to provide a single payment for groups of services that are typically performed together during a single clinical encounter and that result in the provision of a complete service. Combining payment for multiple independent services into a single OPPS payment in this way enables hospitals to manage their resources with maximum flexibility by monitoring and adjusting the volume and efficiency of services themselves. An additional advantage to the composite APC model is that we can use data from correctly coded multiple procedure claims to calculate payment rates for the specified combinations of services, rather than relying upon single procedure claims which may be low in volume and/or incorrectly coded. Under the OPPS, we currently have composite APC policies for extended assessment and management services, low dose rate (LDR) prostate brachytherapy, cardiac electrophysiologic evaluation and ablation services, mental health services, and multiple imaging services. We refer readers to the CY 2008 OPPS/ASC final rule with comment period for a full discussion of the development of the composite APC methodology (72 FR 66611 through 66614 and 66650 through 66652).

At its February 2010 meeting, the APC Panel recommended that, in order to support stem cell transplantation, CMS consider creating a composite APC or custom APC that captures the costs of stem cell acquisition performed in conjunction with recipient transplantation and preparation of tissue. We are accepting this APC Panel recommendation to consider creating a composite APC or custom APC that captures the costs of stem cell acquisition performed in conjunction with recipient transplantation and preparation of tissue, and will report the results of our assessment to the APC Panel at a future meeting.

For CY 2011, we are proposing to continue our established composite APC policies for extended assessment and management, LDR prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, mental health services, and multiple imaging services, as discussed in sections II.A.2.e.(1), II.A.2.e.(2), II.A.2.e.(3), II.A.2.e.(4), and II.A.2.e.(5), respectively, of this proposed rule.

(1) Extended Assessment and Management Composite APCs (APCs 8002 and 8003)

For CY 2011, we are proposing to continue to include composite APC 8002 (Level I Extended Assessment and Management Composite) and composite APC 8003 (Level II Extended Assessment and Management Composite) in the OPPS. For CY 2008, we created these two composite APCs to provide payment to hospitals in certain circumstances when extended assessment and management of a patient occur (an extended visit). In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. In the circumstances when observation care is provided in conjunction with a high level visit or direct referral and is an integral part of a patient's extended encounter of care, payment is made for the entire care encounter through one of two composite APCs as appropriate.

As defined for the CY 2008 OPPS, composite APC 8002 describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct referral for observation services in conjunction with observation services of substantial duration (72 FR 66648 through 66649). Composite APC 8003 describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) Type A emergency department visit, a high level (Level 5) Type B emergency department visit, or critical care services in conjunction with observation services of substantial duration. HCPCS code G0378 (Observation services, per hour) is assigned status indicator "N," signifying that its payment is always packaged. As noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66648 through 66649), the Integrated Outpatient Code Editor (I/OCE) evaluates every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the OPPS Pricer, determines the appropriate status indicator, APC, and

payment for every code on a claim. The specific criteria that must be met for the two extended assessment and management composite APCs to be paid are provided below in the description of the claims that were selected for the calculation of the proposed CY 2011 median costs for these composite APCs. We are not proposing to change these criteria for the CY 2011 OPPS.

When we created composite APCs 8002 and 8003 for CY 2008, we retained as general reporting requirements for all observation services those criteria related to physician order and evaluation, documentation, and observation beginning and ending time as listed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66812). These are more general requirements that encourage hospitals to provide medically reasonable and necessary care and help to ensure the proper reporting of observation services on correctly coded hospital claims that reflect the full charges associated with all hospital resources utilized to provide the reported services. We also issued guidance clarifying the correct method for reporting the starting time for observation services sections 290.2.2 through 290.5 in the Medicare Claims Processing Manual (Pub. 100–4), Chapter 4, through Transmittal 1745, Change Request 6492, issued May 22, 2009 and implemented July 6, 2009. We are not proposing to change these reporting requirements for the CY 2011 OPPS.

For CY 2011, we are proposing to continue the extended assessment and management composite APC payment methodology for APCs 8002 and 8003. We continue to believe that the composite APCs 8002 and 8003 and related policies provide the most appropriate means of paying for these services. We are proposing to calculate the median costs for APCs 8002 and 8003 using all single and "pseudo" single procedure claims for CY 2009 that meet the criteria for payment of each composite APC.

Specifically, to calculate the proposed median costs for composite APCs 8002 and 8003, we selected single and "pseudo" single procedure claims that met each of the following criteria:

1. Did not contain a HCPCS code to which we have assigned status indicator "T" that is reported with a date of service 1 day earlier than the date of service associated with HCPCS code G0378. (By selecting these claims from single and "pseudo" single claims, we had already assured that they would not contain a code for a service with status indicator "T" on the same date of service.);

2. Contained 8 or more units of HCPCS code G0378; and

3. Contained one of the following codes:

- In the case of composite APC 8002, HCPCS code G0379 (Direct referral of patient for hospital observation care) on the same date of service as G0378; or CPT code 99205 (Office or other outpatient visit for the evaluation and management of a new patient (Level 5)); or CPT code 99215 (Office or other outpatient visit for the evaluation and management of an established patient (Level 5)) provided on the same date of service or one day before the date of service for HCPCS code G0378.
- In the case of composite APC 8003, CPT code 99284 (Emergency department visit for the evaluation and management of a patient (Level 4)); CPT code 99285 (Emergency department visit for the evaluation and management of a patient (Level 5)); CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes); or HCPCS code G0384 (Level 5 hospital emergency department visit provided in a Type B emergency department) provided on the same date of service or one day before the date of service for HCPCS code G0378. (As discussed in detail in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68684), we added HCPCS code G0384 to the eligibility criteria for composite APC 8003 for CY 2009.)

As discussed further in section IX. of this proposed rule, and consistent with our CY 2008, CY 2009, and CY 2010 final policies, when calculating the median costs for the clinic, Type A emergency department visit, Type B emergency department visit, and critical care APCs (0604 through 0617 and 0626 through 0630), we utilize our methodology that excludes those claims for visits that are eligible for payment through the two extended assessment and management composite APCs, that is APC 8002 or APC 8003. We believe that this approach results in the most accurate cost estimates for APCs 0604 through 0617 and 0626 through 0630 for CY 2011.

At its February 2010 meeting, the APC Panel recommended that CMS study the feasibility of expanding the extended assessment and management composite APC methodology to include services commonly furnished in conjunction with visits and observation services, such as drug infusion, electrocardiogram, and chest X-ray. We are accepting this recommendation, and we will share our assessment with the APC Panel at a future meeting.

In summary, for CY 2011, we are proposing to continue to include composite APCs 8002 and 8003 in the OPPS. We are proposing to continue the extended assessment and management composite APC payment methodology and criteria that we finalized for CYs 2009 and 2010. We also are proposing to calculate the median costs for APCs 8002 and 8003 using the same methodology that we used to calculate the medians for composite APCs 8002 and 8003 for the CY 2008 OPPS (72 FR 66649). That is, we used all single and "pseudo" single procedure claims from CY 2009 that met the criteria for payment of each composite APC and applied the standard packaging and trimming rules to the claims before calculating the proposed CY 2011 median costs. The proposed CY 2011 median cost resulting from this methodology for composite APC 8002 is approximately $401, which was calculated from 17,398 single and "pseudo" single bills that met the required criteria. The proposed CY 2011 median cost for composite APC 8003 is approximately $743, which was calculated from 201,189 single and "pseudo" single bills that met the required criteria.

(2) Low Dose Rate (LDR) Prostate Brachytherapy Composite APC (APC 8001)

LDR prostate brachytherapy is a treatment for prostate cancer in which hollow needles or catheters are inserted into the prostate, followed by permanent implantation of radioactive sources into the prostate through the needles/catheters. At least two CPT codes are used to report the composite treatment service because there are separate codes that describe placement of the needles/catheters and the application of the brachytherapy sources: CPT code 55875 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) and CPT code 77778 (Interstitial radiation source application; complex). Generally, the component services represented by both codes are provided in the same operative session in the same hospital on the same date of service to the Medicare beneficiary being treated with LDR brachytherapy for prostate cancer. As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66653), OPPS payment rates for CPT code 77778, in particular, had fluctuated over the years. We were frequently informed by the public that reliance on single procedure claims to set the median costs for these services resulted in use of mainly

incorrectly coded claims for LDR prostate brachytherapy because a correctly coded claim should include, for the same date of service, CPT codes for both needle/catheter placement and application of radiation sources, as well as separately coded imaging and radiation therapy planning services (that is, a multiple procedure claim).

In order to base payment on claims for the most common clinical scenario, and to further our goal of providing payment under the OPPS for a larger bundle of component services provided in a single hospital encounter, beginning in CY 2008, we provide a single payment for LDR prostate brachytherapy when the composite service, reported as CPT codes 55875 and 77778, is furnished in a single hospital encounter. We base the payment for composite APC 8001 (LDR Prostate Brachytherapy Composite) on the median cost derived from claims for the same date of service that contain both CPT codes 55875 and 77778 and that do not contain other separately paid codes that are not on the bypass list. In uncommon occurrences in which the services are billed individually, hospitals continue to receive separate payments for the individual services. We refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66652 through 66655) for a full history of OPPS payment for LDR prostate brachytherapy and a detailed description of how we developed the LDR prostate brachytherapy composite APC.

For CY 2011, we are proposing to continue paying for LDR prostate brachytherapy services using the composite APC methodology proposed and implemented for CYs 2008, 2009, and 2010. That is, we are proposing to use CY 2009 claims on which both CPT codes 55875 and 77778 were billed on the same date of service with no other separately paid procedure codes (other than those on the bypass list) to calculate the payment rate for composite APC 8001. Consistent with our CY 2008 through CY 2010 practice, we are proposing not to use the claims that meet these criteria in the calculation of the median costs for APCs 0163 (Level IV Cystourethroscopy and Other Genitourinary Procedures) and 0651 (Complex Interstitial Radiation Source Application), the APCs to which CPT codes 55875 and 77778 are assigned, respectively. The median costs for APCs 0163 and 0651 would continue to be calculated using single and "pseudo" single procedure claims. We continue to believe that this composite APC contributes to our goal of creating hospital incentives for efficiency and cost containment, while providing hospitals with the most flexibility to manage their resources. We also continue to believe that data from claims reporting both services required for LDR prostate brachytherapy provide the most accurate median cost upon which to base the composite APC payment rate.

Using partial year CY 2009 claims data available for this proposed rule, we were able to use 788 claims that contained both CPT codes and 55875 and 77778 to calculate the median cost upon which the proposed CY 2011 payment for composite APC 8001 is based. The proposed median cost for composite APC 8001 for CY 2011 is approximately $3,265. This is an increase compared to the CY 2010 OPPS/ASC final rule with comment period in which we calculated a final median cost for this composite APC of approximately $3,084 based on a full year of CY 2008 claims data. The proposed CY 2011 median cost for this composite APC is slightly less than $3,604, the sum of the proposed median costs for APCs 0163 and 0651 ($2,606 + $998), the APCs to which CPT codes 55875 and 77778 map if one service is billed on a claim without the other. We believe the proposed CY 2011 median cost for composite APC 8001 of approximately $3,265, calculated from claims we believe to be correctly coded, would result in a reasonable and appropriate payment rate for this service in CY 2011.

(3) Cardiac Electrophysiologic Evaluation and Ablation Composite APC (APC 8000)

Cardiac electrophysiologic evaluation and ablation services frequently are performed in varying combinations with one another during a single episode-of-care in the hospital outpatient setting. Therefore, correctly coded claims for these services often include multiple codes for component services that are reported with different CPT codes and that, prior to CY 2008, were always paid separately through different APCs (specifically, APC 0085 (Level II Electrophysiologic Evaluation), APC 0086 (Ablate Heart Dysrhythm Focus), and APC 0087 (Cardiac Electrophysiologic Recording/Mapping)). As a result, there would never be many single bills for cardiac electrophysiologic evaluation and ablation services, and those that are reported as single bills would often represent atypical cases or incorrectly coded claims. As described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66655 through 66659), the APC Panel and the public expressed persistent concerns regarding the limited and reportedly unrepresentative single bills available for use in calculating the median costs for these services according to our standard OPPS methodology.

Effective January 1, 2008, we established APC 8000 (Cardiac Electrophysiologic Evaluation and Ablation Composite) to pay for a composite service made up of at least one specified electrophysiologic evaluation service and one specified electrophysiologic ablation service. Calculating a composite APC for these services allowed us to utilize many more claims than were available to establish the individual APC median costs for these services, and we also saw this composite APC as an opportunity to advance our stated goal of promoting hospital efficiency through larger payment bundles. In order to calculate the median cost upon which the payment rate for composite APC 8000 is based, we used multiple procedure claims that contained at least one CPT code from group A for evaluation services and at least one CPT code from group B for ablation services reported on the same date of service on an individual claim. Table 9 in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66656) identified the CPT codes that are assigned to groups A and B. For a full discussion of how we identified the group A and group B procedures and established the payment rate for the cardiac electrophysiologic evaluation and ablation composite APC, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66655 through 66659). Where a service in group A is furnished on a date of service that is different from the date of service for a code in group B for the same beneficiary, payments are made under the appropriate single procedure APCs and the composite APC does not apply.

For CY 2011, we are proposing to continue to pay for cardiac electrophysiologic evaluation and ablation services using the composite APC methodology proposed and implemented for CY 2008, CY 2009, and CY 2010. Consistent with our CY 2008 through CY 2010 practice, we are proposing not to use the claims that meet the composite payment criteria in the calculation of the median costs for APC 0085 and APC 0086, to which the CPT codes in both groups A and B for composite APC 8000 are otherwise assigned. Median costs for APCs 0085 and 0086 would continue to be calculated using single procedure claims. We continue to believe that the composite APC methodology for cardiac electrophysiologic evaluation and

ablation services is the most efficient and effective way to use the claims data for the majority of these services and best represents the hospital resources associated with performing the common combinations of these services that are clinically typical. Furthermore, this approach creates incentives for efficiency by providing a single payment for a larger bundle of major procedures when they are performed together, in contrast to continued separate payment for each of the individual procedures.

Using partial year CY 2009 claims data available for this proposed rule, we were able to use 8,964 claims containing a combination of group A and group B codes and calculated a proposed median cost of approximately $10,834 for composite APC 8000. This is an increase compared to the CY 2010 OPPS/ASC final rule with comment period in which we calculated a final median cost for this composite APC of approximately $10,026 based on a full year of CY 2008 claims data. We believe the proposed median cost of $10,834 calculated from a high volume of correctly coded multiple procedure claims would result in an accurate and appropriate proposed payment for cardiac electrophysiologic evaluation and ablation services when at least one evaluation service is furnished during the same clinical encounter as at least one ablation service. Table 6 below list the groups of procedures upon which we are proposing to base composite APC 8000 for CY 2011.

BILLING CODE 4120–01–P

TABLE 6.—PROPOSED GROUPS OF CARDIAC ELECTROPHYSIOLOGIC EVALUATION AND ABLATION PROCEDURES UPON WHICH COMPOSITE APC 8000 IS BASED

Codes Used in Combinations: At Least One in Group A and One in Group B	CY 2010 CPT Code	Proposed Single Code CY 2011 APC	Proposed CY 2011 SI (Composite)
Group A			
Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia	93619	0085	Q3
Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording	93620	0085	Q3
Group B			
Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	93650	0085	Q3
Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination	93651	0086	Q3
Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia	93652	0086	Q3

BILLING CODE 4120–01–C

(4) Mental Health Services Composite APC (APC 0034)

We are proposing to continue our longstanding policy of limiting the aggregate payment for specified less resource-intensive mental health services furnished on the same date to the payment for a day of partial hospitalization, which we consider to be the most resource-intensive of all outpatient mental health treatment for CY 2011. We refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18452 through 18455) for the initial discussion of this longstanding policy. We continue to believe that the costs associated with administering a partial hospitalization program represent the most resource-intensive of all outpatient mental health treatment. Therefore, we do not believe that we should pay more for a day of individual mental health services under

the OPPS than the partial hospitalization per diem payment.

As discussed in detail in section X. of this proposed rule, for CY 2011, we are proposing to use a provider-specific two tiered payment approach for partial hospitalization services that distinguishes payment made for services furnished in a CMHC from payment made for services furnished in a hospital. Specifically, we are proposing one APC for partial hospitalization program days with three services furnished in a CMHC (APC 0172, Level I Partial Hospitalization (3 services) for CMHCs) and one APC for days with four or more services furnished in a CMHC (APC 0173, Level II Partial Hospitalization (4 or more services) for CMHCs). We are proposing that the payment rates for these two APCs be based upon the median per diem costs calculated using data only from CMHCs. Similarly, we are proposing one APC for partial hospitalization program days with three services furnished in a hospital (APC 0175, Level I Partial Hospitalization (3 services) for Hospital-Based PHPs), and one APC for days with four or more services furnished in a hospital (APC 0176, Level II Partial Hospitalization (4 or more services) for Hospital-Based PHPs). We are proposing that the payment rates for these two APCs be based on the median per diem costs calculated using data only from hospitals.

Because our longstanding policy of limiting the aggregate payment for specified less resource-intensive mental health services furnished on the same date to the payment rate for the most resource-intensive of all outpatient mental health treatment, we are proposing to set the CY 2011 payment rate for APC 0034 (Mental Health Services Composite) at the same rate as we are proposing for APC 0176, which is the maximum partial hospitalization per diem payment. We believe this APC payment rate would provide the most appropriate payment for composite APC 0034, taking into consideration the intensity of the mental health services and the differences in the HCPCS codes for mental health services that could be paid through this composite APC compared with the HCPCS codes that could be paid through partial hospitalization APC 0176. When the aggregate payment for specified mental health services provided by one hospital to a single beneficiary on one date of service based on the payment rates associated with the APCs for the individual services exceeds the maximum per diem partial hospitalization payment, we are proposing that those specified mental health services would be assigned to APC 0034. We are proposing that APC 0034 would have the same payment rate as APC 0176 and that the hospital would continue to be paid one unit of APC 0034. The I/OCE currently determines, and we are proposing for CY 2011 that it would continue to determine, whether to pay these specified mental health services individually or to make a single payment at the same rate as the APC 0176 per diem rate for partial hospitalization for all of the specified mental health services furnished by the hospital on that single date of service.

(5) Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008)

Prior to CY 2009, hospitals received a full APC payment for each imaging service on a claim, regardless of how many procedures were performed during a single session using the same imaging modality. Based on extensive data analysis, we determined that this practice neither reflected nor promoted the efficiencies hospitals can achieve when performing multiple imaging procedures during a single session (73 FR 41448 through 41450). As a result of our data analysis, and in response to ongoing recommendations from MedPAC to improve payment accuracy for imaging services under the OPPS, we expanded the composite APC model developed in CY 2008 to multiple imaging services. Effective January 1, 2009, we provide a single payment each time a hospital bills more than one imaging procedure within an imaging family on the same date of service. We utilize three imaging families based on imaging modality for purposes of this methodology: (1) Ultrasound; (2) computed tomography (CT) and computed tomographic angiography (CTA); and (3) magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA). The HCPCS codes subject to the multiple imaging composite policy, and their respective families, are listed in Table 13 of the CY 2010 OPPS/ASC final rule with comment period (74 FR 60403 through 60407).

While there are three imaging families, there are five multiple imaging composite APCs due to the statutory requirement at section 1833(t)(2)(G) of the Act that we differentiate payment for OPPS imaging services provided with and without contrast. While the ultrasound procedures included in the policy do not involve contrast, both CT/CTA and MRI/MRA scans can be provided either with or without contrast. The five multiple imaging composite APCs established in CY 2009 are:

- APC 8004 (Ultrasound Composite);
- APC 8005 (CT and CTA without Contrast Composite);
- APC 8006 (CT and CTA with Contrast Composite);
- APC 8007 (MRI and MRA without Contrast Composite); and
- APC 8008 (MRI and MRA with Contrast Composite).

We define the single imaging session for the "with contrast" composite APCs as having at least one or more imaging procedures from the same family performed with contrast on the same date of service. For example, if the hospital performs an MRI without contrast during the same session as at least one other MRI with contrast, the hospital will receive payment for APC 8008, the "with contrast" composite APC.

Hospitals continue to use the same HCPCS codes to report imaging procedures, and the I/OCE determines when combinations of imaging procedures qualify for composite APC payment or map to standard (sole service) APCs for payment. We make a single payment for those imaging procedures that qualify for composite APC payment, as well as any packaged services furnished on the same date of service. The standard (noncomposite) APC assignments continue to apply for single imaging procedures and multiple imaging procedures performed across families. For a full discussion of the development of the multiple imaging composite APC methodology, we refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68559 through 68569).

At its February 2010 meeting, the APC Panel recommended that CMS continue providing analysis on an ongoing basis of the impact on beneficiaries of the multiple imaging composite APCs as data become available. We are accepting this recommendation and will provide the requested analysis to the APC Panel at a future meeting.

In summary, for CY 2011, we are proposing to continue paying for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite payment methodology. The proposed CY 2011 payment rates for the five multiple imaging composite APCs (APC 8004, APC 8005, APC 8006, APC 8007, and APC 8008) are based on median costs calculated from the partial year CY 2009 claims available for this proposed rule that would have qualified for composite payment under the current policy (that is, those claims with more than one

procedure within the same family on a single date of service). To calculate the proposed median costs, we used the same methodology that we used to calculate the final CY 2010 median costs for these composite APCs. That is, we removed any HCPCS codes in the OPPS imaging families that overlapped with codes on our bypass list ("overlap bypass codes") to avoid splitting claims with multiple units or multiple occurrences of codes in an OPPS imaging family into new "pseudo" single claims. The imaging HCPCS codes that we removed from the bypass list for purposes of calculating the proposed multiple imaging composite APC median costs appear in Table 8 of this proposed rule. (We note that, consistent with our proposal in section II.A.1.b. of this proposed rule to add CPT code 70547 (Magnetic resonance angiography, neck; without contrast material(s)) to the list of bypass codes for CY 2011, we also are proposing to add CPT code 70547 to the list of proposed OPPS imaging family services overlapping with HCPCS codes on the proposed CY 2010 bypass list.) We integrated the identification of imaging composite "single session" claims, that is, claims with multiple imaging procedures within the same family on the same date of service, into the creation of "pseudo" single procedure claims to ensure that claims were split in the "pseudo" single process into accurate reflections of either a composite "single session" imaging service or a standard sole imaging service resource cost. Like all single bills, the new composite "single session" claims were for the same date of service and contained no other separately paid services in order to isolate the session imaging costs. Our last step after processing all claims through the "pseudo" single process was to reassess the remaining multiple procedure claims using the full bypass list and bypass process in order to determine if we could make other "pseudo" single bills. That is, we assessed whether a single separately paid service remained on the claim after removing line-items for the "overlap bypass codes."

We were able to identify 1.7 million "single session" claims out of an estimated 2.7 million potential composite cases from our ratesetting claims data, or well over half of all eligible claims, to calculate the proposed CY 2011 median costs for the multiple imaging composite APCs. Table 7 below lists the HCPCS codes that would be subject to the proposed multiple imaging composite policy and their respective families for CY 2011.

BILLING CODE 4120–01–P

TABLE 7.—PROPOSED OPPS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCs

Family 1 – Ultrasound	
Proposed CY 2011 APC 8004 (Ultrasound Composite)	**Proposed CY 2011 Approximate APC Median Cost = $197**
76604	Us exam, chest
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/Doppler
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76870	Us exam, scrotum
76857	Us exam, pelvic, limited
Family 2 - CT and CTA with and without Contrast	
Proposed CY 2011 APC 8005 (CT and CTA without Contrast Composite)*	**Proposed CY 2011 Approximate APC Median Cost = $431**
70450	Ct head/brain w/o dye
70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70490	Ct soft tissue neck w/o dye
71250	Ct thorax w/o dye
72125	Ct neck spine w/o dye
72128	Ct chest spine w/o dye
72131	Ct lumbar spine w/o dye
72192	Ct pelvis w/o dye
73200	Ct upper extremity w/o dye
73700	Ct lower extremity w/o dye
74150	Ct abdomen w/o dye
74261	Ct colonography, w/o dye
Proposed CY 2011 APC 8006 (CT and CTA with Contrast Composite)	**Proposed CY 2011 Approximate APC Median Cost = $649**
70487	Ct maxillofacial w/dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye

70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70488	Ct maxillofacial w/o & w/dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72191	Ct angiograph pelv w/o&w/dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74262	Ct colonography, w/dye
75635	Ct angio abdominal arteries
* If a "without contrast" CT or CTA procedure is performed during the same session as a "with contrast" CT or CTA procedure, the I/OCE will assign APC 8006 rather than APC 8005.	
Family 3 - MRI and MRA with and without Contrast	
Proposed CY 2011 APC 8007 (MRI and MRA without Contrast Composite)*	**Proposed CY 2010 Approximate APC Median Cost = $732**
70336	Magnetic image, jaw joint
70540	Mri orbit/face/neck w/o dye

70544	Mr angiography head w/o dye
70547	Mr angiography neck w/o dye
70551	Mri brain w/o dye
70554	Fmri brain by tech
71550	Mri chest w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
72195	Mri pelvis w/o dye
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73718	Mri lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye
74181	Mri abdomen w/o dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
C8901	MRA w/o cont, abd
C8904	MRI w/o cont, breast, uni
C8907	MRI w/o cont, breast, bi
C8910	MRA w/o cont, chest
C8913	MRA w/o cont, lwr ext
C8919	MRA w/o cont, pelvis
Proposed CY 2011 APC 8008 (MRI and MRA with Contrast Composite)	**Proposed CY 2011 Approximate APC Median Cost = $1,028**
70549	Mr angiograph neck w/o&w/dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70548	Mr angiography neck w/dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
72142	Mri neck spine w/dye
72147	Mri chest spine w/dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye

72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
75561	Cardiac mri for morph w/dye
75563	Card mri w/stress img & dye
C8900	MRA w/cont, abd
C8902	MRA w/o fol w/cont, abd
C8903	MRI w/cont, breast, uni
C8905	MRI w/o fol w/cont, brst, un
C8906	MRI w/cont, breast, bi
C8908	MRI w/o fol w/cont, breast,
C8909	MRA w/cont, chest
C8911	MRA w/o fol w/cont, chest
C8912	MRA w/cont, lwr ext
C8914	MRA w/o fol w/cont, lwr ext
C8918	MRA w/cont, pelvis
C8920	MRA w/o fol w/cont, pelvis
* If a "without contrast" MRI or MRA procedure is performed during the same session as a "with contrast" MRI or MRA procedure, the I/OCE will assign APC 8008 rather than 8007.	

TABLE 8.—PROPOSED OPPS IMAGING FAMILY SERVICES OVERLAPPING WITH HCPCS CODES ON THE PROPOSED CY 2011 BYPASS LIST

Family 1 – Ultrasound	
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/Doppler
76856	Us exam, pelvic, complete
76870	Us exam, scrotum
76857	Us exam, pelvic, limited
Family 2 - CT and CTA with and without Contrast	
70450	Ct head/brain w/o dye
70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70490	Ct soft tissue neck w/o dye
71250	Ct thorax w/o dye
72125	Ct neck spine w/o dye
72128	Ct chest spine w/o dye
72131	Ct lumbar spine w/o dye
72192	Ct pelvis w/o dye
73200	Ct upper extremity w/o dye
73700	Ct lower extremity w/o dye
74150	Ct abdomen w/o dye
Family 3 - MRI and MRA with and without Contrast	
70336	Magnetic image, jaw joint
70544	Mr angiography head w/o dye
70551	Mri brain w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73718	Mri lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye

76856	Us exam, pelvic, complete
76870	Us exam, scrotum
76857	Us exam, pelvic, limited
Family 2 - CT and CTA with and without Contrast	
70450	Ct head/brain w/o dye
70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70490	Ct soft tissue neck w/o dye
71250	Ct thorax w/o dye
72125	Ct neck spine w/o dye
72128	Ct chest spine w/o dye
72131	Ct lumbar spine w/o dye
72192	Ct pelvis w/o dye
73200	Ct upper extremity w/o dye
73700	Ct lower extremity w/o dye
74150	Ct abdomen w/o dye
Family 3 - MRI and MRA with and without Contrast	
70336	Magnetic image, jaw joint
70544	Mr angiography head w/o dye
70551	Mri brain w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73718	Mri lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye

BILLING CODE 4120–01–C

3. Proposed Changes to Packaged Services

a. Background

The OPPS, like other prospective payment systems, relies on the concept of averaging, where the payment may be more or less than the estimated cost of providing a service or bundle of services for a particular patient, but with the exception of outlier cases, the payment is adequate to ensure access to appropriate care. Packaging payment for multiple interrelated services into a single payment creates incentives for providers to furnish services in the most efficient way by enabling hospitals to manage their resources with maximum flexibility, thereby encouraging long-term cost containment. For example, where there are a variety of supplies that could be used to furnish a service, some of which are more expensive than others, packaging encourages hospitals to use the least expensive item that meets the patient's needs, rather than to routinely use a more expensive item. Packaging also encourages hospitals to negotiate carefully with manufacturers and suppliers to reduce the purchase price of items and services or to explore alternative group purchasing arrangements, thereby encouraging the most economical health care. Similarly, packaging encourages hospitals to establish protocols that ensure that necessary services are furnished, while carefully scrutinizing the services ordered by practitioners to maximize the efficient use of hospital resources. Packaging payments into larger payment bundles promotes the stability of payment for services over time. Finally, packaging also may reduce the importance of refining service-specific payment because there is more opportunity for hospitals to average payment across higher cost cases requiring many ancillary services and lower cost cases requiring fewer ancillary services. For these reasons, packaging payment for services that are typically ancillary and supportive to a primary service has been a fundamental part of the OPPS since its implementation in August 2000.

We assign status indicator "N" to those HCPCS codes that we believe are always integral to the performance of the primary modality; therefore, we always package their costs into the costs of the separately paid primary services with which they are billed. Services assigned status indicator "N" are unconditionally packaged.

We assign status indicator "Q1" ("STVX–Packaged Codes"), "Q2" ("T–Packaged Codes"), or "Q3" (Codes that may be paid through a composite APC) to each conditionally packaged HCPCS code. An "STVX-packaged code"

describes a HCPCS code whose payment is packaged when one or more separately paid primary services with the status indicator of "S," "T," "V," or "X" are furnished in the hospital outpatient encounter. A "T-packaged code" describes a code whose payment is packaged when one or more separately paid surgical procedures with the status indicator of "T" are provided during the hospital encounter. "STVX-packaged codes" and "T-packaged codes" are paid separately in those uncommon cases when they do not meet their respective criteria for packaged payment. "STVX-packaged codes" and "T-packaged codes" are conditionally packaged. We refer readers to section XIII.A.1. of this proposed rule for a complete listing of status indicators.

We use the term "dependent service" to refer to the HCPCS codes that represent services that are typically ancillary and supportive to a primary diagnostic or therapeutic modality. We use the term "independent service" to refer to the HCPCS codes that represent the primary therapeutic or diagnostic modality into which we package payment for the dependent service. In future years, as we consider the development of larger payment groups that more broadly reflect services provided in an encounter or episode-of-care, it is possible that we might propose to bundle payment for a service that we now refer to as "independent."

Hospitals include HCPCS codes and charges for packaged services on their claims, and the estimated costs associated with those packaged services are then added to the costs of separately payable procedures on the same claims in establishing payment rates for the separately payable services. We encourage hospitals to report all HCPCS codes that describe packaged services that were provided, unless the CPT Editorial Panel or CMS provide other guidance. The appropriateness of the OPPS payment rates depend on the quality and completeness of the claims data that hospitals submit for the services they furnish to our Medicare beneficiaries.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66610 through 66659), we adopted the packaging of payment for items and services in seven categories into the payment for the primary diagnostic or therapeutic modality to which we believe these items and services are typically ancillary and supportive. The seven categories are: (1) Guidance services; (2) image processing services; (3) intraoperative services; (4) imaging supervision and interpretation services; (5) diagnostic radiopharmaceuticals; (6) contrast media; and (7) observation services. We specifically chose these categories of HCPCS codes for packaging because we believe that the items and services described by the codes in these categories are typically ancillary and supportive to a primary diagnostic or therapeutic modality and, in those cases, are an integral part of the primary service they support.

In addition, in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66650 through 66659), we finalized additional packaging for the CY 2008 OPPS, which included the establishment of new composite APCs for CY 2008, specifically APC 8000 (Cardiac Electrophysiologic Evaluation and Ablation Composite), APC 8001 (LDR Prostate Brachytherapy Composite), APC 8002 (Level I Extended Assessment & Management Composite), and APC 8003 (Level II Extended Assessment & Management Composite). In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68559 through 68569), we expanded the composite APC model to one new clinical area—multiple imaging services. We created five multiple imaging composite APCs for payment in CY 2009 that incorporate statutory requirements to differentiate between imaging services provided with contrast and without contrast as required by section 1833(t)(2)(G) of the Act. The multiple imaging composite APCs are: APC 8004 (Ultrasound Composite); APC 8005 (CT and CTA without Contrast Composite); APC 8006 (CT and CTA with Contrast Composite); APC 8007 (MRI and MRA without Contrast Composite); and APC 8008 (MRI and MRA with Contrast Composite). We discuss composite APCs in more detail in section II.A.2.e. of this proposed rule.

We recognize that decisions about packaging and bundling payment involve a balance between ensuring that payment is adequate to enable the hospital to provide quality care and establishing incentives for efficiency through larger units of payment. Therefore we welcome public comments regarding our packaging proposals for calendar year (CY) 2011 OPPS.

b. Packaging Issues

(1) CMS Presentation of Findings Regarding Expanded Packaging at the February 2010 APC Panel Meeting

In deciding whether to package a service or pay for a code separately, we have historically considered a variety of factors, including whether the service is normally provided separately or in conjunction with other services; how likely it is for the costs of the packaged code to be appropriately mapped to the separately payable codes with which it was performed; and whether the expected cost of the service is relatively low.

As discussed in section I.E. of this proposed rule, the APC Panel advises CMS on the clinical integrity of payment groups and their weights, and the APC Panel has a Packaging Subcommittee that studies and makes recommendations on issues pertaining to services that are not separately payable under the OPPS, but whose payments are bundled or packaged into APC payments. The APC Panel has considered packaging issues at several earlier meetings. For discussions of earlier APC Panel meetings and recommendations, we refer readers to previously published hospital OPPS/ASC proposed and final rules on the CMS Web site at: *http://www.cms.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage.*

During the August 5–6, 2009 meeting of the APC Panel, we agreed to continue to provide the Panel with information on the impact of increased packaging on Medicare beneficiaries building on the analyses we had presented at the February 2009 APC Panel meeting. We did not share additional packaging data with the APC Panel at the August 2009 meeting because we had already presented analysis comparing CY 2007 and CY 2008 claims data and believed the APC Panel's discussions would benefit from analyses of CY 2007 and CY 2009 claims data. We indicated that we planned to incorporate analysis of CY 2009 claims into the information we would bring to the APC Panel for its review at the winter 2010 meeting.

At the February 17–18, 2010 APC Panel meeting, we presented subsequent analyses that compared CY 2007 claims processed through September 30, 2007 to CY 2009 claims processed through September 30, 2009. Similar to the initial analysis that we presented to the APC Panel in 2009, the HCPCS codes that we compared are the ones that we identified in the CY 2008 OPPS final rule with comment period as fitting into one of the packaging categories, including HCPCS codes that became effective for CY 2009. As noted above, the seven packaging categories in our CY 2008 packaging proposal are guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast media, and observation services. We note that, similar to the initial analysis, we did not

make any adjustments for inflation, changes in the Medicare population, changes in payment due to APC recalibration, changes in frequency due to known changes in code definitions and coding practices, or changes in the population of hospitals paid under the OPPS. A summary of these data analyses is provided below.

Analysis of the diagnostic radiopharmaceuticals category showed that the diagnostic radiopharmaceuticals were billed 1 percent more often during the first 9 months of CY 2009 as compared to the first 9 months of CY 2007. We noticed very little change in the frequency of hospitals reporting one or more diagnostic radiopharmaceutical between CY 2007 and CY 2009. Beginning in CY 2008, we required reporting of a radiolabeled product (including diagnostic radiopharmaceuticals) when billing a nuclear medicine procedure, and we believe that the modest increases in frequency of reporting diagnostic radiopharmaceuticals and the percentage of reporting hospitals generally reflects hospitals adhering to our reporting requirements.

We also found that nuclear medicine procedures (into which diagnostic radiopharmaceuticals were packaged) and associated diagnostic radiopharmaceuticals were billed approximately 3 million times during the first 9 months of both CY 2007 and CY 2009. Further analysis revealed that we paid hospitals over $637 million for nuclear medicine procedures and diagnostic radiopharmaceuticals during the first 9 months of CY 2007, when diagnostic radiopharmaceuticals were separately payable, and approximately the same amount for nuclear medicine procedures and diagnostic radiopharmaceuticals during the first 9 months of CY 2009, when payment for diagnostic radiopharmaceuticals was packaged. This suggests that frequency and payment for nuclear medicine procedures remained fairly steady between the first 9 months of CY 2007 and the first 9 months of CY 2009.

We conducted the same analysis for guidance services that were packaged beginning in CY 2008. Analysis of the guidance category (which includes image-guided radiation therapy services) showed that guidance services were billed 8 percent more often during CY 2009 as compared to CY 2007 and that the number of hospitals reporting guidance services declined by 1 percent between CY 2007 and CY 2009.

We also analyzed the same data for all contrast services that were packaged beginning in CY 2008. Analysis of this category showed that contrast services were billed 9 percent more often during CY 2009 as compared to CY 2007 and that the number of hospitals reporting contrast media increased by 1 percent between CY 2007 and CY 2009.

Analysis of the data for image supervision and interpretation services showed that these services were billed 10 percent more often during CY 2009 as compared to CY 2007 and, similar to guidance services and contrast agents, the number of hospitals reporting image supervision and interpretation services declined by 1 percent between CY 2007 and CY 2009.

We also analyzed the first 9 months of CY 2007 and CY 2009 data related to all image processing services that were packaged beginning in the CY 2008 OPPS. This analysis was difficult because there were significant changes to the CPT codes in this category for CY 2009. For example, the intraoperative procedures described by CPT codes 93320 (which describes spectral Doppler) and 93325 (which describes color flow Doppler) are now reported using one comprehensive code, CPT 93306, which describes complete transthoracic echocardiogram with spectral and color flow Doppler. In an effort to isolate the effects of the changes to coding from our analysis, we removed the data for any codes experiencing significant modifications and observed a 7 percent decrease from CY 2007 to CY 2009 in the frequency of image processing services billed. However, as we pointed out to the APC panel, these numbers are not necessarily the majority of services in the category or reflective of behavioral changes for the services of interest. When we included the image processing services with the revised coding for CY 2009, the data showed a 61-percent decrease in the billing of these services between CY 2007 and CY 2009 and a 6-percent decrease in the number of hospitals reporting these services during the same timeframe.

Our analysis of changes in intraoperative services between CY 2007 and CY 2009 showed a 5-percent decrease in the billing of these services and a 5-percent decrease in the number of hospitals reporting these services during the same timeframe.

As we did for our presentation at the February 2009 APC Panel meeting, we also found that cardiac catheterization and other percutaneous vascular procedures that would typically be accompanied by Intravascular Ultrasound (IVUS), Intracardiac echocardiography (ICE), and Fractional flow reserve (FFR) (including IVUS, ICE, and FFR) were billed approximately 376,000 times in CY 2007 and approximately 473,000 times in CY 2009, representing an increase of 26 percent in the number of services and items billed between CY 2007 and CY 2009. IVUS, ICE, and FFR are intraoperative and image supervision and interpretation services that have received a lot of attention. Further analysis showed that the OPPS paid hospitals over $912 million for cardiac catheterizations, other related services, and IVUS, ICE, and FFR in CY 2007, when IVUS, ICE, and FFR were paid separately. In the first 9 months of CY 2009, the OPPS paid hospitals approximately $1.4 billion for cardiac catheterization and other percutaneous vascular procedures and IVUS, ICE, and FFR, when payments for IVUS, ICE, and FFR were packaged. This is a 58-percent increase in payment from CY 2007. Using the first 9 months of claims data for both CY 2007 and CY 2009, we calculated an average payment per service or item provided of $2,430 in CY 2007 and $3,048 in CY 2009 for cardiac catheterization and other related services, an increase of 25 percent in average payment per item or service. This observed increase in average payment per service is most likely attributable to the observed increase in the frequency of these cardiac catheterization and other percutaneous vascular procedures that would typically be accompanied by IVUS, ICE, and FFR (including IVUS, ICE, and FFR) billed in CY 2009.

We also cannot determine how much of the 58-percent increase in aggregate payment for these services may be due to the packaging of payment for IVUS, ICE, and FFR (and other services that were newly packaged for CY 2008) and how much may be due to annual APC recalibration and typical fluctuations in service frequency. However, we believe that all of these factors contributed to the notable increase in aggregate payment between CY 2007 and CY 2009.

We further analyzed the first 9 months of CY 2007 and CY 2009 claims data for radiation oncology services that would be accompanied by radiation oncology guidance. We found that radiation oncology services (including radiation oncology guidance services) were billed approximately 4 million times in CY 2007 and 3.8 million times in CY 2009, representing a decrease in frequency of approximately 6 percent between CY 2007 and CY 2009. These numbers represented each instance where a radiation oncology service or a radiation oncology guidance service was billed. Our analysis indicated that hospitals were paid over $811 million for radiation oncology services and

radiation oncology guidance services under the OPPS during the first 9 months of CY 2007, when radiation oncology guidance services were separately payable. During the first 9 months of CY 2009, when payments for radiation oncology guidance were packaged, hospitals were paid over $827 million for radiation oncology services under the OPPS. This $827 million included packaged payment for radiation oncology guidance services and represented a 2-percent increase in aggregate payment from CY 2007 to CY 2009. Using the first 9 months of claims data for both CY 2007 and CY 2009, we calculated an average payment per radiation oncology service or item billed of $199 in CY 2007 and $216 in CY 2009, representing a per service increase of 8 percent from CY 2007 to CY 2009.

At the February 2009 meeting, the APC panel also requested that CMS provide separate analyses of radiation oncology guidance, by type of radiation oncology service, specifically, intensity modulated radiation therapy (IMRT), stereotactic radiosurgery (SRS), brachytherapy, and conventional radiation therapy. The results from these analyses are discussed below:

We conducted these analyses on the specified categories using the first 9 months of claims and cost report data from CY 2007, before the expanded packaging went into effect, and the first 9 months of claims and cost report data from CY 2009—the second year of packaged payment for the radiation guidance services. We found that IMRT services were billed approximately 670 thousand times during the first 9 months of CY 2007. During this same timeframe, Medicare paid hospitals approximately $227 million for IMRT services. In comparison, during the first 9 months of CY 2009, IMRT services were billed 713 thousand times, representing an increase in frequency of 6 percent. Further, during the first 9 months of CY 2009, when payments for radiation oncology guidance were packaged into the payments for the separately paid IMRT procedures, we paid hospitals over $298 million, representing a 31-percent increase in payments from CY 2007 to CY 2009.

We further analyzed the data for SRS services and found that, for the first 9 months of CY 2007 and CY 2009, SRS services were billed approximately 9 thousand and 13 thousand times, respectively, representing an increase in frequency of 43 percent. Aggregate Medicare payments for these SRS services increased by 24 percent from $34 million in CY 2007 to $42 million in CY 2009.

Our review of the data for brachytherapy services revealed that, for the first 9 months of CY 2007 and CY 2009, these services were billed approximately 10 thousand and 11 thousand times, respectively, representing an increase in frequency of 8 percent. During this timeframe, aggregate Medicare payments for these brachytherapy services increased by 1 percent from $9.8 million in CY 2007 to $9.9 million in CY 2009.

Our review of the data for conventional radiation therapy services revealed that conventional radiation therapy services were billed 1.4 million times and 1.1 million times, in the first 9 months of CY 2007 and CY 2009, respectively, representing a decrease in frequency of 20 percent. During this timeframe, aggregate Medicare payments for these conventional radiation services decreased by 10 percent from $189 million in CY 2007 to $169 million in CY 2009.

In reviewing our early CY 2009 claims data, which reflect the second year of packaged payment for services in the packaged categories identified in the CY 2008 OPPS/ASC final rule with comment period, we generally observed increases in the billing and reporting of packaged services described by these categories, with the caveat that we are not able to untangle the various causes of declines in the image processing category, indicating steady beneficiary access to these categories of supporting and ancillary services. In aggregate, hospitals do not appear to have significantly changed their reporting patterns as a result of the expanded packaging policy nor do the analyses suggest that hospitals have stopped offering these supporting and ancillary services with the primary diagnostic and therapeutic modalities that they support.

(2) Packaging Recommendations of the APC Panel at Its February 2010 Meeting

During the February 2010 APC panel meeting, the APC Panel accepted the report of the Packaging Subcommittee, heard several presentations related to packaged services, discussed the deliberations of the Packaging Subcommittee, and made 6 recommendations. The Report of the February 2010 meeting of the APC Panel may be found at the Web site at: *http://www.cms.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp*.

To summarize, the APC Panel made the following recommendations regarding packaging of payment under the CY 2011 OPPS:

1. That CMS consider whether CPT code 31627 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation) (also known as electromagnetic navigational bronchoscopy (ENB)) should be packaged or paid separately; if it should be paid separately, CMS should investigate the appropriate APC assignment. The Panel suggests CMS use bronchoscopic ultrasonography (EBUS) as a clinical example for comparison. (Recommendation 1)

2. That CMS make CPT code 96368 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion) and CPT code 96376 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular, each additional sequential intravenous push of the same substance/drug provided in the facility (List separately in addition to code for primary procedure)) separately payable in the CY 2011 OPPS/ASC final rule with comment period at an appropriate payment rate as determined by CMS. (Recommendation 2)

3. That CMS conditionally package payment for the guidance procedures that would accompany breast needle placement (specifically CPT code 19290 (Preoperative placement of needle localization wire, breast); CPT code 19291 (Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure)); CPT code 19295 (Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)); CPT code 77031 (Stereotactic localization guidance for breast biopsy or needle placement (*e.g.,* for wire localization or for injection)), each lesion, radiological supervision and interpretation); CPT code 77032 (Mammographic guidance for needle placement, breast (*e.g.,* for wire localization or for injection), each lesion, radiological supervision and interpretation); CPT code 76942 (Ultrasonic guidance for needle placement (*e.g.,* biopsy, aspiration, injection, localization device), imaging supervision and interpretation)) when these guidance services are performed separately. (Recommendation 3)

4. The Panel encourages the public to submit common clinical scenarios involving currently packaged HCPCS codes and recommendations of specific services or procedures for which

payment would be most appropriately packaged under the OPPS for review by the Packaging Subcommittee members. (Recommendation 4)

5. That CMS continue providing analysis on an ongoing basis of the impact on beneficiaries of the multiple imaging composite APCs as data become available. (Recommendation 5)

6. That the work of the Packaging Subcommittee continue. (Recommendation 6)

We address each of these recommendations in the discussion that follows:

Recommendation 1

At the APC Panel's February 2010 meeting, the manufacturer asserted that use of ENB technology during a bronchoscopy procedure enables access to distal lesions that are otherwise not accessible without use of the ENB technology. The manufacturer also argued that without separate payment for ENB, hospitals would likely not adopt the technology and the population that would likely benefit from ENB would not have access to this technology. In response to the manufacturer's assertion, the APC Panel asked CMS to consider whether CPT code 31627, which describes Electromagnetic Navigational Bronchoscopy (ENB), should be packaged or paid separately; and if it should be paid separately, the APC Panel asked CMS to investigate the appropriate APC assignment. CPT code 31627 is new for CY 2010, and we assigned it a new interim status indicator of "N" in our CY 2010 OPPS/ASC final rule with comment period based on our packaging policies (discussed in section II.A.3.a. of this proposed rule). We have considered the information available to us for CPT code 31627 and believe that the code describes a procedure that is supportive of and ancillary to the primary diagnostic or therapeutic modality, in this case, bronchoscopy procedures (for example, CPT code 31622 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed: diagnostic, with cell washing, when performed (separate procedure)). We currently package payment for CPT code 31627, and we continue to believe that this is the appropriate treatment of that code. Therefore, we are proposing to package payment for CPT code 31627. As we have discussed in past rules, in making our decision on whether to package a service or pay for it separately we consider a variety of factors, including whether the service is normally provided separately or in conjunction with other services because it supports those services. By proposing to packaging payment for this procedure, we would be treating it in the same manner as similar computer-assisted, navigational diagnostic procedures that are supportive of and ancillary to a primary diagnostic or therapeutic modality. In its recommendation regarding whether to make separate payment under an APC for CPT code 31627, the APC Panel suggested that we use bronchoscopic ultrasonography as a clinical example for comparison. We consider CPT code 31620 (Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure)) to be a suitable comparison because it describes another bronchoscopic procedure in which a guidance technology (that is, ultrasonography) is used to achieve the therapeutic benefit of the procedure. Similar to our proposed payment for CPT code 31627, payment for CPT code 31620 is currently packaged into the primary modality with which it would be appropriately billed. In CY 2008, as part of our increased packaging proposal, we identified the EBUS procedure as an intraoperative ancillary service that would typically be reported in conjunction with an independent service. In addition, similar to CPT code 31627, CPT code 31620 is an add-on code that, per CPT reporting guidelines, would only be appropriately reported in conjunction with specified bronchoscopy procedures with which it would be performed. Based on these general comparisons of CPT code 31627 to the EBUS procedure described by CPT code 31620, we believe that our proposal to package payment for CPT code 31627 is consistent with the packaging approach that we have adopted in recent years. As we have stated in past rules with regard to EBUS, we also fully expect that, to the extent these services are billed appropriately, payment for the primary service would reflect the cost of the packaged ENB procedure. For example, in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68584), we discussed packaging of CPT code 31620; we state that we observed increased packaged costs associated with the services into which CPT code 31620 had been packaged, which increased the APC payment rates for bronchoscopy procedures.

In summary, we continue to believe that CPT code 31627 describes a procedure that is ancillary to and supportive of the primary service with which it is often billed. Therefore, for CY 2011, we are proposing to maintain CPT code 31627 as a packaged service.

Recommendation 2

We are not accepting the APC Panel's recommendation that CMS make CPT code 96368 and CPT code 96376 separately payable for the CY 2011 OPPS. We consider a variety of factors in making a decision whether to package a service or pay for it separately, including whether the service is normally provided separately or in conjunction with other services and 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. CPT codes 96376 and 96368 describe concurrent and sequential drug administration services that have always been packaged under the OPPS. From the inception of the OPPS through CY 2006, we paid for drug administration under the OPPS using HCPCS alphanumeric codes that packaged payment for concurrent infusions and administration of new drugs into the payment for the alphanumeric codes for drug administration. In CY 2007, we adopted CPT codes for drug administration services. The CY 2007 CPT codes did not separately recognize administration of new drugs during the same encounter with a separate CPT code. Therefore, administration of a new drug continued to be packaged into payment for the service of which it was a part. Moreover, for CY 2007, CPT code 90768 (Intravenous infusion, for therapy, prophylaxis, or diagnosis; concurrent infusion), which was replaced by CPT code 96368, was packaged under the OPPS, continuing the longstanding practice of not making separate payment for concurrent infusion. We also pointed out that, during our implementation of this new CPT code, while it was new for CY 2007, it represented the same procedures as described by the previous drug administration HCPCS code set, and, as a result, the payment data for these procedures would be captured in the claims that were available to us for ratesetting purposes.

Similarly, CPT codes 96368 and 96376, which were created by CPT in 2008, are replacement codes for those same procedures that were described by the previous drug administration code sets and their associated data would be captured in our claims database. The costs for these services, concurrent infusion and additional push of the same drug, would continue to be packaged into payment for the drug administration codes with which they

are reported. In making our decision whether to package a service or pay for it separately, we consider a variety of factors, including whether the service is normally provided separately or in conjunction with other services. CPT codes 96368 and 96376 describe concurrent and sequential drug administration services that, per CPT guidelines, are always provided in association with an initial drug administration service. Therefore, they continue to be appropriately packaged into the payment for the separately payable services that they usually accompany. For example, CPT code 96376 would be billed with CPT code 96374 (Therapeutic, prophylactic, or diagnostic injection; intravenous push, single or initial substance/drug), which describes an initial intravenous push code and, as a result, the cost for CPT code 96376 would be reflected in the total cost for CPT code 96374. Moreover, payment for these services has always been packaged into payment for the drug administration services without which they cannot be correctly reported.

These two codes each describe services that, by definition, are always provided in conjunction with an initial drug administration code. These services have been packaged since the inception of the OPPS, and we continue to believe they are appropriately packaged into the payment for the separately payable services without which, under CPT guidelines and definitions, they cannot be appropriately reported. Therefore, for CY 2011, we are proposing to make packaged payment for CPT code 96368 and CPT code 96376 and assign them a status indicator of "N."

Recommendation 3

We are not accepting the APC Panel's recommendation that we conditionally package CPT codes 19290, 19291, 19295, 77031, 77032, and 76942. During the APC Panel's February 2010 meeting, we shared with the Packaging Subcommittee our most recent claims data for the guidance procedures that would accompany breast needle placement, demonstrating that, for some of these services, the code was billed by itself up to 25 percent of the time. While the Packaging Subcommittee broadly discussed clinical scenarios in which these services may be billed separately, it remains unclear to us why these services are being performed separately and whether they should be paid separately. We believe that these services typically are performed in conjunction with surgical procedures involving the breast and, therefore, are appropriately packaged. Therefore, we are not accepting the APC panel's recommendation that we conditionally package payment for these guidance procedures when they are performed separately. For CY 2011, we are proposing to maintain the unconditional packaged payment status for these procedures. Specifically, we are proposing to package payment, indicated by a status indicator of "N," for CPT codes 19290, 19291, 19295, 77031, 77032, and 76942, into the primary modality with which they would be appropriately billed. However, observing such a sizable percentage of services that are the only service appearing on a claim for a packaged item, especially when these services do not receive separate payment, leads us to encourage the public to submit any clinical scenarios in their public comments involving these services that show the circumstances under which these services may be appropriately billed without a primary procedure that is furnished on the same date.

Recommendation 4

We are accepting the APC Panel's recommendation to continue to encourage submission of common clinical scenarios involving currently packaged HCPCS codes to the Packaging Subcommittee for its ongoing review. We also encourage recommendations from the public on specific services or procedures whose payment would be most appropriately packaged under the OPPS. Additional detailed suggestions for the Packaging Subcommittee should be submitted by e-mail to *APCPanel@cms.hhs.gov* with Packaging Subcommittee in the subject line.

Recommendation 5

We are accepting the APC Panel's recommendation that CMS provide information to the APC Panel on the impact of the creation of the imaging composite APCs on services to beneficiaries. Our proposal with regard to the imaging composite APCs is discussed in detail in section II.A.2.e.(5) of this proposed rule.

Recommendation 6

The Packaging Subcommittee of the APC Panel was established to review packaging issues. We are accepting the APC Panel's recommendation that the Packaging Subcommittee remain active until the next APC Panel meeting. We note that the APC Panel Packaging Subcommittee is currently active and that we will share additional issues and new data concerning the packaged status of codes with the APC Panel Packaging Subcommittee as that information becomes available.

4. Proposed Calculation of OPPS Scaled Payment Weights

Using the proposed APC median costs discussed in sections II.A.1. and II.A.2. of this proposed rule, we calculated the proposed relative payment weights for each APC for CY 2011 shown in Addenda A and B to this proposed rule. In years prior to CY 2007, we standardized all the relative payment weights to APC 0601 (Mid Level Clinic Visit) because mid-level clinic visits were among the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC.

Beginning with the CY 2007 OPPS (71 FR 67990), we standardized all of the relative payment weights to APC 0606 (Level 3 Clinic Visits) because we deleted APC 0601 as part of the reconfiguration of the clinic visit APCs. We selected APC 0606 as the base because APC 0606 was the mid-level clinic visit APC (that is, Level 3 of five levels). Therefore, for CY 2011, to maintain consistency in using a median for calculating unscaled weights representing the median cost of some of the most frequently provided services, we are proposing to continue to use the median cost of the mid-level clinic visit APC (APC 0606) to calculate unscaled weights. Following our standard methodology, but using the proposed CY 2011 median cost for APC 0606, for CY 2011 we assigned APC 0606 a relative payment weight of 1.00 and divided the median cost of each APC by the proposed median cost for APC 0606 to derive the proposed unscaled relative payment weight for each APC. The choice of the APC on which to base the proposed 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 budget neutral manner. Budget neutrality ensures that the estimated aggregate weight under the OPPS for CY 2011 is neither greater than nor less than the estimated aggregate weight that would have been made without the changes. To comply with this requirement concerning the APC changes, we are proposing to compare the estimated aggregate weight using the CY 2010 scaled relative weights to the estimated aggregate weight using the proposed CY 2011 unscaled relative

weights. For CY 2010, we multiply the CY 2010 scaled APC relative weight applicable to a service paid under the OPPS by the volume of that service from CY 2009 claims to calculate the total weight for each service. We then add together the total weight for each of these services in order to calculate an estimated aggregate weight for the year. For CY 2011, we perform the same process using the proposed CY 2011 unscaled weights rather than scaled weights. We then calculate the weight scaler by dividing the CY 2010 estimated aggregate weight by the proposed CY 2011 estimated aggregate weight. The service-mix is the same in the current and prospective years because we use the same set of claims for service volume in calculating the aggregate weight for each year. For a detailed discussion of the weight scaler calculation, we refer readers to the OPPS claims accounting document available on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/*. We included payments to CMHCs in our comparison of estimated unscaled weight in CY 2011 to estimated total weight in CY 2010 using CY 2009 claims data, holding all other components of the payment system constant to isolate changes in total weight. Based on this comparison, we adjusted the unscaled relative weights for purposes of budget neutrality. The proposed CY 2011 unscaled relative payment weights were adjusted by multiplying them by a proposed weight scaler of 1.3650 to ensure budget neutrality of the proposed CY 2011 relative weights.

Section 1833(t)(14) of the Act provides the payment rates for certain "specified covered outpatient drugs." That section 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." Therefore, the cost of those specified covered outpatient drugs (as discussed in section V.B.3. of this proposed rule) was included in the proposed budget neutrality calculations for the CY 2011 OPPS.

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

B. Proposed Conversion Factor Update

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis by applying the OPD fee schedule increase factor. Under the authority in section 1833(t)(3)(C)(iv) of the Act, for CY 2010, the OPD fee schedule increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act. The proposed hospital market basket increase for FY 2011 published in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24062) prior to changes required by the Affordable Care Act and the HCERA is 2.4 percent. New section 1833(t)(3)(F)(iii) and (G)(i) of the Act (as added by 3401(i) of the Affordable Care Act and as amended by 10319(g) of such Act and section 1105(e) of HCERA) require a .25 percentage point reduction to the CY 2011 OPD fee schedule increase factor, resulting in a proposed CY 2011 OPPS market basket update of 2.15 percent. To set the proposed OPPS conversion factor for CY 2011, we increased the CY 2010 conversion factor of $67.241 by 2.15 percent. We announced the CY 2010 OPPS conversion factor of $67.241 in the **Federal Register** Notice CMS 1504–N, entitled "Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System for CY 2010, and Extension of Part B Payment for Services Furnished by Hospitals or Clinics Operated by the Indian Health Service, Indian Tribes, or Tribal Organizations Made by the Affordable Care Act and ASC Changes Made By Previous Correction Notices," which is being published around the time of this proposed rule. Hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) are subject to a reduction of 2.0 percentage points from the OPD fee schedule increase factor adjustment to the conversion factor. For a complete discussion of the HOP QDRP requirements and the payment reduction for hospitals that fail to meet those requirements, we refer readers to section XVI. of this proposed rule.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the proposed conversion factor for CY 2011 to ensure that any revisions we are proposing to make to our updates for a revised wage index and rural adjustment are made on a budget neutral basis. We calculated a proposed overall budget neutrality factor of 1.0011 for wage index changes by comparing total payments from our simulation model using the FY 2011 IPPS proposed wage indices to those payments using the current (FY 2010) IPPS wage indices, as adopted on a calendar year basis for the OPPS, as indicated in the **Federal Register** notice announcing Affordable Care Act changes to the wage indices (*See* CMS 1504–N referenced above). For CY 2011, we are not proposing a change to our rural adjustment policy. Therefore, the proposed budget neutrality factor for the rural adjustment is 1.0000. In addition, to accommodate the proposed cancer hospital adjustment described in section II.F. of this preamble, we calculated an additional proposed budget neutrality factor of 0.9934 by comparing total payments from our simulation model for CY 2011 including the proposed adjustment for cancer hospitals to total payments from our simulation model for CY 2011 without the proposed adjustment for cancer hospitals.

For this proposed rule, we estimated that pass-through spending for both drugs and biologicals and devices for CY 2011 would equal approximately $86.9 million, which represents 0.20 percent of total projected CY 2011 OPPS spending. Therefore, the conversion factor would also be adjusted by the difference between the 0.14 percent estimate of pass-through spending for CY 2010 and the 0.20 percent estimate of CY 2011 pass-through spending. Finally, estimated payments for outliers remain at 1.0 percent of total OPPS payments for CY 2011.

The proposed OPD fee schedule increase factor of 2.15 percent for CY 2011, the required proposed wage index budget neutrality adjustment of approximately 1.0011, the proposed cancer hospital budget neutrality adjustment of 0.9934, and the proposed adjustment of 0.06 percent of projected OPPS spending for the difference in the pass-through spending resulted in a proposed conversion factor for CY 2011 of $68.267, which reflects the full proposed OPD fee schedule increase. To calculate the proposed CY 2011 reduced market basket conversion factor for those hospitals that fail to meet the requirements of the HOP QDRP for the full CY 2011 payment update, we made all other adjustments discussed above, but used a proposed reduced market basket increase update factor of 0.15 percent (that is, an unadjusted OPD fee schedule increase factor of 2.4 percent reduced by 0.25 percentage point as required by the Affordable Care Act and HCERA and further reduced by 2.0 percentage points as required by section 1833(t)(17)(A)(i) of the Act for failure to comply with the OPD quality reporting requirements). This resulted in a proposed reduced conversion factor for

CY 2011 of $66.930 for those hospitals that fail to meet the HOP QDRP requirements.

OPD Fee Schedule Increase Factor

In accordance with section 1833(t)(3)(C)(iv) of the Act, each year we update the OPPS conversion factor by an OPD fee schedule increase factor. For purposes of section 1833(t)(3)(C)(iv) of the Act, subject to 1833(t)(17) and 1833(t)(F), the OPD fee schedule increase factor is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished in each of 2000 and 2002. For hospitals that do not meet the HOP QDRP reporting requirements discussed in section XVI of this proposed rule, the update is equal to the OPD fee schedule increase factor less an additional 2.0 percentage points. In accordance with these statutory provisions, in the CY 2010 OPPS final rule (74 FR 60419), we finalized an OPD fee schedule increase factor equal to the IPPS full market basket update of 2.1 percent. Hospitals that failed to meet the HOP QDRP reporting requirements were subject to a reduced OPD fee schedule increase factor of 0.1 percent.

We note that section 1833(t)(3)(F)(ii) and (G)(i) of the Act as added by section 3401(i) of Public Law 111–148 (Affordable Care Act) and as amended by section 10319(g) of such Act and section 1105(e) of Public Law 111–152 (HCERA) require that after determining the OPD fee schedule increase factor, the Secretary shall reduce such factor for CY 2010 by 0.25 percentage point. Therefore, the reduction of 0.25 percentage point applied to the full IPPS hospital operating market basket increase factor of 2.1 percent results in a revised OPD fee schedule increase factor of 1.85 percent. For hospitals that do not meet the HOP QDRP reporting requirements, the update is equal to the OPD fee schedule increase factor, less the additional 0.25 percentage point required by section 1833(t)(F)(ii) and (G)(i) of the Act, minus 2.0 percentage points. New section 1833(t)(3)(F) of the Act further states the application of 1833(t)(3)(F) may result in the OPD fee schedule increase factor under 1833(t)(3)(C)(iv) of the Act being less than zero for a year. Thus, the CY 2010 OPD fee schedule increase factor was 1.85 percent (that is, 2.1 percent minus 0.25 percentage point) for hospitals that met the HOP QDRP reporting requirements and negative 0.15 percent (2.1 percent, less the 0.25 percentage point, minus the 2.0 percentage points) for hospitals failing to meet the HOP QDRP reporting requirements.

As with the CY 2010 OPD fee schedule increase factor, new section 1833(t)(3)(F)(ii) and (G)(i) of the Act requires that the CY 2011 OPD fee schedule increase factor be reduced by 0.25 percentage point, subject to the hospital submitting quality information under rules established by the Secretary in accordance with section 1833(t)(17) of the Act. For hospitals that do not meet the HOP QDRP reporting requirements, the update is equal to the OPD fee schedule increase factor minus 0.25 percentage point minus 2.0 percentage points. Section 1833(t)(3)(F) of the Act further states that this amendment may result in the applicable percentage increase being less than zero.

In the FY 2011 IPPS proposed rule, consistent with current law, based on IHS Global Insight, Inc.'s first quarter 2010 forecast, with historical data through the 2009 fourth quarter, we estimated that the FY 2011 IPPS market basket update would be 2.4 percent (75 FR 24016). However, consistent with the amendments to section 1833(t)(3)(F)(ii) and (G)(i) of the Act, we are required to reduce the OPD fee schedule increase factor by 0.25 percentage point. Therefore, the proposed market basket update to the CY 2011 OPD fee schedule increase factor is 2.15 percent (that is, the CY 2011 estimate of the OPD fee schedule increase factor of 2.4 percent minus 0.25 percentage point). For hospitals that do not meet the HOP QDRP reporting requirements, the proposed update to the OPPS conversion factor is 0.15 percent (that is, the adjusted CY 2011 estimate of the market basket rate-of increase of 2.15 percent minus 2.0 percentage points).

We are proposing to revise 42 CFR 419.32 to reflect the Affordable Care Act and HCERA requirements for 0.25 percentage point reductions to the OPPS fee schedule increase factor for CY 2010 and CY 2011 respectively in revised paragraph 42 CFR 419.32(b)(1)(iv).

C. Proposed Wage Index Changes

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate, which includes the copayment standardized amount, that is attributable to labor and labor-related cost. This adjustment must be made in a budget neutral manner and budget neutrality is discussed in section II.B. of this proposed rule.

The OPPS labor-related share is 60 percent of the national OPPS payment. This labor-related share is based on a regression analysis that determined that approximately 60 percent of the costs of services paid under the OPPS were attributable to wage costs. We confirmed that this labor-related share for outpatient services is still appropriate during our regression analysis for the payment adjustment for rural hospitals in the CY 2006 OPPS final rule with comment period (70 FR 68553). Therefore, we are not proposing to revise this policy for the CY 2011 OPPS. We refer readers to section II.H. of this proposed rule for a description and example of how the wage index for a particular hospital is used to determine the payment for the hospital.

As discussed in section II.A.2.c. of this proposed rule, for estimating national median APC costs, we standardize 60 percent of estimated claims costs for geographic area wage variation using the same FY 2011 pre-reclassified wage index that the IPPS uses to standardize costs. This standardization process removes the effects of differences in area wage levels from the determination of a national unadjusted OPPS payment rate and the copayment amount.

As published in the original OPPS April 7, 2000 final rule with comment period (65 FR 18545), the OPPS has consistently adopted the final IPPS wage index as the wage index for adjusting the OPPS standard payment amounts for labor market differences. Thus, the wage index that applies to a particular acute care short-stay hospital under the IPPS would also apply to that hospital under the OPPS. As initially explained in the September 8, 1998 OPPS proposed rule, we believed and continue to believe that using the IPPS wage index as the source of an adjustment factor for the OPPS is reasonable and logical, given the inseparable, subordinate status of the HOPD within the hospital overall. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. Therefore, in accordance with our established policy, we are proposing to use the final FY 2011 version of the IPPS wage index used to pay IPPS hospitals to adjust the CY 2011 OPPS payment rates and copayment amounts for geographic differences in labor cost for all providers that participate in the OPPS, including providers that are not paid under the IPPS (referred to in this section as "non-IPPS" providers).

The Affordable Care Act contains a number of provisions affecting the FY 2011 IPPS wage index values, including revisions to the reclassification wage comparability criteria that were finalized in the FY 2009 IPPS final rule (73 FR 48568 through 48570), and the application of rural floor budget

neutrality on a national, rather than State-specific, basis through a uniform, national adjustment to the area wage index. These specific provisions are discussed in more detail in the supplemental FY 2011 IPPS/LTCH PPS proposed rule published June 2, 2010 in the **Federal Register** (75 FR 30920). The Affordable Care Act also required CMS to establish an adjustment to create a wage index floor of 1.00 for hospitals located in States determined to be frontier States (section 10324). We discuss this provision and how it applies to hospital outpatient departments in more detail below.

Section 10324 of the Affordable Care Act specifies that, for services furnished beginning CY 2011, the wage adjustment factor applicable to any hospital outpatient department that is located in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II) of the Act) may not be less than 1.00. Further, section 10324 states that this adjustment to the wage index for these outpatient departments should not be made in a budget neutral manner. As such, for the CY 2011 OPPS, we are proposing to adjust the wage index for all HOPDs, including those providers that are not paid under the IPPS, which are identified as being located in a frontier State, in the manner specified in the Affordable Care Act. Specifically, we would adjust the FY 2011 wage index, as adopted on a calendar year basis for the OPPS, for all hospitals paid under the OPPS, including non-IPPS hospitals, located in a frontier State to 1.00 in instances where the assigned FY 2011 wage index (that reflects MGCRB reclassifications, application of the rural floor and rural floor budget neutrality adjustment) for these hospitals is less than 1.00. Similar to our current policy for HOPDs that are affiliated with multicampus hospital systems, we fully expect that the HOPD would receive a wage index based on the geographic location of the specific inpatient hospital with which it is associated. Therefore, if the associated hospital is located in a frontier state, then the wage index adjustment applicable for the hospital would also apply for the affiliated HOPD. We refer readers to the FY 2011 supplemental proposed rule published subsequent to the FY 2011 IPPS/LTCH proposed rule for detailed discussion regarding this provision, including our proposed methodology for identifying which areas meet the definition of frontier States as provided for in section 1886(d)(3)(E)(iii)(II)) of the Act.

In addition, we are proposing to revise § 419.43(c) of the regulations to incorporate the amendments made by section 10324 of the Affordable Care Act. Specifically, we would include a provision under a new paragraph (c)(2) to state that for services furnished beginning January 1, 2011, the wage adjustment factor referenced in the existing regulations applicable to any HOPD that is located in a frontier State, as defined in the statute and regulations, may not be less than 1.00. We also are proposing to add a new paragraph (c)(3) to § 419.43 to not consider these additional payments in budget neutrality.

In addition to the changes required by the Affordable Care Act, we note that the proposed FY 2011 IPPS wage indices continue to reflect a number of adjustments implemented over the past few years, including revised Office of Management and Budget (OMB) standards for defining geographic statistical areas (Core-Based Statistical Areas or CBSAs), reclassification of hospitals to different geographic areas, rural floor provisions, an adjustment for out-migration labor patterns, an adjustment for occupational mix, and a policy for allocating hourly wage data among campuses of multicampus hospital systems that cross CBSAs. We refer readers to the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23936 through 23956) and the supplemental proposed rule (75 FR 30918) for a detailed discussion of all proposed changes, including changes required by the Affordable Care Act, to the FY 2011 IPPS wage indices. In addition, we refer readers to the CY 2005 OPPS final rule with comment period (69 FR 65842 through 65844) and subsequent OPPS rules for a detailed discussion of the history of these wage index adjustments as applied under the OPPS.

The IPPS wage index that we are proposing to adopt in this proposed rule includes all reclassifications that are approved by the Medicare Geographic Classification Review Board (MGCRB) for FY 2011. We note that reclassifications under section 508 of Public Law 108–173 and certain special exception wage indices that were extended by section 106(a) of Public Law 109–432 (MIEA–TRHCA) and section 117(a)(1) of Public Law 110–173 (MMSEA) were set to terminate September 30, 2008, but were further extended by section 124 of Public Law 110–275 (MIPPA) through September 30, 2009 and, most recently, by section 3137 as amended by section 10317 of Public Law 111–148 (Affordable Care Act) through September 30, 2010. We did not make any proposals related to these provisions for the CY 2010 OPPS wage index because Public Law 111–148 (Affordable Care Act) was enacted after issuance of the CY 2010 OPPS/ASC proposed and final rules. In accordance with section 10317 of Public Law 111–148, for CY 2010, we adopted all section 508 geographic reclassifications through September 30, 2010. Similar to our treatment of section 508 reclassifications extended under Public Law 110–173 (MMSEA) as described in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68586), hospitals with section 508 reclassifications will revert to their home area wage index, with out-migration adjustment if applicable, or a current MGCRB reclassification, from October 1, 2010 to December 31, 2010. In addition, as we did for CY 2009, we will recognize the revised wage index values for certain special exception hospitals from January 1, 2010 through December 31, 2010, under the OPPS, in order to give these hospitals the special exception wage indices under the OPPS for the same time period as under the IPPS. We refer readers to the FY 2010 section 508 reclassification **Federal Register** notice published on June 2, 2010 (75 FR 31118) for a detailed discussion of the changes to the wage indices as required by section 10317 of the Affordable Care Act. We also discuss the impact of the extension of reclassifications under section 508 and special exception wage indices in the **Federal Register** notice CMS–1504–N, entitled "Medicare Program; Changes to the Hospital Outpatient Prospective Payment System for CY 2010, Changes to the Ambulatory Surgical Center Payment System for CY 2010, and Extension of Payment under Part B for Services Furnished by Hospitals or Clinics Operated by the Indian Health Service or Tribal Organizations Made by the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 and Changes to the Ambulatory Surgical Center Payment System for CY 2010 Made By Previous Correction Notices" that will be published around the same time as this proposed rule. Because the provisions of section 10317 of the Affordable Care Act expired in 2010 and are not applicable to FY 2011, we are not making any proposals related to those provisions for the OPPS wage indices for CY 2011. However, we note that Congress is currently considering legislation that may further extend section 508 reclassifications and wage indexes for special exception providers for FY 2011, which would be applicable for the CY 2011 OPPS. We will implement any extension occurring before or during the comment period for this proposed rule in our final rule.

For purposes of the OPPS, we are proposing to continue our policy in CY 2011 to allow non-IPPS hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a section 505 out-migration county. We note that because non-IPPS hospitals cannot reclassify, they are eligible for the out-migration wage adjustment. Table 4J in the **Federal Register** for the supplemental FY 2011 IPPS proposed rule (75 FR 31049), identifies counties eligible for the out-migration adjustment and providers receiving the adjustment. As we have done in prior years, we are reprinting Table 4J as Addendum L to this proposed rule with the addition of non-IPPS hospitals that would receive the section 505 out-migration adjustment under the CY 2011 OPPS.

As stated earlier in this section, 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 HOPD within the hospital overall. Therefore, we are proposing to use the final FY 2011 IPPS wage indices for calculating OPPS payments in CY 2011. With the exception of the out-migration wage adjustment table (Addendum L to this proposed rule), which includes non-IPPS hospitals paid under the OPPS, we are not reprinting the FY 2011 IPPS proposed wage indices referenced in this discussion of the wage index. We refer readers to the CMS Web site for the OPPS at: *http://www.cms.gov/HospitalOutpatientPPS/*. At this link, readers will find a link to the FY 2011 IPPS proposed wage index tables.

D. Proposed Statewide Average Default CCRs

In addition to using CCRs to estimate costs from charges on claims for ratesetting, CMS uses overall hospital-specific CCRs calculated from the hospital's most recent cost report to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS during the PPS year. Medicare contractors cannot calculate a CCR for some hospitals because there is no cost report available. For these hospitals, CMS uses the statewide average default CCRs to determine the payments mentioned above until a hospital's Medicare contractor is able to calculate the hospital's actual CCR from its most recently submitted Medicare cost report. These hospitals include, but are not limited to, hospitals that are new, have not accepted assignment of an existing hospital's provider agreement, and have not yet submitted a cost report. CMS also uses the statewide average default CCRs to determine payments for hospitals that appear to have a biased CCR (that is, the CCR falls outside the predetermined ceiling threshold for a valid CCR) or for hospitals whose most recent cost report reflects an all-inclusive rate status (Medicare Claims Processing Manual (Pub. 100–04), Chapter 4, Section 10.11). We are proposing to update the default ratios for CY 2011 using the most recent cost report data. We discuss our policy for using default CCRs, including setting the ceiling threshold for a valid CCR, in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68594 through 68599) in the context of our adoption of an outlier reconciliation policy for cost reports beginning on or after January 1, 2009.

For CY 2011, we are proposing to continue to use our standard methodology of calculating the statewide average default CCRs using the same hospital overall CCRs that we use to adjust charges to costs on claims data for setting the CY 2011 proposed OPPS relative weights. Table 9 below lists the proposed CY 2011 default urban and rural CCRs by State and compares them to last year's default CCRs. These proposed CCRs represent the ratio of total costs to total charges for those cost centers relevant to outpatient services from each hospital's most recently submitted cost report, weighted by Medicare Part B charges. We also adjusted ratios from submitted cost reports to reflect final settled status by applying the differential between settled to submitted overall CCR for the cost centers relevant to outpatient services from the most recent pair of final settled and submitted cost reports. We then weighted each hospital's CCR by the volume of separately paid line-items on hospital claims corresponding to the year of the majority of cost reports used to calculate the overall CCRs. We refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66680 through 66682) and prior OPPS rules for a more detailed discussion of our established methodology for calculating the statewide average default CCRs, including the hospitals used in our calculations and our trimming criteria.

For this proposed rule, approximately 87 percent of the submitted cost reports utilized in the default ratio calculations represented data for cost reporting periods ending in CY 2008 and 12 percent were for cost reporting periods ending in CY 2007. For Maryland, we used an overall weighted average CCR for all hospitals in the nation as a substitute for Maryland CCRs. Few hospitals in Maryland are eligible to receive payment under the OPPS, which limits the data available to calculate an accurate and representative CCR. In general, observed changes in the statewide average default CCRs between CY 2010 and CY 2011 are modest and the few significant changes are associated with areas that have a small number of hospitals.

BILLING CODE 4120–01–P

TABLE 9.—PROPOSED CY 2011 STATEWIDE AVERAGE CCRs

State	Urban/Rural	Proposed CY 2011 Default CCR	Previous Default CCR (CY 2010 OPPS Final Rule)
ALASKA	RURAL	0.479	0.499
ALASKA	URBAN	0.336	0.328
ALABAMA	RURAL	0.217	0.220
ALABAMA	URBAN	0.193	0.193
ARKANSAS	RURAL	0.248	0.251
ARKANSAS	URBAN	0.251	0.263
ARIZONA	RURAL	0.256	0.251
ARIZONA	URBAN	0.212	0.217
CALIFORNIA	RURAL	0.198	0.208
CALIFORNIA	URBAN	0.209	0.210
COLORADO	RURAL	0.347	0.345
COLORADO	URBAN	0.248	0.255
CONNECTICUT	RURAL	0.372	0.375
CONNECTICUT	URBAN	0.317	0.319
DISTRICT OF COLUMBIA	URBAN	0.319	0.324
DELAWARE	RURAL	0.279	0.320
DELAWARE	URBAN	0.362	0.363
FLORIDA	RURAL	0.193	0.198
FLORIDA	URBAN	0.181	0.184
GEORGIA	RURAL	0.262	0.265
GEORGIA	URBAN	0.235	0.246
HAWAII	RURAL	0.359	0.359
HAWAII	URBAN	0.308	0.307
IOWA	RURAL	0.266	0.332
IOWA	URBAN	0.293	0.302
IDAHO	RURAL	0.507	0.507
IDAHO	URBAN	0.417	0.409
ILLINOIS	RURAL	0.256	0.273
ILLINOIS	URBAN	0.245	0.253
INDIANA	RURAL	0.307	0.299
INDIANA	URBAN	0.278	0.296
KANSAS	RURAL	0.285	0.291
KANSAS	URBAN	0.225	0.226
KENTUCKY	RURAL	0.224	0.223
KENTUCKY	URBAN	0.249	0.254
LOUISIANA	RURAL	0.265	0.271

State	Urban/Rural	Proposed CY 2011 Default CCR	Previous Default CCR (CY 2010 OPPS Final Rule)
LOUISIANA	URBAN	0.244	0.259
MARYLAND	RURAL	0.290	0.294
MARYLAND	URBAN	0.262	0.267
MASSACHUSETTS	URBAN	0.323	0.323
MAINE	RURAL	0.457	0.433
MAINE	URBAN	0.452	0.452
MICHIGAN	RURAL	0.313	0.318
MICHIGAN	URBAN	0.322	0.320
MINNESOTA	RURAL	0.498	0.502
MINNESOTA	URBAN	0.327	0.330
MISSOURI	RURAL	0.261	0.266
MISSOURI	URBAN	0.262	0.270
MISSISSIPPI	RURAL	0.241	0.244
MISSISSIPPI	URBAN	0.191	0.192
MONTANA	RURAL	0.428	0.438
MONTANA	URBAN	0.422	0.462
NORTH CAROLINA	RURAL	0.269	0.270
NORTH CAROLINA	URBAN	0.282	0.285
NORTH DAKOTA	RURAL	0.357	0.333
NORTH DAKOTA	URBAN	0.390	0.361
NEBRASKA	RURAL	0.335	0.340
NEBRASKA	URBAN	0.263	0.260
NEW HAMPSHIRE	RURAL	0.340	0.329
NEW HAMPSHIRE	URBAN	0.291	0.285
NEW JERSEY	URBAN	0.236	0.235
NEW MEXICO	RURAL	0.272	0.259
NEW MEXICO	URBAN	0.316	0.329
NEVADA	RURAL	0.280	0.296
NEVADA	URBAN	0.180	0.187
NEW YORK	RURAL	0.414	0.423
NEW YORK	URBAN	0.378	0.383
OHIO	RURAL	0.341	0.350
OHIO	URBAN	0.248	0.250
OKLAHOMA	RURAL	0.265	0.267
OKLAHOMA	URBAN	0.217	0.225
OREGON	RURAL	0.301	0.303
OREGON	URBAN	0.353	0.344
PENNSYLVANIA	RURAL	0.276	0.280
PENNSYLVANIA	URBAN	0.210	0.223

State	Urban/Rural	Proposed CY 2011 Default CCR	Previous Default CCR (CY 2010 OPPS Final Rule)
PUERTO RICO	URBAN	0.520	0.514
RHODE ISLAND	URBAN	0.299	0.299
SOUTH CAROLINA	RURAL	0.235	0.232
SOUTH CAROLINA	URBAN	0.235	0.242
SOUTH DAKOTA	RURAL	0.314	0.320
SOUTH DAKOTA	URBAN	0.256	0.261
TENNESSEE	RURAL	0.229	0.233
TENNESSEE	URBAN	0.211	0.214
TEXAS	RURAL	0.249	0.251
TEXAS	URBAN	0.218	0.222
UTAH	RURAL	0.397	0.397
UTAH	URBAN	0.385	0.400
VIRGINIA	RURAL	0.244	0.242
VIRGINIA	URBAN	0.257	0.255
VERMONT	RURAL	0.415	0.413
VERMONT	URBAN	0.397	0.397
WASHINGTON	RURAL	0.370	0.365
WASHINGTON	URBAN	0.335	0.340
WISCONSIN	RURAL	0.387	0.384
WISCONSIN	URBAN	0.337	0.329
WEST VIRGINIA	RURAL	0.292	0.283
WEST VIRGINIA	URBAN	0.336	0.339
WYOMING	RURAL	0.396	0.407
WYOMING	URBAN	0.300	0.315

BILLING CODE 4120–01–C

E. Proposed OPPS Payment to Certain Rural and Other Hospitals

1. Hold Harmless Transitional Payment Changes Made by Public Law 110–275 (MIPPA)

When the OPPS was implemented, every provider was eligible to receive an additional payment adjustment (called either transitional corridor payments or transitional outpatient payment (TOPs)) 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 (referred to as the pre-BBA amount). Section 1833(t)(7) of the Act provides that the transitional corridor payments are temporary payments for most providers and were intended to ease their transition from the prior reasonable cost-based payment system to the OPPS system. There are two exceptions to this provision, cancer hospitals and children's hospitals, and those hospitals receive the transitional corridor payments on a permanent basis. Section 1833(t)(7)(D)(i) of the Act originally provided for transitional corridor payments to rural hospitals with 100 or fewer beds for covered OPD services furnished before January 1, 2004. However, section 411 of Public Law 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 began with the provider's first cost reporting period beginning on or after January 1, 2004, and ended on December 31, 2005. Accordingly, the authority for making transitional corridor payments under section 1833(t)(7)(D)(i) of the Act, as amended by section 411 of Pub. L. 108–173, for rural hospitals having 100 or fewer beds and SCHs located in rural areas expired on December 31, 2005.

Section 5105 of Public Law 109–171 reinstituted the 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 was less than the provider's pre-BBA amount, the amount of payment was increased by 95 percent of the amount of the difference between the two amounts for CY 2006, by 90 percent of the amount of that difference for CY 2007, and by 85 percent of the amount of that difference for CY 2008.

For CY 2006, we implemented section 5105 of Public Law 109–171 through Transmittal 877, issued on February 24, 2006. In the Transmittal, we did not specifically address whether TOPs apply to essential access community hospitals (EACHs), which are considered to be SCHs under section 1886(d)(5)(D)(iii)(III) of the Act. Accordingly, under the statute, EACHs are treated as SCHs. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68010), we stated that EACHs were not eligible for TOPs under Public Law 109–171. However, we stated they were eligible for the adjustment for rural SCHs. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68010 and 68228), we updated § 419.70(d) of our regulations to reflect the requirements of Public Law 109–171.

In the CY 2009 OPPS/ASC proposed rule (73 FR 41461), we stated that, effective for services provided on or after January 1, 2009, rural hospitals having 100 or fewer beds that are not SCHs would no longer be eligible for TOPs, in accordance with section 5105 of Public Law 109–171. However, subsequent to issuance of the CY 2009 OPPS/ASC proposed rule, section 147 of Public Law 110–275 amended section 1833(t)(7)(D)(i) of the Act by extending the period of TOPs to rural hospitals with 100 beds or fewer for 1 year, for services provided before January 1, 2010. Section 147 of Public Law 110–275 also extended TOPs to SCHs (including EACHs) with 100 or fewer beds for covered OPD services provided on or after January 1, 2009, and before January 1, 2010. In accordance with section 147 of Public Law 110–275, when the OPPS payment is less than the provider's pre-BBA amount, the amount of payment is increased by 85 percent of the amount of the difference between the two payment amounts for CY 2009.

For CY 2009, we revised our regulations at §§ 419.70(d)(2) and (d)(4) and added a new paragraph (d)(5) to incorporate the provisions of section 147 of Public Law 110–275. In addition, we made other technical changes to § 419.70(d)(2) to more precisely capture our existing policy and to correct an inaccurate cross-reference. We also made technical corrections to the cross-references in paragraphs (e), (g), and (i) of § 419.70.

For CY 2010, we made a technical correction to the heading of § 419.70(d)(5) to correctly identify the policy as described in the subsequent regulation text. The paragraph heading now indicates that the adjustment applies to small SCHs, rather than to rural SCHs.

In the CY 2010 OPPS/ASC final rule (74 FR 60425), we stated that, effective for services provided on or after January 1, 2010, rural hospitals and SCHs (including EACHs) having 100 or fewer beds would no longer be eligible for TOPs, in accordance with section 147 of Pub. L. 110–275. However, subsequent to issuance of the CY 2010 OPPS/ASC final rule, section 3121(a) of the Affordable Care Act, Public Law 111–148, amended section 1833(t)(7)(D)(i)(III) of the Act by extending the period of TOPs to rural hospitals that are not SCHs with 100 beds or fewer for 1 year, for services provided before January 1, 2011. Section 3121(a) of Public Law 111–148, amended section 1833(t)(7)(D)(i)(III) of the Act and extended the period of TOPs to SCHs (including EACHs) for 1 year, for services provided before January 1, 2011, with Section 3121(b) of Public Law 111–148 removing the 100-bed limitation applicable to such SCHs for covered OPD services furnished on and after January 1, 2010 and before January 1, 2011. In accordance with section 3121 of Public Law 111–148, when the OPPS payment is less than the provider's pre-BBA amount, the amount of payment is increased by 85 percent of the amount of the difference between the two payment amounts for CY 2010. Accordingly, we are proposing to update section 419.70(d) of the regulations to reflect the TOPs extensions and amendments described in section 3121 of Public Law 111–148.

Effective for services provided on or after January 1, 2011, rural hospitals having 100 or fewer beds that are not SCHs and SCHs (including EACHs) will no longer be eligible for hold harmless TOPs, in accordance with section 3121 of Public Law 111–148.

2. Proposed Adjustment for Rural SCHs Implemented in CY 2006 Related to Public Law 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 sources, and devices paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of Public Law 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 areas and hospitals in urban areas. Our analysis showed a difference in costs for rural SCHs. Therefore, for the CY 2006 OPPS, we finalized a payment adjustment for rural SCHs of 7.1 percent for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, brachytherapy sources, and devices paid under the pass-through payment policy, in accordance with section 1833(t)(13)(B) of the Act.

In CY 2007, we became aware that we did not specifically address whether the adjustment applies to EACHs, which are considered to be SCHs under section 1886(d)(5)(D)(iii)(III) of the Act. Thus, under the statute, EACHs are treated as SCHs. Therefore, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68010 and 68227), for purposes of receiving this rural adjustment, we revised § 419.43(g) to clarify that EACHs are also eligible to receive the rural SCH adjustment, assuming these entities otherwise meet the rural adjustment criteria. Currently, fewer than 10 hospitals are classified as EACHs and as of CY 1998, under section 4201(c) of Public Law 105–33, a hospital can no longer become newly classified as an EACH.

This adjustment for rural SCHs is budget neutral and applied before calculating outliers and copayment. As stated in the CY 2006 OPPS final rule with comment period (70 FR 68560), we would not reestablish the adjustment amount on an annual basis, but we may review the adjustment in the future and, if appropriate, would revise the adjustment. We provided the same 7.1 percent adjustment to rural SCHs, including EACHs, again in CY 2008 and CY 2009. Further, in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68590), we updated the regulations at § 419.43(g)(4) to specify, in general terms, that items paid at charges adjusted to costs by application of a hospital-specific CCR are excluded from the 7.1 percent payment adjustment.

For the CY 2011 OPPS, we are proposing to continue our policy of a budget neutral 7.1 percent payment adjustment for rural SCHs, including EACHs, for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs. We intend to reassess the 7.1 percent adjustment in the near future by examining differences between urban and rural hospitals' costs using updated claims, cost reports, and provider information.

F. Proposed OPPS Payments to Cancer Hospitals Described in Section 1886(d)(1)(B)(v) of the Act

1. Background

Since the inception of the hospital outpatient prospective payment system (OPPS), which was authorized by the Balanced Budget Act of 1997 (BBA), Medicare has paid cancer hospitals identified in section 1886(d)(1)(B)(v) of the Act (cancer hospitals) under the OPPS for covered outpatient hospital services. There are 11 cancer hospitals that meet the classification criteria in section 1886(d)(1)(B)(v) of the Act. These 11 cancer hospitals are exempted from payment under the inpatient prospective payment system (IPPS). With the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999, Congress created section 1833(t)(7) of the Act, "Transitional Adjustment to Limit Decline in Payment," to serve as a permanent payment floor by limiting cancer

hospitals' potential losses under the OPPS. Through 1833(t)(7)(D)(ii) of the Act, a cancer hospital receives the full amount of the difference between payments for covered outpatient services under the OPPS and a pre-BBA amount. That is, cancer hospitals are permanently held harmless to their "pre-BBA" amount, and they receive transitional outpatient payments (TOPs) to ensure that they do not receive a payment that is lower under the OPPS than the payment they would have received before implementation of the OPPS, as set forth in section 1833(t)(7)(F) of the Act. The pre-BBA payment amount is an amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base payment to cost ratio (base PCR) for the hospital. The pre-BBA amount, including the determination of the base PCR, are defined at 42 CFR 419.70(f). TOPs are calculated on Worksheet E Part B of the Hospital and Hospital Health Care Complex Cost Report (form CMS–2552–96) each year. Section 1833(t)(7)(I) of the Act exempts TOPs from budget neutrality calculations. Almost all of the 11 cancer hospitals receive TOPs each year. The volume weighted average payment to cost ratio (PCR) for the cancer hospitals is 0.83, or outpatient payment with TOPs to cancer hospitals is 83 percent of reasonable cost.

Section 3138 of the Affordable Care Act instructs the Secretary to conduct a study to determine if, under the OPPS, outpatient costs incurred by cancer hospitals described in section 1886(d)(1)(1)(v)(B) of the Act with respect to ambulatory classification groups exceed the costs incurred by other hospitals furnishing services under this subsection (section 1833(t) of the Act) as determined appropriate by the Secretary. In addition, section 3138 of the Affordable Care Act requires the Secretary to take into consideration the cost of drugs and biologicals incurred by such hospitals when studying cancer hospital costliness. Further, section 3138 of the Affordable Care Act states that if the cancer hospitals' costs are determined to be greater than the costs of other hospitals paid under the OPPS, the Secretary shall provide an appropriate adjustment to reflect these higher costs. Section 3138 of the Affordable Care Act also requires that this adjustment be budget neutral, and it would be effective for outpatient services provided at cancer hospitals on or after January 1, 2011. Cancer hospitals described in section 1886(d)(1)(B)(v) of the Act remain eligible for TOPs payment (which are not budget neutral) and outlier payments (which are budget neutral).

2. Study of Cancer Hospitals' Costs Relative to Other Hospitals

It has been our standard analytical approach to use a combination of explanatory and payment regression models to assess the costliness of a class of hospitals while controlling for other legitimate influences of costliness, such as ability to achieve economies of scale, to ensure that costliness is due to the type of hospital and to identify appropriate payment adjustments. We used this approach in our CY 2006 OPPS final rule with comment period to establish the 7.1 percent payment adjustment for rural sole community hospitals (70 FR 68556 through 68561). In our discussion for the CY 2006 OPPS proposed rule we stated that a simple comparison of unit costs would not be sufficient to assess the costliness of a class of hospitals because the costs faced by individual hospitals, whether urban or rural, are a function of many varying factors, including local labor supply and the complexity and volume of services provided (70 FR 42699).

In constructing our analysis of cancer hospitals' costs relative to other hospitals, we considered whether our standard analytical approach to use a combination of explanatory and payment regression models would lead to valid results for this particular study, or whether we should develop a different or modified analytic approach. We note that the analyses presented in the CY 2006 OPPS proposed and final rules were designed to establish an adjustment for a large class of rural hospitals. In contrast, section 3138 of the Affordable Care Act is specifically limited to identifying an adjustment for 11 cancer hospitals. With such a small sample size (11 out of approximately 4,000 hospitals paid under the OPPS), we are concerned that the standard explanatory and payment regression models used to establish the rural hospital adjustment would lead to imprecise estimates of payment adjustments for this small group of hospitals. Further, Section 3138 of the Affordable Care Act specifies explicitly that cost comparisons between classes of hospitals must include the cost of drugs and biologicals. In our CY 2006 analysis of rural hospitals, we excluded the cost of drugs and biologicals in our model because the extreme units associated with proper billing for some drugs and biologicals can bias the calculation of a service mix index, or volume weighted average APC relative weight, for each hospital (70 FR 42698). Therefore, we chose not to pursue our standard combination of explanatory and payment regression modeling to identify costliness and determine a cancer hospital adjustment.

While we chose not to use our standard models to calculate a proposed cancer hospital adjustment, we determined it still would be appropriate to construct our usual provider-level analytical dataset consisting of variables related to assessing costliness including average cost per unit for a hospital and the hospitals average APC relative weight as an indicator of the hospitals resource intensity, as measured by the APC relative weights. We used these variables to calculate univariate statistics that describe the costliness and related aspects of cancer hospitals and other hospitals paid under the OPPS. While descriptive statistics cannot control for the myriad factors that contribute to observed costs, we believe that we can assume that stark differences in cost between cancer hospitals and other hospitals paid under the OPPS that would be observable by examining descriptive univariate statistics would provide some indication of relative costliness. We began our analysis of the cancer hospitals as we did for the rural hospitals by creating an analytical dataset of hospitals billing under the OPPS for CY 2009 (a total of 3,933) that were included in our claims dataset for establishing the CY 2011 OPPS proposed APC relative weights (discussed in detail in section II.A. of this proposed rule). This analytical dataset includes the 3,933 OPPS hospitals' total estimated cost (including packaged cost), total lines, total discounted units as modeled for CY 2011 OPPS payment, and the average weight of their separately payable services (total APC weight divided by total units) as modeled for CY 2011 OPPS. We create this dataset from the hospital specific service utilization files that we use to model budget neutrality and to perform impact analyses after we complete estimating a median cost (or equivalent amount depending on unique APC methodologies as discussed in section II of this proposed rule) for each APC. Using the CY 2009 claims that we use to model the CY 2011 proposed OPPS, we use the utilization on those claims to model APC payment under the CY 2011 proposed payment policies, such as proposed payment for drugs and biologicals at ASP+6 percent and proposed reassignment of some HCPCS codes to different APCs. We then summarized this estimated

utilization and payment for each hospital ("hospital-level"). These files consist of hospital-level aggregate costs (including the cost of packaged items and services), total estimated discounted units under the modeled proposed CY 2011 OPPS, total estimated volume of number of occurrences of separately payable HCPCS codes under the modeled proposed CY 2011 OPPS, and total relative weight of separately payable services under the modeled proposed CY 2011 OPPS. The calculation of these summary files are discussed in Stage 6 of our claims accounting narrative available under supporting documentation for this proposed rule on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/HORD/*. After summarizing modeled payment to the hospital-level, we removed 48 hospitals in Puerto Rico from our dataset, because we do not believe that their cost structure reflects the costs of most hospitals paid under the OPPS and because they could bias the calculation of hospital-weighted statistics. We then removed an additional 66 hospitals with a cost per unit of more than 3 standard deviations from the geometric mean (mean of the natural log) because including outliers in hospital-weighted descriptive statistics also could bias the those statistics. This resulted in a dataset with 11 cancer hospitals and 3,808 other hospitals.

We included the following standard hospital-level variables that describe hospital costliness in our analysis file: Outpatient cost per discounted unit under the modeled CY 2011 OPPS (substituting a cost per administration, rather than a cost per unit, for drugs and biologicals); each hospital's proposed CY 2011 wage index as a measure of relative labor cost; the service mix index, or volume-weighted average proposed CY 2011 APC relative weight (including a simulated weight for drugs and biologicals created by dividing the CY 2010 April ASP-based payment amount at ASP+6 percent appearing in Addendum A and B of this proposed rule by the proposed conversion factor of $68.267); outpatient volume based on number of occurrences of HCPCS codes in the CY 2009 claims data; and number of beds. We use these variables because they are key indicators of costliness under the modeled OPPS system, and they allow us to assess the relative costliness of classes of hospitals under the proposed CY 2011 OPPS. We further discuss these variables in our CY 2006 proposed rule analysis (70 FR 42698 through 42701). A hospital's service mix index is a measure of resource intensity of the services provided by the hospital as measured by the proposed CY 2011 OPPS relative weights, and standardizing the cost per discounted unit by the service mix index creates an adjusted cost per unit estimate that reflects the remaining relative costliness of a hospital remaining after receiving the estimated payments that we are proposing to make under the CY 2011 OPPS. In short, if a class of hospitals demonstrates higher cost per unit after standardization by service mix it is an early indication that the class of hospitals may be significantly more costly in the regression models. We used this data to calculate the descriptive univariate statistics for cancer hospitals appearing in Table 10 below. We note that because drugs and biologicals are such a significant portion of the services that the cancer hospitals provide, and because Section 3138 of the Affordable Care Act explicitly requires us to consider the cost of drugs and biologicals, we included the cost of these items in our total cost calculation for each hospital, counting each occurrence of a drug in the modeled proposed CY 2011 data (based on units in CY 2009 claims data). That is, we sought to treat each administration of a drug or biological as one unit.

In reviewing these descriptive statistics, we observe that cancer hospitals had a standardized cost per discounted unit of $150.12 compared to a standardized cost per discounted unit of $94.14 for all other hospitals. That is, cancer hospitals' average cost per discounted unit remains high even after accounting for payment under the modeled proposed CY 2011 payment system, which is not true for all other hospitals. Observing such differences in standardized cost per discounted unit lead us to conclude that cancer hospitals are more costly than other hospitals paid under the OPPS, even without the inferential statistical models that we typically employ.

Table 10. - Means and Standard Deviations for Key Variables by Cancer and Non-Cancer OPPS Hospitals

	Cancer Hospitals		Non-Cancer Hospitals	
Variable	Mean	Standard Deviation	Mean	Standard Deviation
Outpatient Cost per Unit*	$344.20	(64.68)	$264.11	(165.86)
Unit Cost Standardized by Service Mix Wage Indices	$150.12	(31.64)	$94.14	(81.19)
Wage Index	1.10	(0.13)	0.98	(0.16)
Service Mix Index *	2.19	(0.26)	3.18	(2.25)
Outpatient Volume	192,197	(186,063)	34,578	(43,094)
Beds	173	(162.33)	173	(171.46)
Number of Hospitals	11		3,808	

* Includes drugs and biologicals based on per administration rather than per unit

3. Proposed Adjustment for Certain Cancer Hospitals

Having reviewed the cost data from the standard analytic database and determined that cancer hospitals are more costly than other hospitals within the OPPS system, we decided to examine hospital cost report data from Worksheet E Part B (where TOPs are calculated on the Hospital and Hospital Health Care Complex Cost Report each year) in order to determine whether our findings were further supported by cost report data and to determine an appropriate proposed payment adjustment methodology. Analyses on our standard analytic database and descriptive statistics presented in Table 10 above, did not consider TOPs in assessing costliness of cancer hospitals relative to other hospitals furnishing services under section 1833(t) of the Act. This is because section 3138 of the Affordable Care Act requires that any cancer adjustment be made within the budget neutral system. In making a determination about a payment adjustment subject to budget neutrality, we believe it is appropriate to assess costliness and payments within the budget neutral payment system. We note that TOPs are based on reasonable cost and are not part of the budget neutral payment system. Further, TOPs have no associated relative weight that could be included in an assessment of APC-based payment. TOPs are paid at cost report settlement on an aggregate basis, not a per service basis, and we would have no way to break these payments down into a relative weight to incorporate these retrospective aggregate payments in the form of relative weight under the proposed modeled CY 2011 OPPS. The cost report data we selected for the analysis was limited to the OPPS-specific payment and cost data available on Worksheet E Part B, which is also where TOPs are calculated including aggregate OPPS payments, including outlier payments and the cost of medical and other health services. These aggregate measures of cost and payment also include the cost and payment for drugs and biologicals and other adjustments that we typically include in our regression modeling, including wage index adjustment and rural adjustment, if applicable. While this cost report data cannot provide an estimate of cost per unit after controlling for other potential factors that could influence cost per unit, we can use this aggregate cost and payment data to examine the cancer hospitals' OPPS PCR and OPPS PCR with TOPs, and compare these to the OPPS PCR for other hospitals.

PCRs calculated from the most recent cost report data also indicate that costs relative to payments at cancer hospitals are higher than those at other hospitals paid under the OPPS (that is, cancer hospitals have lower PCRs). In order to calculate PCRs for hospitals paid under the OPPS (including cancer hospitals), we used the same extract of cost report data from the Hospital Cost Report Information System (HCRIS), as discussed in section II.A. of this proposed rule, that we used to calculate the CCRs that we used to estimate median costs for this proposed CY 2011 OPPS. Using this cost report data, we included data from Worksheet E Part B for each hospital, keeping data from each hospital's most recent cost report, whether as submitted or settled. We then limited the data set to the hospitals with CY 2009 claims data that we used to model the CY 2011 proposed APC relative weights (3933 hospitals) because we used the claims from these hospitals to calculate the estimated costs we used for the descriptive statistics in our first analysis and because it is appropriate to use the same set of hospitals that we are using to calibrate the modeled proposed CY 2011 OPPS. The cancer hospitals in this data set largely had cost report data from cost reporting periods ending in FY 2008 and FY 2009. The cost report data for the other hospitals were from cost report periods with fiscal year ends ranging from 2005 to 2009. We then removed the cost report data for 48 hospitals from Puerto Rico from our data set because we do not believe that their cost structure reflects the costs of most hospitals paid under the OPPS and therefore may bias the results of the study. We also removed 301 hospitals with cost report data that was not complete (missing OPPS payments including outliers, missing aggregate cost data, or both) so that all cost reports in the study would have both the payment and cost data necessary to calculate a PCR for each hospital, leading to a final analytic file of 3584 hospitals with cost report data. We believe that the costs, PPS payments, and TOPs reported on Worksheet E part B for the hospitals included in our CY 2011 modeling should be sufficiently accurate for assessing hospitals' relative costliness because all of the key elements that we believe to be necessary for the analysis (payment, cost and TOPs) are contained on this worksheet.

Using this much smaller dataset of cost report data, we estimate that on average, the OPPS payments to the 11 cancer hospitals, not including TOPs, are approximately 62 percent of reasonable cost (that is, we calculate a PCR of 0.615 for the cancer hospitals), whereas, we estimate that, on average, the OPPS payments to other hospitals paid under the OPPS are approximately 87 percent of reasonable cost (resulting in a PCR of 0.868). Individual cancer hospitals' OPPS PCRs range from approximately 48 percent to approximately 82 percent. When TOPS are included in the calculation of the PCR, cancer hospitals, as a group, receive payments that are approximately 83 percent of reasonable cost, which is still lower than the average PCR of other OPPS hospitals of approximately 87 percent of reasonable cost. Considering this data, we find that the cancer hospitals are more costly than other hospitals paid under the OPPS. The dataset of hospital cost report data that we used to model this proposed adjustment is available under supporting documentation for this proposed rule on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/HORD/.*

Based on our findings that cancer hospitals, as a class, have a significantly lower volume weighted average PCR than the volume weighted PCR of other hospitals paid under the OPPS and our findings above that the cancer hospitals cost per discounted unit standardized for service mix remains much higher than the standardized cost per discounted unit of all other hospitals, we are proposing an adjustment for cancer hospitals to reflect these higher costs effective January 1, 2011, as mandated by section 3138 of the Affordable Care Act. For purposes of calculating a proposed adjustment, we chose to rely on this straightforward assessment of payments and costs from the cost report data because of the concerns outlined above with respect to the small number of hospitals, and because of the challenges associated with accurately including drug and biological costs in our standard regression models. We believe that an appropriate adjustment would redistribute enough payments from other hospitals paid under the OPPS to the cancer hospitals to give cancer hospitals a PCR that is comparable to the average PCR for other hospitals paid under the OPPS. Therefore, we propose a hospital-specific payment adjustment determined as the percentage of additional payment needed to raise each cancer hospital's PCR to the weighted average PCR for all other hospitals paid under OPPS (0.868) in the CY 2011 dataset. This would be accomplished by adjusting each cancer hospital's OPPS payment by the percentage difference

between their individual PCR (without TOPs) and the weighted average PCR of the other hospitals paid under OPPS.

This proposed methodology would result in the proposed percentage payment adjustments for the 11 cancer hospitals appearing in Table 11. We propose that this hospital-specific adjustment would be applied to the wage adjusted payments for all items, except for items and services paid at charges adjusted to cost or devices receiving pass-through status defined in 42 CFR 419.66. The proposed cancer hospital adjustment would not be applied to items and services paid at charges adjusted to cost because these items and services are always paid the estimated full cost of the item or service. We are proposing to amend 42 CFR to add new section 419.43(i)(2) which would establish the amount of the adjustment to cancer hospitals. We also propose that this adjustment would be budget neutral as set forth in proposed new section 42 CFR 419.43(i)(3), consistent with section 3138 of the Affordable Care Act. We note that outlier payments would be appropriately assessed after application of the cancer adjustment and that TOPs would continue to apply. The changes made by section 3138 of the Affordable Care Act do not affect the existing statutory provisions that provide for outlier payment for all hospitals paid under the OPPS, including cancer hospitals and TOPs payments for cancer hospitals. Further, both outlier payments and TOPs serve as a safety net for hospitals, although outliers are budget neutral and TOPs are not, and TOPs are limited to certain hospitals. As a means of buffering the financial risk associated with a prospective payment system, both adjustments (outliers and TOPs) only should be assessed after final payments have been made. Because outlier payments are made within the budget neutrality, outlier payments should be assessed after all budget neutral payments for an individual service have been made, including the cancer adjustment. The TOPs payments would be assessed after all payments have been made for a cost reporting period. We note that the proposed adjustment for all cancer hospitals would result in an estimated aggregate increase in OPPS payments to cancer hospitals of 41.2 percent for CY 2011, based on cost report data.

BILLING CODE 4120–01–P

TABLE 11. – PROPOSED HOSPITAL-SPECIFIC ADJUSTMENT FOR CANCER HOSPITALS WITHOUT REGARD TO TOPs AND OUTLIER PAYMENTS

Provider Number	Hospital	Percent of Increase Without TOPs or Outlier Payment
050146	CITY OF HOPE HELFORD CLIN RESEARCH HOSP	5.9%
050660	USC KENNETH NORRIS JR CANCER HOSPITAL	11.5%
390196	HOSP OF THE FOX CHASE CANCER CENTER	13.6%
360242	JAMES CANCER HOSPITAL & SOLOVE RESEARCH INSTITUTE	15.7%
330354	ROSWELL PARK CANCER INSTITUTE	16.3%
100079	UNIV OF MIAMI HOSP & CLINIC	21.5%
100271	H LEE MOFFITT CANCER CENTER & RESEARCH INSTITUTE	29.4%
330154	MEM HOSP FOR CANCER AND ALLIED DISEASES	36.4%
220162	DANA-FARBER CANCER INSTITUTE	42.2%
500138	SEATTLE CANCER CARE ALLIANCE	47.6%
450076	UNIV OF TEXAS M D ANDERSON CANCER CENTER	82.6%
Proposed Aggregate Adjustment		41.2%

We propose to recalibrate the "other hospital" PCR target amount and the hospital-specific percentage adjustment for each cancer hospital periodically, but not every year, because we do not believe that these amounts will change

so drastically in any given year to warrant annual recalculation. In the event that a cancer hospital has a PCR that is higher than the volume weighted average PCR for all hospitals, we propose that the specific hospital would not be eligible for this adjustment. We believe that this would indicate that the hospital's costs do not exceed the costs incurred by other hospitals furnishing services under the OPPS and, therefore, an adjustment would not be required and would be unnecessary. We note that the TOPS provision remains in effect and that we will continue to make TOPS to cancer hospitals that continue to have all final OPPS payments (including but not limited to outlier payments, the wage adjustment, and this new cancer hospital adjustment), that are lower than their pre-BBA payment amount. If this proposed adjustment is finalized, we estimate that only one cancer hospital would continue to receive TOPS. We propose to update the hospital-specific cancer hospital payment adjustments in Table 11 using the more recent cost reports that become available for the CY 2011 OPPS/ASC final rule with comment period.

G. Proposed Hospital Outpatient Outlier Payments

1. Background

Currently, the OPPS pays outlier payments on a service-by-service basis. For CY 2010, 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 $2,175 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 the cost of a service 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. Before CY 2009, this outlier payment had historically been considered a final payment by longstanding OPPS policy. We implemented a reconciliation process similar to the IPPS outlier reconciliation process for cost reports with cost reporting periods beginning on or after January 1, 2009 (73 FR 68594 through 68599).

It has been our policy for the past several years to report the actual amount of outlier payments as a percent of total spending in the claims being used to model the proposed OPPS. Our current estimate of total outlier payments as a percent of total CY 2009 OPPS payment, using available CY 2009 claims and the revised OPPS expenditure estimate for the President's Budget for FY 2011, is approximately 1.0 percent of the total aggregated OPPS payments. Therefore, for CY 2009, we estimate that we paid at the CY 2009 outlier target of 1.0 percent of total aggregated OPPS payments.

As explained in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60426 through 60427), we set our projected target for aggregate outlier payments at 1.0 percent of the aggregate total payments under the OPPS for CY 2010. The outlier thresholds were set so that estimated CY 2010 aggregate outlier payments would equal 1.0 percent of the total aggregated payments under the OPPS. Using CY 2009 claims data and CY 2010 payment rates, we currently estimate that the aggregate outlier payments for CY 2010 would be approximately 0.85 percent of the total CY 2010 OPPS payments. The difference between 1.0 percent and 0.85 percent is reflected in the regulatory impact analysis in section XXIII. of this proposed rule. We note that we provide estimated CY 2011 outlier payments for hospitals and CMHCs with claims included in the claims data that we used to model impacts in the Hospital-Specific Impacts—Provider-Specific Data file on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

2. Proposed Outlier Calculation

For CY 2011, we are proposing to continue our policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS for outlier payments. We are proposing that a portion of that 1.0 percent, specifically 0.04 percent, would be allocated to CMHCs for PHP outlier payments. This is the amount of estimated outlier payments that would result from the proposed CMHC outlier threshold as a proportion of total estimated outlier payments. As discussed in section X.D. of this proposed rule, for CMHCs, we are proposing to continue a policy, that if a CMHC's cost for partial hospitalization services, paid under either APC 0172 (Level I Partial Hospitalization (3 services)) or APC 0173 (Level II Partial Hospitalization (4 or more services)), exceeds 3.40 times the payment for APC 0173, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate. For further discussion of CMHC outlier payments, we refer readers to section X.D. of this proposed rule.

To ensure that the estimated CY 2011 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPPS, we are proposing that the hospital outlier threshold be set so that outlier payments would be triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $2,025 fixed-dollar threshold. This proposed threshold reflects the methodology discussed below in this section, as well as the proposed APC recalibration for CY 2011.

We calculated the proposed fixed-dollar threshold for this proposed rule using largely the same methodology as we did in CY 2009 (73 FR 41462). For purposes of estimating outlier payments for this proposed rule, we used the hospital-specific overall ancillary CCRs available in the April 2010 update to the Outpatient Provider-Specific File (OPSF). The OPSF contains provider-specific data, such as the most current CCR, which are maintained by the Medicare contractors and used by the OPPS Pricer to pay claims. The claims that we use to model each OPPS update lag by 2 years. For this proposed rule, we used CY 2009 claims to model the CY 2011 OPPS. In order to estimate the proposed CY 2011 hospital outlier payments for this proposed rule, we inflated the charges on the CY 2009 claims using the same inflation factor of 1.1059 that we used to estimate the IPPS fixed-dollar outlier threshold for the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24068). We used an inflation factor of 1.0516 to estimate CY 2010 charges from the CY 2009 charges reported on CY 2009 claims. The methodology for determining this charge inflation factor was discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24068). As we stated in the CY 2005 OPPS final rule with comment period (69 FR 65845), we believe that the use of this charge inflation factor is appropriate for the OPPS because, with the exception of the inpatient routine service cost centers, hospitals use the same ancillary and outpatient cost centers to capture costs and charges for inpatient and outpatient services.

As noted in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68011), we are concerned that we could systematically overestimate the OPPS hospital outlier threshold if we did not apply a CCR inflation adjustment factor. Therefore, we are proposing to apply the same CCR inflation adjustment factor

that we proposed to apply for the FY 2011 IPPS outlier calculation to the CCRs used to simulate the proposed CY 2011 OPPS outlier payments that determine the fixed-dollar threshold. Specifically, for CY 2011, we are proposing to apply an adjustment of 0.9890 to the CCRs that were in the April 2010 OPSF to trend them forward from CY 2010 to CY 2011. The methodology for calculating this adjustment is discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24068 through 24070).

Therefore, to model hospital outlier payments for this proposed rule, we applied the overall CCRs from the April 2010 OPSF file after adjustment (using the proposed CCR inflation adjustment factor of 0.9890 to approximate CY 2011 CCRs) to charges on CY 2009 claims that were adjusted (using the proposed charge inflation factor of 1.1059 to approximate CY 2011 charges). We simulated aggregated CY 2011 hospital outlier payments using these costs for several different fixed-dollar thresholds, holding the 1.75 multiple threshold constant and assuming that outlier payment would continue to be made at 50 percent of the amount by which the cost of furnishing the service would exceed 1.75 times the APC payment amount, until the total outlier payments equaled 1.0 percent of aggregated estimated total CY 2011 OPPS payments. We estimated that a proposed fixed-dollar threshold of $2,025, combined with the proposed multiple threshold of 1.75 times the APC payment rate, would allocate 1.0 percent of aggregated total OPPS payments to outlier payments. We are proposing to continue to make an outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the proposed fixed-dollar $2,025 threshold are met. For CMHCs, if a CMHC's cost for partial hospitalization services, paid under either APC 0172 or APC 0173, exceeds 3.40 times the payment for APC 0173, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate.

Section 1833(t)(17)(A) of the Act, which applies to hospitals as defined under section 1886(d)(1)(B) of the Act, requires that hospitals that fail to report data required for the quality measures selected by the Secretary, in the form and manner required by the Secretary under 1833(t)(17)(B) of the Act, incur a 2.0 percentage point reduction to their OPD fee schedule increase factor, that is, the annual payment update factor. The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that will apply to certain outpatient items and services furnished by hospitals that are required to report outpatient quality data and that fail to meet the HOP QDRP requirements. For hospitals that fail to meet the HOP QDRP requirements, we are proposing to continue our policy that we implemented in CY 2009 that the hospitals' costs would be compared to the reduced payments for purposes of outlier eligibility and payment calculation. For more information on the HOP QDRP, we refer readers to section XVI. of this proposed rule.

In the CY 2009 OPPS/ASC final rule with comment period (73 CFR 68599), we adopted as final policy a process to reconcile hospital or CMHC outlier payments at cost report settlement for services furnished during cost reporting periods beginning in CY 2009. OPPS outlier reconciliation ensures accurate outlier payments for those facilities whose CCRs fluctuate significantly relative to the CCRs of other facilities, and who receive a significant amount of outlier payments. As under the IPPS, we do not adjust the fixed-dollar threshold or amount of total OPPS payment set aside for outlier payments for reconciliation activity because such action would be contrary to the prospective nature of the system. Our outlier threshold calculation assumes that overall ancillary CCRs accurately estimate hospital costs based on the information available to us at the time we set the prospective fixed-dollar outlier threshold. For these reasons, we are not incorporating any assumptions about the effects of reconciliation into our calculation of the proposed OPPS fixed-dollar outlier threshold.

H. Proposed Calculation of an Adjusted Medicare Payment From the National Unadjusted Medicare Payment

The basic methodology for determining prospective payment rates for HOPD services under the OPPS is set forth in existing regulations at 42 CFR part 419, subparts C and D. The payment rate for most services and procedures for which payment is made under the OPPS is the product of the conversion factor calculated in accordance with section II.B. of this proposed rule and the relative weight determined under section II.A. of this proposed rule. Therefore, the proposed national unadjusted payment rate for most APCs contained in Addendum A to this proposed rule and for most HCPCS codes to which separate payment under the OPPS has been assigned in Addendum B to this proposed rule was calculated by multiplying the proposed CY 2011 scaled weight for the APC by the proposed CY 2011 conversion factor.

We note that section 1833(t)(17) of the Act, which applies to hospitals as defined under section 1886(d)(1)(B) of the Act, requires that hospitals that fail to submit data required to be submitted on quality measures selected by the Secretary, in the form and manner and at a time specified by the Secretary, incur a 2.0 percentage point reduction to their OPD fee schedule increase factor, that is, the annual payment update factor. The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that apply to certain outpatient items and services provided by hospitals that are required to report outpatient quality data and that fail to meet the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) requirements. For further discussion of the payment reduction for hospitals that fail to meet the requirements of the HOP QDRP, we refer readers to section XVII.D. of this proposed rule.

We demonstrate in the steps below how to determine the APC payments that would be made in a calendar year under the OPPS to a hospital that fulfills the HOP QDRP requirements and to a hospital that fails to meet the HOP QDRP requirements for a service that has any of the following status indicator assignments: "P," "Q1," "Q2," "Q3," "R," "S," "T," "U," "V," or "X" (as defined in Addendum D1 to this proposed rule), in a circumstance in which the multiple procedure discount does not apply, the procedure is not bilateral, and conditionally packaged services (status indicator of "Q1" and "Q2") qualify for separate payment. We note that although blood and blood products with status indicator "R" and brachytherapy sources with status indicator "U" are not subject to wage adjustment, they are subject to reduced payments when a hospital fails to meet the HOP QDRP requirements because the national unadjusted payment rates for these services are updated by the OPD fee schedule increase factor.

Individual providers interested in calculating the payment amount that they would receive for a specific service from the national unadjusted payment rates presented in Addenda A and B to this proposed rule should follow the formulas presented in the following steps. For purposes of the payment calculations below, we refer to the national unadjusted payment rate for hospitals that meet the requirements of

the HOP QDRP as the "full" national unadjusted payment rate. We refer to the national unadjusted payment rate for hospitals that fail to meet the requirements of the HOP QDRP as the "reduced" national unadjusted payment rate. The reduced national unadjusted payment rate is calculated by multiplying the reporting ratio of 0.980 times the "full" national unadjusted payment rate. The national unadjusted payment rate used in the calculations below is either the full national unadjusted payment rate or the reduced national unadjusted payment rate, depending on whether the hospital met its HOP QDRP requirements in order to receive the full CY 2011 OPPS increase factor.

Step 1. Calculate 60 percent (the labor-related portion) of the proposed national unadjusted payment rate. Since the initial implementation of the OPPS, we have used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. We refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18496 through 18497) for a detailed discussion of how we derived this percentage. We confirmed that this labor-related share for hospital outpatient services is still appropriate during our regression analysis for the payment adjustment for rural hospitals in the CY 2006 OPPS final rule with comment period (70 FR 68553).

The formula below is a mathematical representation of Step 1 and identifies the labor-related portion of a specific payment rate for a specific service.

X is the labor-related portion of the national unadjusted payment rate.

X = .60 * (national unadjusted payment rate)

Step 2. Determine the wage index area in which the hospital is located and identify the wage index level that applies to the specific hospital. The wage index values assigned to each area reflect the geographic statistical areas (which are based upon OMB standards) to which hospitals are assigned for FY 2011 under the IPPS, reclassifications through the MGCRB, section 1886(d)(8)(B) "Lugar" hospitals, reclassifications under section 1886(d)(8)(E) of the Act, as defined in § 412.103 of the regulations, and hospitals designated as urban under section 601(g) of Public Law 98–21. We note that the reclassifications of hospitals under section 508 of Public Law 108–173, as extended by section 3137 of the Affordable Care Act, expires on September 30, 2010, and, therefore, are not applicable under the IPPS for FY 2011. Therefore, these reclassifications will not apply to the CY 2011 OPPS. (For further discussion of the changes to the FY 2011 IPPS wage indices, as applied to the CY 2011 OPPS, we refer readers to section II.C. of this proposed rule.) In section II.C. of this proposed rule, we also discuss our proposal to implement section 10324 of the Affordable Care Act, which establishes a wage index floor of 1.00 for frontier States, effective for services furnished on and after January 1, 2011.

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 Public Law 108–173. Addendum L to this proposed rule contains the qualifying counties and the associated proposed wage index increase developed for the FY 2011 IPPS and published as Table 4J in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24182). This step is to be followed only if the hospital is not reclassified or redesignated under section 1886(d)(8) or section 1886(d)(10) of the Act.

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

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

X_a is the labor-related portion of the national unadjusted payment rate (wage adjusted).

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

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

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

Y is the nonlabor-related portion of the national unadjusted payment rate.

Y = .40 * (national unadjusted payment rate)

Adjusted Medicare Payment = Y + X_a

Step 6. If a provider is a SCH, set forth in the regulations at § 412.92, or an EACH, which is considered to be a SCH under section 1886(d)(5)(D)(iii)(III) of the Act, and located in a rural area, as defined in § 412.64(b), or is treated as being located in a rural area under § 412.103, multiply the wage index adjusted payment rate by 1.071 to calculate the total payment.

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

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

We have provided examples below of the calculation of both the proposed full and reduced national unadjusted payment rates that would apply to certain outpatient items and services performed by hospitals that meet and that fail to meet the HOP QDRP requirements, using the steps outlined above. For purposes of this example, we use a provider that is located in Brooklyn, New York that is assigned to CBSA 35644. This provider bills one service that is assigned to APC 0019 (Level I Excision/Biopsy). The proposed CY 2011 full national unadjusted payment rate for APC 0019 is $335.76. The proposed reduced national unadjusted payment rate for a hospital that fails to meet the HOP QDRP requirements is $329.04. This reduced rate is calculated by multiplying the reporting ratio of 0.980 by the full unadjusted payment rate for APC 0019.

The proposed FY 2011 wage index for a provider located in CBSA 35644 in New York is 1.3154. The proposed labor-related portion of the full national unadjusted payment is $264.99 (.60 * $335.76 * 1.3154). The proposed labor-related portion of the reduced national unadjusted payment is $259.69 (.60 * $329.04 * 1.3154). The proposed nonlabor-related portion of the full national unadjusted payment is $134.30 (.40 * $335.76). The proposed nonlabor-related portion of the reduced national unadjusted payment is $131.62 (.40 * $329.04). The sum of the labor-related and nonlabor-related portions of the full national adjusted payment is $399.29 ($264.99 + $134.30). The sum of the reduced national adjusted payment is $391.31 ($259.69 + $131.62).

I. Proposed Beneficiary Copayments

1. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining the unadjusted copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment

rate (determined on a national unadjusted basis) for that service in the year does not exceed a specified percentage. As specified in section 1833(t)(8)(C)(ii)(V) of the Act, for all services paid under the OPPS in CY 2010, and in calendar years thereafter, the percentage is 40 percent of the APC payment rate.

Section 1833(t)(3)(B)(ii) of the Act provides that, for a covered OPD service (or group of such services) furnished in a year, the national unadjusted copayment amount cannot be less than 20 percent of the OPD fee schedule amount. Until CY 2011, sections 1834(d)(2)(C)(ii) and 1834(d)(3)(C)(ii) of the Act further require that the copayment for screening flexible sigmoidoscopies and screening colonoscopies be equal to 25 percent of the payment amount. Since the beginning of the OPPS, we have applied the 25 percent copayment to screening flexible sigmoidoscopies and screening colonoscopies. However, section 4104 of the Affordable Care Act eliminated the coinsurance (to which section 1833(t)(2)(B) refers as the "copayment") for preventive services that meet certain requirements, including flexible sigmoidoscopies and screening colonscopies, and waived the Part B deductible for screening colonoscopies that become diagnostic during the procedure. We discuss our proposal to implement this provision in section XII.B. of this proposed rule.

2. Proposed OPPS Copayment Policy

For CY 2011, we are proposing to determine copayment amounts for new and revised APCs using the same methodology that we implemented beginning in CY 2004. (We refer readers to the November 7, 2003 OPPS final rule with comment period (68 FR 63458).) In addition, we are proposing to use the same standard rounding principles that we have historically used in instances where the application of our standard copayment methodology would result in a copayment amount that is less than 20 percent and cannot be rounded, under standard rounding principles, to 20 percent. (We refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66687) in which we discuss our rationale for applying these rounding principles.) The national unadjusted copayment amounts for services payable under the OPPS that would be effective January 1, 2011, are shown in Addenda A and B to this proposed rule. As discussed in section XVI.D. of this proposed rule, for CY 2011, the Medicare beneficiary's minimum unadjusted copayment and national unadjusted copayment for a service to which a reduced national unadjusted payment rate applies would equal the product of the reporting ratio and the national unadjusted copayment, or the product of the reporting ratio and the minimum unadjusted copayment, respectively, for the service.

3. Proposed Calculation of an Adjusted Copayment Amount for an APC Group

Individuals interested in calculating the national copayment liability for a Medicare beneficiary for a given service provided by a hospital that met or failed to meet its HOP QDRP requirements should follow the formulas presented in 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 0019, $67.16 is 20 percent of the full national unadjusted payment rate of $335.76. For APCs with only a minimum unadjusted copayment in Addendum A and B of this proposed rule, the beneficiary payment percentage is 20 percent.

The formula below is a mathematical representation of Step 1 and calculates national copayment as a percentage of national payment for a given service.

B is the beneficiary payment percentage.

B = National unadjusted copayment for APC/national unadjusted payment rate for APC

Step 2. Calculate the appropriate wage-adjusted payment rate for the APC for the provider in question, as indicated in Steps 2 through 4 under section II.H. of this proposed rule. Calculate the rural adjustment for eligible providers as indicated in Step 6 under section II.H. of this proposed rule.

Step 3. Multiply the percentage calculated in Step 1 by the payment rate calculated in Step 2. The result is the wage-adjusted copayment amount for the APC.

The formula below is a mathematical representation of Step 3 and applies the beneficiary percentage to the adjusted payment rate for a service calculated under section II.H. of this proposed rule, with and without the rural adjustment, to calculate the adjusted beneficiary copayment for a given service.

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

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

Step 4. For a hospital that failed to meet its HOP QDRP requirements, multiply the copayment calculated in Step 3 by the reporting ratio of 0.980.

The proposed unadjusted copayments for services payable under the OPPS that would be effective January 1, 2011, are shown in Addenda A and B to this proposed rule. We note that the national unadjusted payment rates and copayment rates shown in Addenda A and B to this proposed rule reflect the full market basket conversion factor increase, as discussed in section XVI.D. of this proposed rule.

III. Proposed OPPS Ambulatory Payment Classification (APC) Group Policies

A. Proposed OPPS Treatment of New HCPCS and CPT Codes

CPT and Level II HCPCS codes are used to report procedures, services, items, and supplies under the hospital OPPS. Specifically, CMS recognizes the following codes on OPPS claims: (1) Category I CPT codes, which describe medical services and procedures; (2) Category III CPT codes, which describe new and emerging technologies, services, and procedures; and (3) Level II HCPCS codes, which are used primarily to identify products, supplies, temporary procedures, and services not described by CPT codes. CPT codes are established by the American Medical Association (AMA) and the Level II HCPCS codes are established by the CMS HCPCS Workgroup. These codes are updated and changed throughout the year. CPT and HCPCS code changes that affect the OPPS are published both through the annual rulemaking cycle and through the OPPS quarterly update Change Requests (CRs). CMS releases new Level II HCPCS codes to the public or recognizes the release of new CPT codes by the AMA and makes these codes effective (that is, the codes can be reported on Medicare claims) outside of the formal rulemaking process via OPPS quarterly update CRs. This quarterly process offers hospitals access to codes that may more accurately describe items or services furnished and/or provides payment or more accurate payment for these items or services in a timelier manner than if CMS waited for the annual rulemaking process. We solicit comments on these new codes and finalize our proposals related to these codes through our annual rulemaking process. In Table 12 below, we summarize our proposed process for updating codes through our OPPS quarterly update CRs, seeking public comments, and finalizing their treatment under the OPPS.

TABLE 12.—COMMENT TIMEFRAME FOR NEW OR REVISED HCPCS CODES

OPPS Quarterly Update CR	Type of Code	Effective Date	Comments Sought	When Finalized
April 1, 2010	Level II HCPCS Codes	April 1, 2010	CY 2011 OPPS/ASC proposed rule	CY 2011 OPPS/ASC final rule with comment period
July 1, 2010	Level II HCPCS Codes	July 1, 2010	CY 2011 OPPS/ASC proposed rule	CY 2011 OPPS/ASC final rule with comment period
	Category I (certain vaccine codes) and III CPT codes	July 1, 2010	CY 2011 OPPS/ASC proposed rule	CY 2011 OPPS/ASC final rule with comment period
October 1, 2010	Level II HCPCS Codes	October 1, 2010	CY 2011 OPPS/ASC final rule with comment period	CY 2012 OPPS/ASC final rule with comment period
January 1, 2011	Level II HCPCS Codes	January 1, 2011	CY 2011 OPPS/ASC final rule with comment period	CY 2012 OPPS/ASC final rule with comment period
	Category I and III CPT Codes	January 1, 2011	CY 2011 OPPS/ASC final rule with comment period	CY 2012 OPPS/ASC final rule with comment period

This process is discussed in detail below and we have separated our discussion into two sections based on whether we are proposing to solicit public comments in this CY 2011 OPPS/ASC proposed rule on a specific group of the CPT and Level II HCPCS codes or whether we are proposing to solicit public comments on another specific group of the codes in the CY 2011 OPPS/ASC final rule with comment period. We note that we sought public comments in the CY 2010 OPPS/ASC final rule with comment period on the new CPT and Level II HCPCS codes that were effective January 1, 2010. We also sought public comments in the CY 2010 OPPS/ASC final rule with comment period on the new Level II HCPCS codes effective October 1, 2009. These new codes with an effective date of October 1, 2009, or January 1, 2010, were flagged with comment indicator "NI" (New code, interim APC assignment; comments will be accepted on the interim APC assignment for the new code) in Addendum B to the CY 2010 OPPS/ASC final rule with comment period to indicate that we were assigning them an interim payment status and an APC and payment rate, if applicable, which were subject to public comment following publication of the CY 2010 OPPS/ASC final rule with comment period. We will respond to public comments and finalize our proposed OPPS treatment of these codes in the CY 2011 OPPS/ASC final rule with comment period.

1. Proposed Treatment of New Level II HCPCS Codes and Category I CPT Vaccine Codes and Category III CPT Codes for Which We Are Soliciting Public Comments in This Proposed Rule

Effective April 1 and July 1 of CY 2010, we make effective a total of 22 new Level II HCPCS codes, 4 new Category I CPT vaccine codes, and 11 new Category III CPT codes that were not addressed in the CY 2010 OPPS/ASC final rule with comment period that updated the OPPS. Twenty-two new Level II HCPCS codes are effective for the April and July 2010 updates, and of the 22 new HCPCS codes, a total of 14 Level II HCPCS codes are newly recognized for separate payment under the OPPS.

Through the April 2010 OPPS quarterly update CR (Transmittal 1924, Change Request 6857, dated February 26, 2010), we allowed separate payment for a total of six of the 22 Level II HCPCS codes. Specifically, as displayed in Table 13 below, these included HCPCS code C9258 (Injection, telavancin, 10 mg), C9259 (Injection, pralatrexate, 1 mg), C9260 (Injection, ofatumumab, 10 mg), C9261 (Injection, ustekinumab, 1 mg), C9262 (Fludarabine phosphate, oral, 1 mg), and C9263 (Injection, ecallantide, 1 mg).

In addition to the six HCPCS C-codes, five new HCPCS G-codes were made effective on April 1, 2010. We did not recognize the five new HCPCS G-codes for separate payment under the OPPS because they were either paid under another Medicare payment system or were noncovered services under Medicare. Specifically, we assigned HCPCS G0432 (Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV–1 or HIV–2, screening), G0433 (Infectious agent antigen detection by enzyme-linked immunosorbent assay

(ELISA) technique, antibody, HIV–1 or HIV–2, screening), G0435 (Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV–1 or HIV–2, screening), and G9143 (Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)), to status indicator "A" (Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS) to indicate that these services are paid under the Medicare Clinical Laboratory Fee Schedule (CLFS). Further, we did not recognize for separate payment HCPCS G9147 (Outpatient Intravenous Insulin Treatment (OIVIT) and assigned it to status indicator "E" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) because this service is nationally a noncovered service under Medicare.

TABLE 13.—LEVEL II HCPCS CODES WITH A CHANGE IN OPPS STATUS INDICATOR OR NEWLY IMPLEMENTED IN APRIL 2010

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 Status Indicator	Proposed CY 2011 APC
C9258	Injection, telavancin, 10 mg	G	9258
C9259	Injection, pralatrexate, 1 mg	G	9259
C9260	Injection, ofatumumab, 10 mg	G	9260
C9261	Injection, ustekinumab, 1 mg	G	9261
C9262*	Fludarabine phosphate, oral, 1 mg	G	9262
C9263	Injection, ecallantide, 1 mg	G	9263
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, qualitative or semiquantitative, multiple-step method, HIV-1 or HIV-2, screening	A	NA
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening	A	NA
G0435	Infectious agent detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening	A	NA
G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)	A	NA
G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for: respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration	E	NA

*Level II HCPCS code C9262 was deleted June 30, 2010, and replaced with HCPCS code Q2025 effective July 1, 2010.

Through the July 2010 OPPS quarterly update CR (Transmittal 1980, Change Request 6996, dated June 4, 2010), which included HCPCS codes that were made effective July 1, 2010, we allowed separate payment for 8 of the 22 new Level II HCPCS codes. Specifically, as displayed in Table 14, we provided separate payment for HCPCS codes C9264 (Injection, tocilizumab, 1 mg), C9265 (Injection, romidepsin, 1 mg), C9266 (Injection, collagenase clostridium histolyticum, 0.1 mg), C9267 (Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO), C9268 (Capsaicin, patch, 10cm2), C9367 (Skin substitute, Endoform Dermal Template, per square centimeter), Q2025 (Fludarabine phosphate oral, 10mg), and C9800 (Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies).

We note that HCPCS code C9262 was made effective April 1, 2010, and deleted June 30, 2010, when it was replaced with HCPCS code Q2025. As discussed in section V.A.3. of this proposed rule, pass-through status began for this drug on April 1, 2010. Because HCPCS code Q2025 describes the same drug as HCPCS code C9262, we are continuing its pass-through status and assigning the HCPCS Q-code to the same APC and status indicator as its predecessor HCPCS C-code, as shown in Table 14. Specifically, HCPCS code Q2025 is assigned to APC 9262 and status indicator "G."

Of the 12 HCPCS codes that were made effective July 1, 2010, we did not recognize for separate payment four HCPCS codes. Specifically, we did not recognize HCPCS codes G0428 (Collagen Meniscus Implant procedure for filling meniscal defects (*e.g.,* CMI, collagen scaffold, Menaflex)), G0429 (Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (*e.g.,* as a result of highly active antiretroviral therapy), Q2026 (Injection, Radiesse, 0.1 ml), and Q2027 (Injection, Sculptra, 0.1 ml). Under the hospital OPPS, we have assigned HCPCS code G0428 to status indicator "E" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) because this service is nationally noncovered by Medicare. Further, because HCPCS code C9800 describes both the injection procedure and the dermal filler supplies, we have assigned HCPCS codes G0429, Q2026, and Q2027 to status indicator "B" to indicate that these HCPCS codes are not recognized by OPPS when submitted on an outpatient hospital Part B bill type 12x and 13x. Specifically, hospitals must report HCPCS code C9800 to report the dermal filler supplies and the dermal filler injection procedure. Under the hospital OPPS, we have assigned HCPCS code C9800 to APC 0135 with a status indicator "T". We refer readers to Table 14 below for a complete list of the HCPCS codes that were made effective July 1, 2010.

TABLE 14.—NEW LEVEL II HCPCS CODES IMPLEMENTED IN JULY 2010

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 Status Indicator	Proposed CY 2011 APC	Proposed CY 2011 Payment Rate
C9264	Injection, tocilizumab, 1 mg	G	9264	$3.52
C9265	Injection, romidepsin, 1 mg	G	9265	$223.78
C9266	Injection, collagenase clostridium histolyticum, 0.1 mg	G	9266	$382.78
C9267	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	G	9267	$122.07
C9268	Capsaicin, patch, 10cm2	G	9268	$11.18
C9367	Skin substitute, Endoform Dermal Template, per square centimeter	G	9367	$4.35
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	T	0135	$298.46
G0428	Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)	E	NA	NA
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)	B	NA	NA
Q2025*	Fludarabine phosphate oral, 10mg	G	9262	$8.18
Q2026	Injection, Radiesse, 0.1 ml	B	NA	NA
Q2027	Injection, Sculptra, 0.1 ml	B	NA	NA

*Level II HCPCS code Q2025 was previously described under HCPCS code C9262.

For CY 2011, we are proposing to continue our established policy of recognizing Category I CPT vaccine codes for which FDA approval is imminent and Category III CPT codes that the AMA releases in January of each year for implementation in July through the OPPS quarterly update process. Under the OPPS, Category I vaccine codes and Category III CPT codes that are released on the AMA Web site in January are made effective in July of the same year through the July quarterly update CR, consistent with the AMA's implementation date for the codes. Through the July 2010 OPPS quarterly update CR, we allow separate payment for 10 of the 11 new Category III CPT codes effective July 1, 2010. Specifically, as displayed in Table 15 below, we allow separate payment for CPT codes 0223T (Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; single, with interpretation and report), 0224T (Multiple, including serial trended analysis and limited reprogramming of device parameter—AV or VV delays only, with interpretation and report), 0225T (Multiple, including serial trended analysis and limited reprogramming of device parameter—AV and VV delays, with interpretation and report), 0226T (Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed), 0227T (Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)), 0228T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level), 0229T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)), 0230T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level), 0231T (Injection(s),

anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)), and 0232T (Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed). We note that CMS has issued a noncoverage determination (NCD) specifically for chronic, non-healing cutaneous wounds and acute surgical wounds when the autologous platelet rich plasma (PRP) is applied directly to the closed incision or for dehiscent wounds. Category III CPT code 0232T has been assigned to APC 0340 to provide a payment amount when payment is appropriate, both under the NCD provisions and any local coverage determinations. Under the hospital OPPS, Category III CPT code 0233T (Skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy) has been assigned to status indicator "A" and hospital payment for this test will be made under the MPFS.

Further, CMS does not recognize the four new H1N1 Category I CPT vaccine codes that are effective on July 1, 2010, for separate payment under the OPPS because we already recognize an existing HCPCS G-code for reporting the H1N1 vaccine, specifically HCPCS code G9142 (Influenza a (h1n1) vaccine, any route of administration), which is effective September 1, 2009. We have assigned HCPCS code G9142 to status indicator "E" under the OPPS because the vaccine is expected to be free. Consequently, Category I CPT vaccine codes 90664 (Influenza virus vaccine, pandemic formulation, live, for intranasal use), 90666 (Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use), 90667 (Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use), and 90668 (Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use), are assigned to status indicator "E" (Not paid under OPPS or any other Medicare payment system). These codes and their status indicators are listed in Table 15 below.

BILLING CODE 4120–01–P

TABLE 15.—CATEGORY I VACCINE AND CATEGORY III CPT CODES IMPLEMENTED IN JULY 2010

CY 2010 CPT Code	CY 2010 Long Descriptor	Proposed CY 2011 Status Indicator	Proposed CY 2011 APC	Proposed CY 2011 Payment Rate
0223T	Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; single, with interpretation and report	S	0099	$26.49
0224T	Multiple, including serial trended analysis and limited reprogramming of device parameter - AV or VV delays only, with interpretation and report	S	0690	$23.57
0225T	Multiple, including serial trended analysis and limited reprogramming of device parameter - AV and VV delays, with interpretation and report	S	0690	$23.57
0226T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	X	0340	$45.00
0227T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	T	0146	$388.30
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level	T	0207	$484.15
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)	T	0206	$250.28
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level	T	0207	$484.15
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)	T	0206	$250.28
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	X	0340	$45.00
0233T	Skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy	A	NA	NA
90664	Influenza virus vaccine, pandemic formulation, live, for intranasal use	E	NA	NA
90666	Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use	E	NA	NA
90667	Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use	E	NA	NA
90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use	E	NA	NA

BILLING CODE 4120–01–C

For CY 2011, we are soliciting public comments on the proposed status indicators and the proposed APC assignments and payment rates, if applicable, for the Level II HCPCS codes and the Category I vaccine codes and Category III CPT codes that are newly recognized in April or July 2010 through the respective OPPS quarterly update CRs. These codes are listed in Tables 13, 14, and 15 of this proposed rule. We are proposing to finalize their status indicators and their APC assignments and payment rates, if applicable, in the CY 2011 OPPS/ASC final rule with comment period. Because the July 2010 OPPS quarterly update CR is issued close to the publication of this proposed rule, the Level II HCPCS codes and the Category I vaccine and Category III CPT codes implemented through the July 2010 OPPS quarterly update CR could not be included in Addendum B to this proposed rule, but these codes are listed in Tables 14 and 15, respectively. We are proposing to incorporate them into Addendum B to the CY 2011 OPPS/ASC final rule with comment period, which is consistent with our annual OPPS update policy. The Level II HCPCS codes implemented or modified through the April 2010 OPPS update CR and displayed in Table 13 are included in Addendum B to this proposed rule, where their proposed CY 2011 payment rates also are shown.

2. Proposed Process for New Level II HCPCS Codes and Category I and Category III CPT Codes for Which We Will Be Soliciting Public Comments on the CY 2011 OPPS/ASC Final Rule With Comment Period

As has been our practice in the past, we incorporate those new Category I and III CPT codes and new Level II HCPCS codes that are effective January 1 in the final rule with comment period updating the OPPS for the following calendar year. These codes are released to the public via the CMS HCPCS (for Level II HCPCS codes) and AMA Web sites (for CPT codes), and also through the January OPPS quarterly update CRs. In the past, we also have released new Level II HCPCS codes that are effective October 1 through the October OPPS quarterly update CRs and incorporated these new codes in the final rule with comment period updating the OPPS for the following calendar year. All of these codes are flagged with comment indicator "NI" in Addendum B to the OPPS/ASC final rule with comment period to indicate that we are assigning them an interim payment status which is subject to public comment. Specifically, the status indicator and the APC assignment, and payment rate, if applicable, for all such codes flagged with comment indicator "NI" are open to public comment in the final rule with comment period, and we respond to these comments in the OPPS/ASC final rule with comment period for the next calendar year's OPPS/ASC update. We are proposing to continue this process for CY 2011. Specifically, for CY 2011, we are proposing to include in Addendum B to the CY 2011 OPPS/ASC final rule with comment period the new Category I and III CPT codes effective January 1, 2011 (including those Category I vaccine and Category III CPT codes that were released by the AMA in July 2010) that would be incorporated in the January 2011 OPPS quarterly update CR and the new Level II HCPCS codes, effective October 1, 2010, or January 1, 2011, that would be released by CMS in its October 2010 and January 2011 OPPS quarterly update CRs. These codes would be flagged with comment indicator "NI" in Addendum B to the CY 2011 OPPS/ASC final rule with comment period to indicate that we have assigned them an interim OPPS payment status. Their status indicators and their APC assignments and payment rates, if applicable, would be open to public comment in the CY 2011 OPPS/ASC final rule with comment period and would be finalized in the CY 2012 OPPS/ASC final rule with comment period.

B. Proposed OPPS Changes—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 department services. Section 1833(t)(2)(B) of the Act provides that the Secretary may establish groups of covered OPD services within this classification system, so that services classified within each group are comparable clinically and with respect to the use of resources (and so that an implantable item is classified to the group that includes the services to which the item relates). In accordance with these provisions, we developed a grouping classification system, referred to as APCs, as set forth in § 419.31 of the regulations. We use Level I and Level II HCPCS codes and descriptors to identify and group the services within each APC. The APCs are organized such that each group is homogeneous both clinically and in terms of resource use. Using this classification system, we have established distinct groups of similar services, as well as medical visits. We also have developed separate APC groups for certain medical devices, drugs, biologicals, therapeutic radiopharmaceuticals, and brachytherapy devices.

We have packaged into payment for each procedure or service within an APC group the costs associated with those items or services that are directly related to and supportive of performing the main independent procedures or furnishing the services. Therefore, we do not make separate payment for these 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) observation services; (4) anesthesia; (5) medical/surgical supplies; (6) pharmaceuticals (other than those for which separate payment may be allowed under the provisions discussed in section V. of this proposed rule); (7) incidental services such as venipuncture; and (8) guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, and contrast media. Further discussion of packaged services is included in section II.A.3. of this proposed rule.

In CY 2008, we implemented composite APCs to provide a single payment for groups of services that are typically performed together during a single clinical encounter and that result in the provision of a complete service (72 FR 66650 through 66652). Under CY 2010 OPPS policy, we provide composite APC payment for certain extended assessment and management services, low dose rate (LDR) prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, mental health services, and multiple imaging services. Further discussion of composite APCs is included in section II.A.2.e. of this proposed rule.

Under the OPPS, we generally pay for hospital outpatient services on a rate-per-service basis, where the service may be reported with one or more HCPCS codes. Payment varies according to the APC group to which the independent service or combination of services is assigned. Each APC weight represents the hospital median cost of the services included in that APC relative to the hospital median cost of the services included in APC 0606 (Level 3 Hospital Clinic Visits). The APC weights are scaled to APC 0606 because it is the middle level hospital clinic visit APC (that is, where the Level 3 hospital clinic visit CPT code of five levels of hospital clinic visits is assigned), and because middle level hospital clinic visits are among the most frequently

furnished services in the hospital outpatient setting.

Section 1833(t)(9)(A) of the Act requires the Secretary to review not less often than annually and revise the groups, the relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, 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, also requires the Secretary, beginning in CY 2001, to consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the APC groups and the relative payment weights (the APC Panel recommendations for specific services for the CY 2011 OPPS and our responses to them are discussed in the relevant specific sections throughout this proposed rule).

Finally, 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 cost (or mean cost as elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) 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 (but the Secretary may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act).

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 cost 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. We are proposing to make exceptions to this limit on the variation of costs within each APC group in unusual cases, such as low-volume items and services for CY 2011.

During the APC Panel's February 2010 meeting, we presented median cost and utilization data for services furnished during the period of January 1, 2009 through September 30, 2009, 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 2011 are contained mainly in sections III.C. and III.D. of this proposed rule.

In addition to the assignment of specific services to APCs that we discussed with the APC Panel, we also identified APCs with 2 times violations that were not specifically discussed with the APC Panel but for which we are proposing changes to their HCPCS codes' APC assignments in Addendum B to this proposed rule. In these cases, to eliminate a 2 times violation or to improve clinical and resource homogeneity, we are proposing to reassign the codes to APCs that contain services that are similar with regard to both their clinical and resource characteristics. We also are proposing to rename existing APCs or create new clinical APCs to complement proposed HCPCS code reassignments. In many cases, the proposed HCPCS code reassignments and associated APC reconfigurations for CY 2011 included in this proposed rule are related to changes in median costs of services that were observed in the CY 2009 claims data newly available for CY 2011 ratesetting. We also are proposing changes to the status indicators for some codes that are not specifically and separately discussed in this proposed rule. In these cases, we are proposing to change the status indicators for some codes because we believe that another status indicator would more accurately describe their payment status from an OPPS perspective based on the policies that we are proposing for CY 2011.

Addendum B to this proposed rule identifies with comment indicator "CH" those HCPCS codes for which we are proposing a change to the APC assignment or status indicator that were initially assigned in the April 2010 Addendum B update (via Transmittal 1924, Change Request 6857, dated February 26, 2010).

3. Proposed Exceptions to the 2 Times Rule

As discussed earlier, we may make exceptions to the 2 times limit on the variation of costs within each APC group in unusual cases such as low-volume items and services. Taking into account the APC changes that we are proposing for CY 2011 based on the APC Panel recommendations discussed mainly in sections III.C. and III.D. of this proposed rule, the other proposed changes to status indicators and APC assignments as identified in Addendum B to this proposed rule, and the use of CY 2009 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 outpatient setting
- Frequency of service (volume)
- Opportunity for upcoding and code fragments.

For a detailed discussion of these criteria, we refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18457 and 18458).

Table 16 of this proposed rule lists 17 APCs that we are proposing to exempt from the 2 times rule for CY 2011 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 CY 2009 claims data used to determine the APC payment rates that we are proposing for CY 2011. The median costs for hospital outpatient services for these and all other APCs that were used in the development of this proposed rule can be found on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/01_overview.asp.*

TABLE 16.—PROPOSED APC EXCEPTIONS TO THE 2 TIMES RULE FOR CY 2011

Proposed CY 2011 APC	Proposed CY 2011 APC Title
0051	Level III Musculoskeletal Procedures Except Hand and Foot
0057	Bunion Procedures
0058	Level I Strapping and Cast Application
0080	Diagnostic Cardiac Catheterization
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices
0138	Level II Closed Treatment Fracture Finger/Toe/Trunk
0142	Small Intestine Endoscopy
0173	Level II Partial Hospitalization (4 or more services)
0235	Level I Posterior Segment Eye Procedures
0245	Level I Cataract Procedures without IOL Insert
0303	Treatment Device Construction
0325	Group Psychotherapy
0340	Minor Ancillary Procedures
0344	Level IV Pathology
0432	Health and Behavior Services
0604	Level 1 Hospital Clinic Visits
0664	Level I Proton Beam Radiation Therapy

C. New Technology APCs

1. Background

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 2 years if sufficient data upon which to base a decision for reassignment have not been collected.

We note that the cost bands for New Technology APCs range from $0 to $50 in increments of $10, from $50 to $100 in increments of $50, from $100 through $2,000 in increments of $100, and from $2,000 through $10,000 in increments of $500. These cost bands identify the APCs to which new technology procedures and services with estimated service costs that fall within those cost bands are assigned under the OPPS. Payment for each APC is made at the mid-point of the APC's assigned cost band. For example, payment for New Technology APC 1507 (New Technology—Level VII ($500–$600)) is made at $550. Currently, there are 82 New Technology APCs, ranging from the lowest cost band assigned to APC 1491 (New Technology—Level IA ($0–$10)) through the highest cost band assigned to APC 1574 (New Technology—Level XXXVII ($9,500–$10,000). In CY 2004 (68 FR 63416), we last restructured the New Technology APCs to make the cost intervals more consistent across payment levels and refined the cost bands for these APCs to retain two parallel sets of New Technology APCs, one set with a status indicator of "S" (Significant Procedures, Not Discounted when Multiple. Paid under OPPS; separate APC payment) and the other set with a status indicator of "T" (Significant Procedure, Multiple Reduction Applies. Paid under OPPS; separate APC payment). These current New Technology APC configurations allow us to price new technology services more appropriately and consistently.

Every year we receive many requests for higher payment amounts under our New Technology APCs for specific procedures under the OPPS because they require the use of expensive equipment. We again 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 increases are limited to the hospital inpatient market basket. We believe that our payment rates generally reflect the costs that are associated with providing care to Medicare beneficiaries in cost-efficient settings, and we believe that our rates are adequate to ensure access to services.

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, parties request that Medicare make higher payment amounts under our New Technology APCs for new procedures in that transitional phase. These requests, and their accompanying estimates for expected total patient utilization, often reflect very low rates of patient use of expensive equipment, 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 in a particular circumstance, 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, including those made through New Technology APCS, 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 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. Proposed Movement of Procedures From New Technology APCs to Clinical APCs

As we explained in the November 30, 2001 final rule (66 FR 59902), we generally keep a procedure in the New Technology APC to which it is initially assigned until we have collected sufficient data to enable us to move the procedure to a clinically appropriate APC. However, in cases where we find that our original New Technology APC assignment was based on inaccurate or inadequate information (although it was the best information available at the time), or where the New Technology APCs are restructured, we may, based on more recent resource utilization information (including claims data) or the availability of refined New Technology APC cost bands, reassign the procedure or service to a different New Technology APC that most appropriately reflects its cost.

Consistent with our current policy, for CY 2011, we are proposing to retain services within New Technology APC groups until we gather sufficient data to enable us to assign the service to a clinically appropriate APC. The flexibility associated with this policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 2 years if sufficient data upon which to base a decision for reassignment have not been collected.

Table 17 below lists the HCPCS codes and associated status indicators that we are proposing to reassign from a New Technology APC to a clinically appropriate APC or to a different New Technology APC for CY 2011. For CY 2010, there are four services described by a HCPCS G-code receiving payment through a New Technology APC. Specifically, HCPCS code G0416 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1–20 specimens), is assigned to New Technology APC 1505 (New Technology—Level V ($300–$400)); HCPCS code G0417 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21–40 specimens), is assigned to New Technology APC 1507 (New Technology—Level VII ($500–$600)); G0418 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41–60 specimens), is assigned to New Technology APC 1511 (New Technology—Level XI ($900—$1000)); and HCPCS code G0419 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens), is assigned to New Technology APC 1513 (New Technology—Level XIII ($1100–$1200)). Based on the CY 2009 OPPS claims data available for this proposed rule, we believe that we have sufficient claims data to propose reassignment of HCPCS codes G0416 and G0417. Specifically, for HCPCS code G0416, our claims data show a median cost of approximately $113 based on 251 single claims out of 1,373 total claims for this service in CY 2009. For HCPCS code G0417, our claims data show a median cost of approximately $489 based on 5 single claims out of 135 total claims. We discuss our identification of single procedure claims, including "pseudo" single procedure claims, for ratesetting in section II.A.2. of this proposed rule. We believe we have sufficient claims data to propose the reassignment of HCPCS G-codes G0416 and G0417 to more appropriate APCs for CY 2011. Therefore, for CY 2011, we are proposing to reassign these procedures to more appropriate APCs. Specifically, we are proposing to reassign HCPCS G-code G0416 from New Technology APC 1505 to clinical APC 0661 (Level V Pathology), which has an APC median cost of approximately $165, and HCPCS G-code G0417 from New Technology APC 1507 (New Technology—Level VII ($500 to $600)) to New Technology APC 1506 (New Technology—Level VI ($400–$500)). We believe that HCPCS G-code G0416 is comparable clinically and with respect to the use of resources as other pathology services currently assigned to APC 0661. We also believe that HCPCS G-code G0417 would be more appropriately placed in New Technology APC 1506 in light of the median cost data available to us. Specifically, the HCPCS median cost of approximately $489 for HCPCS code G0417 closely aligns with the APC median cost of approximately $489 for APC 1506. We believe that HCPCS code G0417 would be more appropriately placed in APC 1506 based on clinical and resource considerations. These services and their proposed APC assignments are displayed in Table 17 below.

For CY 2011, we are proposing to continue the New Technology APC assignments for HCPCS G-codes G0418 and G0419, which is based on our understanding of the clinical and cost characteristics of the procedures described by these HCPCS codes. We do not believe we have enough claims data to assign these codes to a different APC. Specifically, our claims data show no single claims, out of 29 total claims, for HCPCS code G0418. Similarly, our data show no single claims, out of 3 total claims, for HCPCS code G0419. While we believe that these services always will be low volume, given the number of specimens being collected, we believe that we should continue their New Technology payments for another year to see if more claims data become available for HCPCS codes G0418 and G0419. Specifically, we are proposing to continue to assign HCPCS G-code G0418 to New Technology APC 1511 (New Technology—Level XI ($900–$1,000)) and HCPCS G-code G0419 to New Technology APC 1513 (New Technology—Level XIII ($1,100–$1,200)).

TABLE 17.—PROPOSED CY 2011 REASSIGNMENT OF NEW TECHNOLOGY PROCEDURES

CY 2010 HCPCS Code	CY 2010 Short Descriptor	CY 2010 SI	CY 2010 APC	Proposed CY 2011 SI	Proposed CY 2011 APC
G0416	Sat biopsy prostate 1-20 spc	S	1505	X	0661
G0417	Sat biopsy prostate 21-40	S	1507	S	1506

D. Proposed OPPS APC-Specific Policy: Skin Repair (APCs 0134 and 0135)

At the August 2009 APC Panel meeting, one public presenter requested that the APC Panel recommend that CMS reassign the Apligraf application CPT codes, specifically CPT codes 15340 (Tissue cultured allogeneic skin substitute; first 25 sq cm or less) and 15341 (Tissue cultured allogeneic skin substitute; each additional 25 sq cm, or part thereof), from APC 0134 (Level II Skin Repair) to APC 0135 (Level III Skin Repair). The same presenter requested that CMS continue to assign the Dermagraft application CPT codes, specifically CPT codes 15365 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children) and 15366 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof), to APC 0134. The public presenter believed that the CY 2010 proposal to continue to assign both the Apligraf and the Dermagraft application CPT codes to APC 0134 would create a financial incentive favoring the Dermagraft application. Specifically, the presenter explained that CPT instructions allow the separate reporting of the CPT codes for site preparation and debridement when Dermagraft is applied, while the CPT instructions for Apligraf application codes specify that site preparation and debridement cannot be separately reported. The presenter believed that this reporting difference and the resulting expected differences in the associated application procedure costs could be addressed by assigning the Apligraf application CPT codes to a higher paying APC than the Dermagraft application CPT codes, instead of the same APC as CMS proposed for CY 2010.

During the discussion, the APC Panel members were provided with the historical information on the coding and APC assignments for the skin substitute application procedures assigned to APCs 0134 and 0135. Specifically, the Apligraf application CPT codes 15340 and 15341, the Dermagraft application CPT codes 15365 and 15366, as well as the Oasis application CPT codes 15430 (Acellular xenograft implant; first 100 sq cm or less, or 1% of body area of infants and children) and 15431 (Acellular xenograft implant; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof), were at one time assigned to the same APC level (Level II Skin Repair). However, because of violations of the two times rule, CMS reconfigured the skin repair APCs and reassigned the Oasis application CPT codes 15430 and 15431 to APC 0135 (Level III Skin Repair) in CY 2008.

At the August 2009 APC Panel meeting, panel members debated whether the differences in sizes in each product's application CPT codes and the ability to bill separately for site preparation and debridement for Dermagraft application required different APC placement for any of the skin substitute application codes. We note that the long descriptors for the Apligraf application CPT codes 15340 and 15341 are scaled to "25 sq cm," whereas the Oasis application CPT codes 15430 and 15431 and the Dermagraft application CPT codes 15365 and 15366 are scaled to "100 sq cm." After review of median cost data from the CY 2008 hospital outpatient claims available at that time (those processed from January 1, 2008 through December 31, 2009), the APC Panel recommended that CMS continue to assign all six skin substitute application CPT codes to their existing APCs for CY 2010. In addition, because of the variable sizes associated with the skin repair application CPT codes, the Panel requested that CMS provide data at the next Panel meeting on the frequency of primary and add-on CPT codes billed for the Apligraf, Oasis, and Dermagraft applications in order to assess the variability in billing for the application of these products. In addition, because of the CPT instructions allowing site preparation and debridement to be reported separately only for the Dermagraft application, the Panel requested median cost data for site preparation and debridement.

We accepted the APC Panel's recommendation to continue to assign the skin repair CPT codes for the application of Apligraf, Oasis, and Dermagraft skin substitutes to the same procedural APCs for CY 2010 as their CY 2009 assignments. As a result, we continued to assign the Apligraf application CPT codes 15340 and 15341 and the Dermagraft application CPT codes 15365 and 15366 to APC 0134 and assigned the Oasis application CPT codes 15430 and 15431 to APC 0135 for CY 2010.

At the February 2010 APC Panel meeting, CMS presented the results of the data requested at the August 2009 meeting to the APC Panel. In response to data on the frequency of primary and add-on CPT codes, based on our analysis of the available CY 2009 hospital outpatient claims data on frequency of primary and add-on CPT codes billed for the Apligraf, Oasis, and Dermagraft applications (claims processed from January 1 through September 30, 2009), we found that hospitals report the application of Apligraf with only the primary code (CPT code 15340) on 77 percent of claims, while the add-on CPT code 15341 is billed in addition to the primary code on another 23 percent of claims. Specifically, our data showed that for the Apligraf application, there were a total of 8,614 claims with only the primary CPT code 15340 reported, and 2,545 claims with the add-on CPT code 15341 also reported on the same date of service. We note that each unit of the add-on CPT code is paid at 50 percent of the payment for the primary code in addition to the full payment for the primary code. We also found in our analysis that, on claims with the Dermagraft and Oasis application CPT codes, hospitals report the primary code only in approximately 98 to 99 percent of the cases. In addition, in response to the request for data for site preparation and debridement that may be reported

separately for the Dermagraft application, we found that approximately 87 percent of procedures for the application of Dermagraft were reported without debridement or site preparation on the same day. Similarly, we found that the Apligraf and Oasis procedures were rarely reported with the site preparation or debridement CPT procedure codes on the same day. Specifically, we found that the CPT procedure code for the application of Apligraf was reported without site preparation or debridement in approximately 94 percent of these cases, and that the CPT procedure code for application of Oasis was reported without site preparation or debridement in approximately 95 percent of these cases. Our data analysis also showed that the CPT median costs for the Apligraf application CPT code 15340 and the Dermagraft application CPT code 15365 are very similar. Specifically, the CPT code-specific median cost of CPT code 15340 is approximately $234 for the Apligraf application and approximately $237 for CPT code 15365 for the Dermagraft application. In contrast, the CPT median cost for the Oasis application primary CPT code 15430 of approximately $299 is higher.

At the February 2010 APC Panel meeting, a public presenter again requested that the APC Panel recommend that CMS reassign the Apligraf application CPT codes 15340 and 15341 from APC 0134 to APC 0135. The presenter indicated that the additional payment for site preparation and debridement procedures that may be reported separately with the Dermagraft application can significantly affect the total payment for the procedure. The presenter also provided data on the use of each product in relation to the size of the wounds treated, and concluded that the size of the wound treated does not affect the resources used. After further review of the available CY 2009 hospital outpatient claims data, the APC Panel recommended that CPT codes 15340 and 15341 remain in APC 0134.

We are accepting the recommendation of the APC Panel and are proposing to continue to assign the CPT skin repair codes for the application of Apligraf, Dermagraft, and Oasis skin substitutes to the same procedural APCs as their CY 2010 assignments for CY 2011. We also are proposing to continue to pay separately for the Apligraf, Dermagraft, and Oasis products themselves in CY 2011. Specifically, we are proposing to continue to assign the Apligraf application CPT codes 15340 and 15341 and the Dermagraft application CPT codes 15365 and 15366 to APC 0134, with a proposed APC median cost of approximately $222. We are proposing to continue to assign the Oasis application CPT codes 15430 and 15431 to APC 0135, with a proposed APC median cost of approximately $325.

For CY 2011, we also are proposing to create two new Level II HCPCS G-codes to report the application of Apligraf or Dermagraft specific to the lower extremities in order to provide appropriate and consistent payment for these services as they are commonly furnished, consistent with the CY 2011 proposal for the MPFS. (We refer readers to the CY 2011 MPFS proposed rule for additional information regarding the MPFS proposal.) The proposed HCPCS codes are: GXXX1 (Application of tissue cultured allogeneic skin substitute or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; first 25 sq cm or less); and GXXX2 (Application of tissue cultured allogeneic skin or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; each additional 25 sq cm). As indicated in the HCPCS G-code descriptors, these codes would not allow separate reporting of CPT codes for site preparation or debridement. We believe the descriptors of these proposed HCPCS G-codes more specifically reflect the characteristics of the application of Apligraf or Dermagraft to the lower limb so that reporting would result in more accurate cost data for OPPS ratesetting and, ultimately, more appropriate payment. Consistent with the proposed CY 2011 APC assignment for the Apligraf and Dermagraft application CPT codes, we are proposing to assign new HCPCS codes GXXX1 and GXXX2 to APC 0134, with a proposed APC median cost of approximately $222. We are specifically interested in public comment on the appropriateness of recognizing these proposed new HCPCS G-codes under the OPPS and their proposed APC assignments.

IV. Proposed OPPS Payment for Devices

A. Pass-Through Payments for Devices

1. Expiration of Transitional Pass-Through Payments for Certain Devices

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 pass-through payment eligibility period begins with the first date on which transitional pass-through payments may be made for any medical device that is described by the category. We may establish a new device category for pass-through payment in any quarter. Under our established policy, we base the pass-through status expiration dates for the category codes on the date on which a category is in effect. The date on which a category is in effect is the first date on which pass-through payment may be made for any medical device that is described by such category. We propose and finalize the dates for expiration of pass-through status for device categories as part of the OPPS annual update.

We also have an established policy to package the costs of the devices that are no longer eligible for pass-through payments into the costs of the procedures with which the devices are reported in the claims data used to set the payment rates (67 FR 66763). 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.

There currently are no device categories eligible for pass-through payment, and there are no categories for which we would propose expiration of pass-through status in CY 2011. If we create new device categories for pass-through payment status during the remainder of CY 2010 or during CY 2011, we will propose future expiration dates in accordance with the statutory requirement that they be eligible for pass-through payments for at least 2, but not more than 3, years from the date on which pass-through payment for any medical device described by the category may first be made.

2. Proposed Provisions for Reducing Transitional Pass-Through Payments to Offset Costs Packaged Into APC Groups

a. Background

We have an established policy 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). We deduct from the pass-through payments for identified device categories eligible for pass-through payments an amount that reflects the portion of the APC payment amount that we determine is associated with the cost of the device, defined as the device APC offset amount, as required by section 1833(t)(6)(D)(ii) of the Act. We have consistently employed an established methodology 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, using claims data from the period used for the most

recent recalibration of the APC rates (72 FR 66751 through 66752). We establish and update the applicable device APC offset amounts for eligible pass-through device categories through the transmittals that implement the quarterly OPPS updates.

We currently have published a list of all procedural APCs with the CY 2010 portions (both percentages and dollar amounts) of the APC payment amounts that we determine are associated with the cost of devices, on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/01_overview.asp.* The dollar amounts are used as the device APC offset amounts. In addition, in accordance with our established practice, the device APC offset amounts in a related APC are used in order to evaluate whether the cost of a device in an application for a new device category for pass-through payment is not insignificant in relation to the APC payment amount for the service related to the category of devices, as specified in our regulations at § 419.66(d).

As of CY 2009, the costs of implantable biologicals without pass-through status are packaged into the payment for the procedures in which they are inserted or implanted because implantable biologicals without pass-through status are not separately paid (73 FR 68633 through 68636). For CY 2010, we finalized a new policy to specify that the pass-through evaluation process and pass-through payment methodology for implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) and that are newly approved for pass-through status beginning on or after January 1, 2010, be the device pass-through process and payment methodology only. As a result, for CY 2010, we included implantable biologicals in our calculation of the device APC offset amounts (74 FR 60476). We calculated and set the device APC offset amount for a newly established device pass-through category, which could include a newly eligible implantable biological, beginning in CY 2010 using the same methodology we have historically used to calculate and set device APC offset amounts for device categories eligible for pass-through payment (72 FR 66751 through 66752), with one modification. Because implantable biologicals are considered devices rather than drugs for purposes of pass-through evaluation and payment under our established policy, the device APC offset amounts include the costs of implantable biologicals. For CY 2010, we also finalized a policy to utilize the revised device APC offset amounts to evaluate whether the cost of an implantable biological in an application for a new device category for pass-through payment is not insignificant in relation to the APC payment amount for the service related to the category of devices. Further, for CY 2010, we also no longer used the "policy-packaged" drug APC offset amounts for evaluating the cost significance of implantable biological pass-through applications under review and for setting the APC offset amounts that would apply to pass-through payment for those implantable biologicals, effective for new pass-through status determinations beginning in CY 2010 (74 FR 60463).

b. Proposed Policy

For CY 2011, we are proposing to continue our policy that the pass-through evaluation process and pass-through payment methodology for implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) and that are newly approved for pass-through status beginning on or after January 1, 2010, be the device pass-through process and payment methodology only. The rationale for this policy is provided in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60471 through 60477). We also are proposing to continue our established policies for calculating and setting the device APC offset amounts for each device category eligible for pass-through payment. We also are proposing to continue to review each new device category on a case-by-case basis to determine whether device costs associated with the new category are already packaged into the existing APC structure. If device costs packaged into the existing APC structure are associated with the new category, we would deduct the device APC offset amount from the pass-through payment for the device category. As stated earlier, these device APC offset amounts also would be used in order to evaluate whether the cost of a device in an application for a new device category for pass-through payment is not insignificant in relation to the APC payment amount for the service related to the category of devices (§ 419.66(d)).

We also are proposing to continue our policy established in CY 2010 to include implantable biologicals in our calculation of the device APC offset amounts. In addition, we are proposing to continue to calculate and set any device APC offset amount for a new device pass-through category that includes a newly eligible implantable biological beginning in CY 2011 using the same methodology we have historically used to calculate and set device APC offset amounts for device categories eligible for pass-through payment, and to include the costs of implantable biologicals in the calculation of the device APC offset amounts, as we did for CY 2010.

In addition, we are proposing to update, on the CMS Web site at *http://www.cms.gov/HospitalOutpatientPPS,* the list of all procedural APCs with the final CY 2011 portions of the APC payment amounts that we determine are associated with the cost of devices so that this information is available for use by the public in developing potential CY 2011 device pass-through payment applications and by CMS in reviewing those applications.

In summary, for CY 2011, consistent with the policy established for CY 2010, we are proposing to continue the following policies related to pass-through payment for devices: (1) Treating implantable biologicals, that are surgically inserted or implanted (through a surgical incision or a natural orifice) and that are newly approved for pass-through status on or after January 1, 2010, as devices for purposes of the OPPS pass-through evaluation process and payment methodology; (2) including implantable biologicals in calculating the device APC offset amounts; (3) using the device APC offset amounts to evaluate whether the cost of a device (defined to include implantable biologicals) in an application for a new device category for pass-through payment is not insignificant in relation to the APC payment amount for the service related to the category of devices; and (4) reducing device pass-through payments based on device costs already included in the associated procedural APCs, when we determine that device costs associated with the new category are already packaged into the existing APC structure.

B. Proposed Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices

1. Background

In recent years, there have been several field actions on and recalls of medical devices as a result of implantable device failures. In many of these cases, the manufacturers have offered devices without cost to the hospital or with credit for the device being replaced if the patient required a more expensive device. In order to ensure that payment rates for procedures involving devices reflect only the full costs of those devices, our

standard rate-setting methodology for device-dependent APCs uses only claims that contain the correct device code for the procedure, do not contain token charges, do not contain the "FB" modifier signifying that the device was furnished without cost or with a full credit, and do not contain the "FC" modifier signifying that the device was furnished with partial credit. As discussed in section II.A.2.d.(1) of this proposed rule, we are proposing to continue to use our standard rate-setting methodology for device-dependent APCs for CY 2011.

To ensure equitable payment when the hospital receives a device without cost or with full credit, in CY 2007 we implemented a policy to reduce the payment for specified device-dependent APCs by the estimated portion of the APC payment attributable to device costs (that is, the device offset) when the hospital receives a specified device at no cost or with full credit (71 FR 68071 through 68077). Hospitals are instructed to report no cost/full credit cases using the "FB" modifier on the line with the procedure code in which the no cost/full credit device is used. In cases in which the device is furnished without cost or with full credit, the hospital is instructed to report a token device charge of less than $1.01. 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) with a full credit for the device being replaced, the hospital is instructed to report as the device charge the difference between its usual charge for the device being implanted and its usual charge for the device for which it received full credit. In CY 2008, we expanded this payment adjustment policy to include cases in which hospitals receive partial credit of 50 percent or more of the cost of a specified device. Hospitals are instructed to append the "FC" modifier to the procedure code that reports the service provided to furnish the device when they receive a partial credit of 50 percent or more of the cost of the new device. We reduce the OPPS payment for the implantation procedure by 100 percent of the device offset for no cost/full credit cases when both a specified device code is present on the claim and the procedure code maps to a specified APC. Payment for the implantation procedure is reduced by 50 percent of the device offset for partial credit cases when both a specified device code is present on the claim and the procedure code maps to a specified APC. Beneficiary copayment is based on the reduced payment amount when either the "FB" or the "FC" modifier is billed and the procedure and device codes appear on the lists of procedures and devices to which this policy applies. We refer readers to the CY 2008 OPPS/ASC final rule with comment period for more background information on the "FB" and "FC" payment adjustment policies (72 FR 66743 through 66749).

2. Proposed APCs and Devices Subject to the Adjustment Policy

For CY 2011, we are proposing to continue to apply the existing policy of reducing OPPS payment for specified APCs by 100 percent of the device offset amount when a hospital furnishes a specified device without cost or with a full credit and by 50 percent of the device offset amount when the hospital receives partial credit in the amount of 50 percent or more of the cost for the specified device. Because the APC payments for the related services are specifically constructed to ensure that the full cost of the device is included in the payment, we continue to believe it is appropriate to reduce the APC payment in cases in which the hospital receives a device without cost, with full credit, or with partial credit, in order to provide equitable payment in these cases. (We refer readers to section II.A.2.d.(1) of this proposed rule for a description of our standard rate-setting methodology for device-dependent APCs.) Moreover, the payment for these devices comprises a large part of the APC payment on which the beneficiary copayment is based, and we continue to believe it is equitable that the beneficiary cost sharing reflects the reduced costs in these cases.

We also are proposing to continue using the three criteria established in the CY 2007 OPPS/ASC final rule with comment period for determining the APCs to which this policy applies (71 FR 68072 through 68077). Specifically, (1) all procedures assigned to the selected APCs must involve implantable devices that would be reported if device insertion procedures were performed; (2) the required devices must be surgically inserted or implanted devices that remain in the patient's body after the conclusion of the procedure (at least temporarily); and (3) the device offset amount must be significant, which, for purposes of this policy, is defined as exceeding 40 percent of the APC cost. We are proposing to continue to restrict the devices to which the APC payment adjustment would apply to a specific set of costly devices to ensure that the adjustment would not be triggered by the implantation of an inexpensive device whose cost would not constitute a significant proportion of the total payment rate for an APC. We continue to believe these criteria are appropriate because free devices and device credits are likely to be associated with particular cases only when the device must be reported on the claim and is of a type that is implanted and remains in the body when the beneficiary leaves the hospital. We believe that the reduction in payment is appropriate only when the cost of the device is a significant part of the total cost of the APC into which the device cost is packaged, and that the 40-percent threshold is a reasonable definition of a significant cost.

We examined the offset amounts calculated from the CY 2011 proposed rule data and the clinical characteristics of APCs to determine whether the APCs to which the no cost/full credit and partial credit device adjustment policy applies in CY 2010 continue to meet the criteria for CY 2011, and to determine whether other APCs to which the policy does not apply in CY 2010 would meet the criteria for CY 2011. Based on the CY 2009 claims data available for this proposed rule, we are not proposing any changes to the APCs and devices to which this policy applies. Table 18 below lists the proposed APCs to which the payment adjustment policy for no cost/full credit and partial credit devices would apply in CY 2011 and displays the proposed payment adjustment percentages for both no cost/full credit and partial credit circumstances. We are proposing that the no cost/full credit adjustment for each APC to which this policy would continue to apply would be the device offset percentage for the APC (the estimated percentage of the APC cost that is attributable to the device costs that are packaged into the APC). We also are proposing that the partial credit device adjustment for each APC would continue to be 50 percent of the no cost/full credit adjustment for the APC as shown in Table 18. Table 19 below lists the proposed devices to which this policy would apply in CY 2011. We will update the lists of APCs and devices to which the no cost/full credit and partial credit device adjustment policy would apply for CY 2011, consistent with the three selection criteria discussed earlier in this section, based on the final CY 2009 claims data available for the CY 2011 OPPS/ASC final rule with comment period.

BILLING CODE 4120–01–P

TABLE 18.—PROPOSED APCs TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY WOULD APPLY

Proposed CY 2011 APC	Proposed CY 2011 APC Title	Proposed CY 2011 Device Offset Percentage for No Cost/ Full Credit Case	Proposed CY 2011 Device Offset Percentage for Partial Credit Case
0039	Level I Implantation of Neurostimulator Generator	85%	43%
0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%
0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes	63%	31%
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	70%	35%
0090	Insertion/Replacement of Pacemaker Pulse Generator	72%	36%
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	46%	23%
0107	Insertion of Cardioverter-Defibrillator	88%	44%
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	87%	44%
0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	78%	39%
0227	Implantation of Drug Infusion Device	81%	41%
0259	Level VII ENT Procedures	86%	43%
0315	Level II Implantation of Neurostimulator Generator	88%	44%
0385	Level I Prosthetic Urological Procedures	61%	30%
0386	Level II Prosthetic Urological Procedures	71%	36%
0418	Insertion of Left Ventricular Pacing Elect.	72%	36%
0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
0648	Level IV Breast Surgery	45%	23%
0654	Insertion/Replacement of a	73%	37%

Proposed CY 2011 APC	Proposed CY 2011 APC Title	Proposed CY 2011 Device Offset Percentage for No Cost/ Full Credit Case	Proposed CY 2011 Device Offset Percentage for Partial Credit Case
	permanent dual chamber pacemaker		
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	73%	37%
0680	Insertion of Patient Activated Event Recorders	71%	35%

TABLE 19.—PROPOSED DEVICES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY WOULD APPLY

CY 2010 Device HCPCS Code	CY 2010 Short Descriptor
C1721	AICD, dual chamber
C1722	AICD, single chamber
C1728	Cath, brachytx seed adm
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
C1789	Prosthesis, breast, imp
C1813	Prosthesis, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro rechg bat sys
C1881	Dialysis access system
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Prosthesis, penile, non-inf
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8600	Implant breast silicone/eq
L8614	Cochlear device/system
L8680	Implt neurostim elctr each
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8690	Aud osseo dev, int/ext comp

<FNP>

V. Proposed OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

A. Proposed OPPS Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals, and Radiopharmaceuticals

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 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.

Transitional pass-through payments also are provided for certain "new" drugs and biological agents that were not being paid for as an HOPD service as of December 31, 1996, and whose cost is "not insignificant" in relation to the OPPS payments for the procedures or services associated with the new drug or biological. For pass-through payment purposes, radiopharmaceuticals are included as "drugs." Under the statute, transitional pass-through payments for a drug or biological described in section 1833(t)(6)(C)(i)(II) of the Act can be made for at least 2 years but not more than 3 years after the product's first payment as a hospital outpatient service under Part B. Proposed CY 2011 pass-through drugs and biologicals and their designated APCs are assigned status indicator "G" in Addenda A and B to this proposed rule.

Section 1833(t)(6)(D)(i) of the Act specifies that the pass-through payment amount, in the case of a drug or biological, is the amount by which the amount determined under section 1842(o) of the Act for the drug or biological exceeds the portion of the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the drug or biological. If the drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the pass-through payment amount is determined by the Secretary to be equal to the average price for the drug or biological for all competitive acquisition areas and the year established under such section as calculated and adjusted by the Secretary.

This methodology for determining the pass-through payment amount is set forth in § 419.64 of the regulations, which specifies that the pass-through payment equals the amount determined under section 1842(o) of the Act minus the portion of the APC payment that CMS determines is associated with the drug or biological. Section 1847A of the Act 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, as applied under the OPPS, uses several sources of data as a basis for payment, including the ASP, wholesale acquisition cost (WAC), and average wholesale price (AWP). In this proposed rule, the term "ASP methodology" and "ASP-based" are inclusive of all data sources and methodologies described therein. Additional information on the ASP methodology can be found on the CMS Web site at: *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice.*

As noted above, section 1833(t)(6)(D)(i) of the Act also states that if a drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the payment rate is equal to the average price for the drug or biological for all competitive acquisition areas and the year established as calculated and adjusted by the Secretary. Section 1847B of the Act establishes the payment methodology for Medicare Part B drugs and biologicals under the competitive acquisition program (CAP). The Part B drug CAP was implemented on July 1, 2006, and included approximately 190 of the most common Part B drugs provided in the physician's office setting. As we noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68633), the Part B drug CAP program was suspended beginning in CY 2009 (Medicare Learning Network (MLN) Matters Special Edition 0833, available via the Web site: *http://www.medicare.gov*). Therefore, there is no effective Part B drug CAP rate for pass-through drugs and biologicals as of January 1, 2009. Consistent with what we indicated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60466), if the program is reinstituted during CY 2011 and Part B drug CAP rates become available, we would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program. Otherwise, we would continue to use the rate that would be paid in the physician's office setting for drugs and biologicals with pass-through status.

For CYs 2005, 2006, and 2007, we estimated the OPPS pass-through payment amount for drugs and biologicals to be zero based on our interpretation that the "otherwise applicable Medicare OPD fee schedule" amount was equivalent to the amount to be paid for pass-through drugs and biologicals under section 1842(o) of the Act (or section 1847B of the Act, if the drug or biological is covered under a competitive acquisition contract). We concluded for those years that the resulting difference between these two rates would be zero. For CYs 2008 and 2009, we estimated the OPPS pass-through payment amount for drugs and biologicals to be $6.6 million and $23.3 million, respectively. For CY 2010, we estimated that the OPPS pass-through payment estimate for drugs and biologicals to be $35.5 million. Our proposed OPPS pass-through payment estimate for drugs and biologicals in CY 2011 is $15 million, which is discussed in section VI.B. of this proposed rule.

The pass-through application and review process for drugs and biologicals is explained on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp.*

2. Proposed Drugs and Biologicals With Expiring Pass-Through Status in CY 2010

We are proposing that the pass-through status of 18 drugs and biologicals would expire on December 31, 2010, as listed in Table 20 of this proposed rule. All of these drugs and biologicals will have received OPPS pass-through payment for at least 2 years and no more than 3 years by December 31, 2010. These items were approved for pass-through status on or before January 1, 2009. With the exception of those groups of drugs and biologicals that are always packaged when they do not have pass-through status, specifically diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals, our standard methodology for providing payment for drugs and biologicals with expiring pass-through status in an upcoming calendar year is to determine the product's estimated per day cost and compare it with the OPPS drug packaging threshold for that calendar year (which is proposed at $70 for CY 2011), as discussed further in section V.B.2 of this proposed rule. If the drug's or biological's estimated per day cost is

less than or equal to the applicable OPPS drug packaging threshold, we would package payment for the drug or biological into the payment for the associated procedure in the upcoming calendar year. If the estimated per day cost of the drug or biological is greater than the OPPS drug packaging threshold, we would provide separate payment at the applicable relative ASP-based payment amount (which is proposed at ASP+6 percent for CY 2011, as discussed further in section V.B.3. of this proposed rule). Section V.B.2.d. of this proposed rule discusses the packaging of all nonpass-through contrast agents, diagnostic radiopharmaceuticals, and implantable biologicals.

TABLE 20.—PROPOSED DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS WOULD EXPIRE DECEMBER 31, 2010

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 SI	Proposed CY 2011 APC
A9581	Injection, gadoxetate disodium, 1 ml	N	N/A
C9248	Injection, clevidipien butyrate, 1 mg	K	9248
C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter	N	N/A
C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	K	9358
C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc	N	N/A
J1267	Injection, doripenem, 10 mg	N	N/A
J1453	Injection, fosaprepitant, 1 mg	K	9242
J1459	Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg	K	1214
J1571	Injection, hepatitis b immune globulin (hepagam b), intramuscular, 0.5 ml	K	0946
J1573	Injection, hepatitis B immune globulin (Hepagam B), intravenous, 0.5ml	K	1138
J1953	Injection, levetiracetam, 10 mg	N	N/A
J2785	Injection, regadenoson, 0.1 mg	K	9244
J2796	Injection,romiplostim, 10 micrograms	K	9245
J9033	Injection, bendamustine hcl, 1 mg	K	9243
J9207	Injection, ixabepilone, 1 mg	K	9240
J9225	Histrelin implant (vantas), 50 mg	K	1711
J9226	Histrelin implant (supprelin la), 50 mg	K	1142
Q4114	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (Flowable Wound Matrix), 1 cc	K	1251

3. Proposed Drugs, Biologicals, and Radiopharmaceuticals With New or Continuing Pass-Through Status in CY 2011

We are proposing to continue pass-through status in CY 2011 for 31 drugs and biologicals. None of these products will have received OPPS pass-through payment for at least 2 years and no more than 3 years by December 31, 2010. These items, which were approved for pass-through status between April 1, 2009 and July 1, 2010, are listed in Table 21 below. The APCs and HCPCS codes for these drugs and biologicals were assigned status indicator "G" in Addenda A and B to this proposed rule.

Section 1833(t)(6)(D)(i) of the Act sets the amount of pass-through payment for pass-through drugs and biologicals (the pass-through payment amount) as the difference between the amount authorized under section 1842(o) of the Act (or, if the drug or biological is

covered under a CAP under section 1847B of the Act, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and the year established under such section as calculated and adjusted by the Secretary) and the portion of the otherwise applicable OPD fee schedule that the Secretary determines is associated with the drug or biological. Payment for drugs and biologicals with pass-through status under the OPPS is currently made at the physician's office payment rate of ASP+6 percent. We believe it is consistent with the statute to continue to provide payment for drugs and biologicals with pass-through status at a rate of ASP+6 percent in CY 2011, the amount that drugs and biologicals receive under section 1842(o) of the Act. Thus, for CY 2011, we are proposing to pay for pass-through drugs and biologicals at ASP+6 percent, equivalent to the rate these drugs and biologicals would receive in the physician's office setting in CY 2011. We are proposing that a $0.00 pass-through payment amount would be paid for most pass-through drugs and biologicals under the CY 2011 OPPS because the difference between the amount authorized under Section 1842(o) which is ASP+6 percent and the portion of the otherwise applicable OPD fee schedule that the Secretary determines is appropriate, proposed at ASP+6 percent is $0. In the case of pass-through contrast agents, diagnostic radiopharmaceuticals, and implantable biologicals, their pass-through payment amount would be equal to ASP+6 percent because, if not on pass-through status, payment for these products would be packaged into the associated procedures.

In addition, we are proposing to continue to update pass-through payment rates on a quarterly basis on the CMS Web site during CY 2011 if later quarter ASP submission (or more recent WAC or AWP information, as applicable) indicate that adjustments to the payment rates for these pass-through drugs or biologicals are necessary. For a full description of this policy, we refer readers to the CY 2006 OPPS/ASC final rule with comment period (70 FR 42722 and 42723). If the Part B drug CAP is reinstated during CY 2011, and a drug or biological that has been granted pass-through status for CY 2011 becomes covered under the Part B drug CAP, we are proposing to provide pass-though payment at the Part B drug CAP rate and to make the appropriate adjustments to the payment rates for these drugs and biologicals on a quarterly basis as appropriate. As is our standard methodology, we annually review new permanent HCPCS codes and delete temporary HCPCS C-codes if an alternate permanent HCPCS code is available for purposes of OPPS billing and payment.

In CY 2011, as is consistent with our CY 2010 policy for diagnostic radiopharmaceuticals, we are proposing to provide payment for both diagnostic and therapeutic radiopharmaceuticals that are granted pass-through status based on the ASP methodology. As stated above, for purposes of pass-through payment, we consider radiopharmaceuticals to be drugs under the OPPS and, therefore, if a diagnostic or therapeutic radiopharmaceutical receives pass-through status during CY 2011, we are proposing to follow the standard ASP methodology to determine its pass-through payment rate that drugs receive under section 1842(o) of the Act, that is, ASP+6 percent. If ASP data are not available for a radiopharmaceutical, we are proposing to provide pass-through payment at WAC+6 percent, the equivalent payment provided to pass-through drugs and biologicals without ASP information. If WAC information is also not available, we are proposing to provide payment for the pass-through radiopharmaceutical at 95 percent of its most recent AWP.

As discussed in more detail in section V.B.2.d. of this proposed rule, over the last 3 years, we implemented a policy whereby payment for all nonpass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals is packaged into payment for the associated procedure, and we are proposing to continue the packaging of these items, regardless of their per day cost, in CY 2011. As stated earlier, pass-through payment is the difference between the amount authorized under section 1842(o) of the Act (or, if the drug or biological is covered under a CAP under section 1847B of the Act, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and the year established under such section as calculated and adjusted by the Secretary) and the portion of the otherwise applicable OPD fee schedule that the Secretary determines is associated with the drug or biological. Because payment for a drug that is either a diagnostic radiopharmaceutical or a contrast agent (identified as a "policy-packaged" drug, first described in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68639)) or for an implantable biological (which we do consider to be a device for all payment purposes as discussed in sections V.A.4. and V.B.2.d. of the CY 2010 OPPS/ASC final rule with comment period (74 FR 60458)) would otherwise be packaged if the product did not have pass-through status, we believe the otherwise applicable OPPS payment amount would be equal to the "policy-packaged" drug or device APC offset amount for the associated clinical APC in which the drug or biological is utilized. The calculation of the "policy-packaged" drug and device APC offset amounts are described in more detail in sections IV.A.2. of this proposed rule. It follows that the copayment for the nonpass-through payment portion (the otherwise applicable fee schedule amount that we would also offset from payment for the drug or biological if a payment offset applies) of the total OPPS payment for those drugs and biologicals would, therefore, be accounted for in the copayment for the associated clinical APC in which the drug or biological is used. According to section 1833(t)(8)(E) of the Act, the amount of copayment associated with pass-through items is equal to the amount of copayment that would be applicable if the pass-through adjustment was not applied. Therefore, as we did in CY 2010, we are proposing to continue to set the associated copayment amount for pass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals that would otherwise be packaged if the item did not have pass-through status to zero for CY 2011. The separate OPPS payment to a hospital for the pass-through diagnostic radiopharmaceutical, contrast agent, or implantable biological, after taking into account any applicable payment offset for the item due to the device or "policy-packaged" APC offset policy, is the item's pass-through payment, which is not subject to a copayment according to the statute. Therefore, we are proposing to not publish a copayment amount for these items in Addenda A and B to the proposed rule.

BILLING CODE 4120–01–P

TABLE 21.—PROPOSED DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2011

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 SI	Proposed CY 2011 APC
A9582	Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries	G	9247
A9583	Injection, gadofosveset trisodium, 1 ml	G	1299
C9250	Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2ml	G	9250
C9255	Injection, paliperidone palmitate, 1 mg	G	9255
C9256	Injection, dexamethasone intravitreal implant, 0.1 mg	G	9256
C9258	Injection, telavancin, 10 mg	G	9258
C9259	Injection, pralatrexate, 1 mg	G	9259
C9260	Injection, ofatumumab, 10 mg	G	9260
C9261	Injection, ustekinumab, 1 mg	G	9261
C9263	Injection, ecallantide, 1 mg	G	9263
C9264	Injection, tocilizumab, 1 mg	G	9624
C9265	Injection, romidepsin, 1 mg	G	9625
C9266	Injection, collagenase clostridium histolyticum, 0.1 mg	G	9266
C9267	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	G	9267
C9268	Capsaicin, patch, 10cm2	G	9268
C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	G	9360
C9361	Collagen matrix nerve wrap (NeuroMend Collagen Nerve Wrap), per 0.5 centimeter length	G	9361
C9362	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc	G	9362
C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	G	9363
C9364	Porcine implant, Permacol, per square centimeter	G	9364
C9367	Skin substitute, Endoform Dermal Template, per square centimeter	G	9367
J0598	Injection, C1 esterase inhibitor (human), 10 units	G	9251
J0641	Injection, levoleucovorin calcium, 0.5 mg	G	1236
J0718	Injection, certolizumab pegol, 1 mg	G	9249
J1680	Injection, human fibrinogen concentrate, 100 mg	G	1290
J2562	Injection, plerixafor, 1 mg	G	9252
J8705	Topotecan, oral, 0.25 mg	G	1238
J9155	Injection, degarelix, 1 mg	G	1296
J9328	Injection, temozolomide, 1 mg	G	9253
Q0138	Injection, Ferumoxytol, for treatment of iron deficiency anemia, 1 mg	G	1297
Q2025	Fludarabine phosphate, oral, 1 mg	G	9262

BILLING CODE 4120–01–C

4. Proposed Provisions for Reducing Transitional Pass-Through Payments for Diagnostic Radiopharmaceuticals and Contrast Agents to Offset Costs Packaged Into APC Groups

a. Background

Prior to CY 2008, diagnostic radiopharmaceuticals and contrast agents were paid separately under the OPPS if their mean per day costs were greater than the applicable year's drug packaging threshold. In CY 2008 (72 FR 66768), we began a policy of packaging payment for all nonpass-through diagnostic radiopharmaceuticals and contrast agents as ancillary and supportive items and services into their associated nuclear medicine procedures. Therefore, beginning in CY 2008, nonpass-through diagnostic radiopharmaceuticals and contrast agents were not subject to the annual OPPS drug packaging threshold to determine their packaged or separately payable payment status, and instead all nonpass-through diagnostic radiopharmaceuticals and contrast agents were packaged as a matter of policy. For CY 2011, we are proposing to continue to package payment for all nonpass-through diagnostic radiopharmaceuticals and contrast agents as discussed in section V.B.2.d. of this proposed rule.

b. Proposed Payment Offset Policy for Diagnostic Radiopharmaceuticals

As previously noted, radiopharmaceuticals are considered to be drugs for OPPS pass-through payment purposes. As described above, section 1833(t)(6)(D)(i) of the Act specifies that the transitional pass-through payment amount for pass-through drugs and biologicals is the difference between the amount paid under section 1842(o) (or the Part B drug CAP rate) and the otherwise applicable OPD fee schedule amount. There is currently one radiopharmaceutical with pass-through status under the OPPS, HCPCS code A9582 (Iobenguane, I–123, diagnostic, per study dose, up to 10 millicuries). HCPCS code A9582 was granted pass-through status beginning April 1, 2009 and will continue on pass-through status in CY 2011. We currently apply the established radiopharmaceutical payment offset policy to pass-through payment for this product. As described earlier in section V.A.3. of this proposed rule, new pass-through diagnostic radiopharmaceuticals will be paid at ASP+6 percent, while those without ASP information will be paid at WAC+6 percent or, if WAC is not available, payment will be based on 95 percent of the product's most recently published AWP.

As a payment offset is necessary in order to provide an appropriate transitional pass-through payment, we deduct from the payment for pass-through radiopharmaceuticals an amount that reflects the portion of the APC payment associated with predecessor radiopharmaceuticals in order to ensure no duplicate radiopharmaceutical payment is made. In CY 2009, we established a policy to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of predecessor diagnostic radiopharmaceuticals when considering a new diagnostic radiopharmaceutical for pass-through payment (73 FR 68638 through 68641). Specifically, we utilize the "policy-packaged" drug offset fraction for APCs containing nuclear medicine procedures, calculated as 1 minus (the cost from single procedure claims in the APC after removing the cost for "policy-packaged" drugs divided by the cost from single procedure claims in the APC). In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60480 through 60484), we finalized a policy to redefine "policy-packaged" drugs as only nonpass-through diagnostic radiopharmaceuticals and contrast agents, as a result of the policy discussed in sections V.A.4. and V.B.2.d. of the CY 2010 OPPS/ASC final rule with comment period (74 FR 60471 through 60477 and 60495 through 60499 respectively) that treats nonpass-through implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) and implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) with newly approved pass-through status beginning in CY 2010 or later as devices, rather than drugs. To determine the actual APC offset amount for pass-through diagnostic radiopharmaceuticals that takes into consideration the otherwise applicable OPPS payment amount, we multiply the "policy-packaged" drug offset fraction by the APC payment amount for the nuclear medicine procedure with which the pass-through diagnostic radiopharmaceutical is used and, accordingly, reduce the separate OPPS payment for the pass-through diagnostic radiopharmaceutical by this amount.

The Integrated Outpatient Code Editor processes claims for nuclear medicine procedures only when they are performed with a radiolabeled product. Therefore, the radiolabeled product edits in the Integrated Outpatient Code Editor require a hospital to report a diagnostic radiopharmaceutical with a nuclear medicine scan in order to receive payment for the nuclear medicine scan. We have received questions from hospitals on how to bill for a nuclear medicine scan when they receive a diagnostic radiopharmaceutical free of charge or with full credit. Currently, if a hospital receives a diagnostic radiopharmaceutical free of charge or with full credit and uses it to provide a nuclear medicine scan, the hospital could choose not to bill for both the nuclear medicine scan and the diagnostic radiopharmaceutical in order to bypass the radiolabeled product edits, but the hospital clearly would not receive OPPS payment for the scan or the diagnostic radiopharmaceutical. The hospital also could report the diagnostic radiopharmaceutical with the nuclear medicine scan and receive an APC payment that includes payment for the diagnostic radiopharmaceutical, but this would lead to inaccurate billing and incorrect payment. This is because the OPPS should not pay for a free item. We believe neither of the above alternatives is satisfactory.

In order to ensure that the OPPS is making appropriate and equitable payments under such circumstances and that a hospital can comply with the required radiolabeled product edits, we are proposing for CY 2011 to instruct hospitals to report the "FB" modifier on the line with the procedure code for the nuclear medicine scan in the APCs listed in Table E3 in which the no cost/full credit diagnostic radiopharmaceutical is used. Modifier -FB is "Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)." Although this modifier is specific to devices, it captures the concept of the hospital receiving a key component of the service without cost. In cases in which the diagnostic radiopharmaceutical is furnished without cost or with full credit, we are proposing to instruct the hospital to report a token charge of less than $1.01. We refer readers to the CY 2008 OPPS/ASC final rule with comment period for more background information on the "FB" payment adjustment policies (72 FR 66743 through 66749). We are proposing that when a hospital bills an -FB with the nuclear medicine scan, the payment amount for procedures in the APCs listed in Table 20 would be reduced by the full "policy-packaged" offset amount appropriate for diagnostic

radiopharmaceuticals. As discussed in our CY 2009 OPPS/ASC final rule with comment period, the "policy packaged" offset amount that we calculate estimates the portion of each APC payment rate that could reasonably be attributed to the cost of predecessor diagnostic radiopharmaceuticals when considering a new diagnostic radiopharmaceutical for pass-through payment (73 FR 68638 through 68641). As in our offset policy, discussed below, we believe it is appropriate to remove the "policy packaged" offset amount from payment for a nuclear medicine scan with a diagnostic radiopharmaceutical received at no cost or full credit which is billed using one of the APCs appearing in Table 22 below because it represents the portion of the APC payment attributable to diagnostic radiopharmaceuticals used in the performance of a nuclear medicine scan. Using the -FB modifier with radiolabeled products will allow the hospital to bill accurately for a diagnostic radiopharmaceutical received free of charge and will allow the hospital to comply with the radiolabeled product edits to ensure appropriate payment.

At this time, we are not proposing to recognize modifier FC, which is defined as "Partial credit received for replaced device," because we were unsure of the circumstances in which hospitals would receive a diagnostic radiopharmaceutical at reduced cost to replace a previously provided diagnostic radiopharmaceutical. We invite public comment on when a diagnostic radiopharmaceutical is provided for a significantly reduced price and whether the "FC" modifier is appropriate for radiolabeled products.

We will continue to post annually on the CMS Web site at *http://www.cms.gov/HospitalOutpatientPPS,* a file that contains the APC offset amounts that would be used for that year for purposes of both evaluating cost significance for candidate pass-through device categories and drugs and biologicals, including diagnostic radiopharmaceuticals, and establishing any appropriate APC offset amounts. Specifically, the file will continue to provide, for every OPPS clinical APC, the amounts and percentages of APC payment associated with packaged implantable devices, including implantable biologicals; "policy-packaged" drugs, including diagnostic radiopharmaceuticals and contrast agents; and "threshold-packaged" drugs and biologicals, which are all other drugs, therapeutic radiopharmaceuticals, and nonimplantable biologicals.

Table 22 below displays the proposed APCs to which nuclear medicine procedures would be assigned in CY 2011 and for which we expect that an APC offset could be applicable in the case of new diagnostic radiopharmaceuticals with pass-through status.

TABLE 22.—PROPOSED APCs TO WHICH NUCLEAR MEDICINE PROCEDURES WOULD BE ASSIGNED FOR CY 2011

Proposed CY 2011 APC	Proposed CY 2011 APC Title
0307	Myocardial Positron Emission Tomography (PET) imaging.
0308	Non-Myocardial Positron Emission Tomography (PET) imaging.
0377	Level II Cardiac Imaging.
0378	Level II Pulmonary Imaging.
0389	Level I Non-imaging Nuclear Medicine.
0390	Level I Endocrine Imaging.
0391	Level II Endocrine Imaging.
0392	Level II Non-imaging Nuclear Medicine.
0393	Hematologic Processing & Studies.
0394	Hepatobiliary Imaging.
0395	GI Tract Imaging.
0396	Bone Imaging.
0397	Vascular Imaging.
0398	Level I Cardiac Imaging.
0400	Hematopoietic Imaging.
0401	Level I Pulmonary Imaging.
0402	Level II Nervous System Imaging.
0403	Level I Nervous System Imaging.
0404	Renal and Genitourinary Studies.
0406	Level I Tumor/Infection Imaging.
0408	Level II Tumor/Infection Imaging.
0414	Level II Tumor/Infection Imaging.

c. Proposed Payment Offset Policy for Contrast Agents

As described above, section 1833(t)(6)(D)(i) of the Act specifies that the transitional pass-through payment amount for pass-through drugs and biologicals is the difference between the amount paid under section 1842(o) (or the Part B drug CAP rate) and the otherwise applicable OPD fee schedule amount. There is currently one contrast agent with pass-through status under the OPPS, HCPCS code A9583 (Injection, gadoxetate disodium, per ml). HCPCS code A9583 was granted pass-through status beginning January 1, 2010, and will continue with pass-through status in CY 2011. As described earlier in section V.A.3. of this proposed rule, new pass-through contrast agents would be paid at ASP+6 percent, while those without ASP information would be paid at WAC+6 percent or, if WAC is not available, payment would be based on 95 percent of the product's most recently published AWP.

We believe that a payment offset is necessary in order to provide an appropriate transitional pass-through payment for contrast agents because all of these items are packaged when they do not have pass-through status. In accordance with our standard offset methodology, for CY 2011 we are proposing to deduct from the payment for pass-through contrast agents an amount that reflects the portion of the APC payment associated with predecessor contrast agents in order to ensure no duplicate contrast agent payment is made.

In CY 2010, we established a policy to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of predecessor contrast agents when considering new contrast agents for pass-through payment (74 FR 60482 through 60484). For CY 2011, we are proposing to continue to apply this same policy to contrast agents. Specifically, we are proposing to utilize the "policy-packaged" drug offset fraction for clinical APCs calculated as 1 minus (the cost from single procedure claims in the APC after removing the cost for "policy-packaged" drugs divided by the cost from single procedure claims in the APC). As discussed above, in CY 2010, we finalized a policy to redefine "policy-packaged" drugs as only nonpass-through diagnostic radiopharmaceuticals and contrast agents (74 FR 60495 through 60499). To determine the actual APC offset amount for pass-through contrast agents that takes into consideration the otherwise applicable OPPS payment amount, we are proposing to multiply the "policy-packaged" drug offset fraction by the APC payment amount for the procedure with which the pass-through contrast agent is used and, accordingly, reduce the separate OPPS payment for the pass-through contrast agent by this amount.

We are proposing to continue to post annually on the CMS Web site at *http://www.cms.gov/HospitalOutpatientPPS,* a file that contains the APC offset amounts that would be used for that year for purposes of both evaluating cost significance for candidate pass-through device categories and drugs and biologicals, including contrast agents, and establishing any appropriate APC offset amounts. Specifically, the file will continue to provide, for every OPPS clinical APC, the amounts and percentages of APC payment associated with packaged implantable devices, "policy-packaged" drugs, and "threshold-packaged" drugs and biologicals.

Proposed procedural APCs for which we expect a contrast agent offset could be applicable in the case of a pass-through contrast agent have been identified as any procedural APC with a "policy-packaged" drug amount greater than $20 that is not a nuclear medicine APC identified in Table 20 above, and these APCs are displayed in Table 23 below. The methodology used to determine a proposed threshold cost for application of a contrast agent offset policy is described in detail in the CY 2010 OPPS/ASC final rule with comment period (70 FR 60483 through 60484). For CY 2011, we are proposing to continue to recognize that when a contrast agent with pass-through status is billed with any procedural APC listed in Table 23, a specific offset based on the procedural APC would be applied to payment for the contrast agent to ensure that duplicate payment is not made for the contrast agent.

BILLING CODE 4120–01–P

TABLE 23.--APCs TO WHICH A CONTRAST AGENT OFFSET MAY BE APPLICABLE FOR CY 2011

Proposed CY 2011 APC	Proposed CY 2011 APC Title
0080	Diagnostic Cardiac Catheterization.
0082	Coronary or Non-Coronary Atherectomy.
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvulopasty.
0093	Vascular Reconstruction/Fistula Repair without Device.
0104	Transcathether Placement of Intracoronary Stents.
0128	Echocardiogram with Contrast.
0152	Level I Percutaneous Abdominal and Biliary Procedures.
0229	Transcathether Placement of Intravascular Shunts.
0278	Diagnostic Urography.
0279	Level II Angiography and Venography.
0280	Level III Angiography and Venography.
0283	Computed Tomography with Contrast.
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast.
0333	Computed Tomography without Contrast followed by Contrast.
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast.
0375	Ancillary Outpatient Services When Patient Expires.
0383	Cardiac Computed Tomographic Imaging.
0388	Discography.
0418	Insertion of Left Ventricular Pacing Elect.
0442	Dosimetric Drug Administration.
0653	Vascular Reconstruction/Fistula Repair with Device.
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents.
0662	CT Angiography.
0668	Level I Angiography and Venography.
8006	CT and CTA with Contrast Composite.
8008	MRI and MRA with Contrast Composite.

<FNP>

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

1. Background

Under the CY 2010 OPPS, we currently pay for drugs, biologicals, and radiopharmaceuticals that do not have pass-through status in one of two ways: Packaged payment into 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 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. (Transmittal A–01–133, issued on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.)

Packaging costs into a single aggregate payment for a service, procedure, or episode-of-care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility.

Section 1833(t)(16)(B) of the Act, as added by section 621(a)(2) of Public Law 108–173, set the threshold for establishing separate APCs for drugs and biologicals at $50 per administration for CYs 2005 and 2006. Therefore, for CYs 2005 and 2006, we paid separately for drugs, biologicals, and radiopharmaceuticals whose per day cost exceeded $50 and packaged the costs of drugs, biologicals, and radiopharmaceuticals whose per day cost was equal to or less than $50 into the procedures with which they were billed. For CY 2007, the packaging threshold for drugs, biologicals, and radiopharmaceuticals that were not new and did not have pass-through status was established at $55. For CYs 2008 and 2009, the packaging threshold for drugs, biologicals, and radiopharmaceuticals that were not new and did not have pass-through status was established at $60. For CY 2010, the packaging threshold for drugs, biologicals, and radiopharmaceuticals that were not new and did not have pass-through status was established at $65. The methodology used to establish the $55 threshold for CY 2007, the $60 threshold for CYs 2008 and 2009, the $65 threshold for CY 2010, and our proposed approach for CY 2011 are discussed in more detail in section V.B.2.b. of this proposed rule.

2. Proposed Criteria for Packaging Payment for Drugs, Biologicals, and Radiopharmaceuticals

a. Background

As indicated in section V.B.1. of this proposed rule, in accordance with section 1833(t)(16)(B) of the Act, the threshold for establishing separate APCs for payment of drugs and biologicals was set to $50 per administration during CYs 2005 and 2006. In CY 2007, we used the fourth quarter moving average Producer Price Index (PPI) levels for prescription preparations to trend the $50 threshold forward from the third quarter of CY 2005 (when the Pub. L. 108–173 mandated threshold became effective) to the third quarter of CY 2007. We then rounded the resulting dollar amount to the nearest $5 increment in order to determine the CY 2007 threshold amount of $55. Using the same methodology as that used in CY 2007 (which is discussed in more detail in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68085 through 68086)), we set the packaging threshold for establishing separate APCs for drugs and biologicals at $60 for CYs 2008 and 2009. For CY 2010 we set the packaging threshold at $65.

Following the CY 2007 methodology, for CY 2011, we used updated fourth quarter moving average PPI levels to trend the $50 threshold forward from the third quarter of CY 2005 to the third quarter of CY 2011 and again rounded the resulting dollar amount ($70.64) to the nearest $5 increment, which yielded a figure of $70. In performing this calculation, we used the most up-to-date forecasted, quarterly PPI estimates from CMS' Office of the Actuary (OACT). As actual inflation for past quarters replaced forecasted amounts, the PPI estimates for prior quarters have been revised (compared with those used in the CY 2007 OPPS/ASC final rule with comment period) and have been incorporated into our calculation. Based on the calculations described above, we are proposing a packaging threshold for CY 2011 of $70. (For a more detailed discussion of the OPPS drug packaging threshold and the use of the PPI for prescription drugs, we refer readers to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68085 through 68086).)

b. Proposed Cost Threshold for Packaging of Payment for HCPCS Codes that Describe Certain Drugs, Nonimplantable Biologicals, and Therapeutic Radiopharmaceuticals ("Threshold-Packaged Drugs")

To determine their proposed CY 2011 packaging status, for this proposed rule, we calculated the per day cost of all drugs on a HCPCS code-specific basis (with the exception of those drugs and biologicals with multiple HCPCS codes that include different dosages as described in section V.B.2.c. of this proposed rule and excluding diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals that we are proposing to continue to package in CY 2011 as discussed in section V.B.2.d. of this proposed rule), nonimplantable biologicals, and therapeutic radiopharmaceuticals (collectively called "threshold-packaged" drugs) that had a HCPCS code in CY 2009 and were paid (via packaged or separate payment) under the OPPS, using CY 2009 claims data processed before January 1, 2010. In order to calculate the per day costs for drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals to determine their proposed packaging status in CY 2011, we used the methodology that was described in detail in the CY 2006 OPPS proposed rule (70 FR 42723 through 42724) and finalized in the CY 2006 OPPS final rule with comment period (70 FR 68636 through 70 FR 68638).

To calculate the CY 2011 proposed rule per day costs, we used an estimated payment rate for each drug and nonimplantable biological HCPCS code of ASP+6 percent (which is the payment rate we are proposing for separately payable drugs and nonimplantable biologicals in CY 2011, as discussed in more detail in section V.B.3.b. of this proposed rule). We used the manufacturer submitted ASP data from the fourth quarter of CY 2009 (data that were used for payment purposes in the physician's office setting, effective April 1, 2010) to determine the proposed rule per day cost.

As is our standard methodology, for CY 2011, we are proposing to use payment rates based on the ASP data from the fourth quarter of CY 2009 for budget neutrality estimates, packaging determinations, impact analyses, and completion of Addenda A and B to this proposed rule because these are the most recent data available for use at the time of development of this proposed rule. These data are also the basis for drug payments in the physician's office

setting, effective April 1, 2010. For items that did not have an ASP-based payment rate, such as some therapeutic radiopharmaceuticals, we used their mean unit cost derived from the CY 2009 hospital claims data to determine their per day cost. We are proposing to package items with a per day cost less than or equal to $70 and identified items with a per day cost greater than $70 as separately payable. Consistent with our past practice, we crosswalked historical OPPS claims data from the CY 2009 HCPCS codes that were reported to the CY 2010 HCPCS codes that we displayed in Addendum B to this proposed rule for payment in CY 2011.

Our policy during previous cycles of the OPPS has been to use updated ASP and claims data to make final determinations of the packaging status of HCPCS codes for drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals for the final rule with comment period. We note that it is also our policy to make an annual packaging determination for a HCPCS code only when we develop the OPPS/ASC final rule for the update year. Only HCPCS codes that are identified as separately payable in the final rule with comment period are subject to quarterly updates. For our calculation of per day costs of HCPCS codes for drugs and nonimplantable biologicals in the CY 2011 OPPS/ASC final rule with comment period, we are proposing to use ASP data from the first quarter of CY 2010, which is the basis for calculating payment rates for drugs and biologicals in the physician's office setting using the ASP methodology, effective July 1, 2010, along with updated hospital claims data from CY 2009. We note that we also would use these data for budget neutrality estimates and impact analyses for the CY 2011 OPPS/ASC final rule with comment period. Payment rates for HCPCS codes for separately payable drugs and nonimplantable biologicals included in Addenda A and B to that final rule with comment period would be based on ASP data from the second quarter of CY 2010, which are the basis for calculating payment rates for drugs and biologicals in the physician's office setting using the ASP methodology, effective October 1, 2010. These rates would then be updated in the January 2011 OPPS update, based on the most recent ASP data to be used for physician's office and OPPS payment as of January 1, 2011. For items that do not currently have an ASP-based payment rate, we would recalculate their mean unit cost from all of the CY 2009 claims data and updated cost report information available for the CY 2011 final rule with comment period to determine their final per day cost.

Consequently, the packaging status of some HCPCS codes for drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals in the CY 2011 OPPS/ASC final rule with comment period using the updated data may be different from the same drug HCPCS code's packaging status determined based on the data used for this proposed rule. Under such circumstances, we are proposing to continue the established policies initially adopted for the CY 2005 OPPS (69 FR 65780) in order to more equitably pay for those drugs whose median cost fluctuates relative to the CY 2011 OPPS drug packaging threshold and the drug's payment status (packaged or separately payable) in CY 2010. Specifically, we are proposing for CY 2011 to apply the following policies to these HCPCS codes for drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals whose relationship to the $70 drug packaging threshold changes based on the final updated data:

- HCPCS codes for drugs and nonimplantable biologicals that were paid separately in CY 2010 and that were proposed for separate payment in CY 2011, and then have per day costs equal to or less than $70, based on the updated ASPs and hospital claims data used for the CY 2011 final rule with comment period, would continue to receive separate payment in CY 2011.
- HCPCS codes for drugs and nonimplantable biologicals that were packaged in CY 2010 and that were proposed for separate payment in CY 2011, and then have per day costs equal to or less than $70, based on the updated ASPs and hospital claims data used for the CY 2011 final rule with comment period, would remain packaged in CY 2011.
- HCPCS codes for drugs and nonimplantable biologicals for which we proposed packaged payment in CY 2011 but then have per day costs greater than $70, based on the updated ASPs and hospital claims data used for the CY 2011 final rule with comment period, would receive separate payment in CY 2011. In the CY 2010 OPPS/ASC final rule (74 FR 60485 through 60489), we implemented a policy to treat oral and injectable forms of 5–HT3 antiemetics comparable to all other threshold packaged drugs, nonimplantable biologicals, and therapeutic radiohpharmaceuticals under our standard packaging methodology of packaging drugs with a per day cost less than $70. For CY 2011, we are proposing to continue our policy of not exempting these 5–HT3 antiemetic products from our standard packaging methodology and to package payment for all of the 5–HT3 antiemetics except palonosetron hydrochloride, consistent with their estimated per day costs from the CY 2009 claims data.

c. Proposed Packaging Determination for HCPCS Codes That Describe the Same Drug or Biological But Different Dosages

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66776), we began recognizing, for OPPS payment purposes, multiple HCPCS codes reporting different dosages for the same covered Part B drugs or biologicals in order to reduce hospitals' administrative burden by permitting them to report all HCPCS codes for drugs and biologicals. In general, prior to CY 2008, the OPPS recognized for payment only the HCPCS code that described the lowest dosage of a drug or biological. We extended this recognition to multiple HCPCS codes for several other drugs under the CY 2009 OPPS (73 FR 68665). During CYs 2008 and 2009, we applied a policy that assigned the status indicator of the previously recognized HCPCS code to the associated newly recognized code(s), reflecting the new code(s)' packaged or separately payable status. In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66775), we explained that once claims data were available for these previously unrecognized HCPCS codes, we would determine the packaging status and resulting status indicator for each HCPCS code according to the general, established HCPCS code-specific methodology for determining a code's packaging status for a given update year. However, we also stated that we planned to closely follow our claims data to ensure that our annual packaging determinations for the different HCPCS codes describing the same drug or biological did not create inappropriate payment incentives for hospitals to report certain HCPCS codes instead of others.

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60490 through 60491), we finalized a policy to make a single packaging determination for a drug, rather than an individual HCPCS code, when a drug has multiple HCPCS codes describing different dosages. We analyzed CY 2008 claims data for the HCPCS codes describing different dosages of the same drug or biological that were newly recognized in CY 2008 and found that our claims data would result in several different packaging determinations for different codes describing the same drug or biological. Furthermore, we found that

our claims data would include few units and days for a number of newly recognized HCPCS codes, resulting in our concern that these data reflected claims from only a small number of hospitals, even though the drug or biological itself may be reported by many other hospitals under the most common HCPCS code. Based on these findings from our first available claims data for the newly recognized HCPCS codes, we believed that adopting our standard HCPCS code-specific packaging determinations for these codes could lead to payment incentives for hospitals to report certain HCPCS codes instead of others, particularly because we do not currently require hospitals to report all drug and biological HCPCS codes under the OPPS in consideration of our previous policy that generally recognized only the lowest dosage HCPCS code for a drug or biological for OPPS payment. For CY 2011, we continue to believe that adopting the standard HCPCS code-specific packaging determinations for these codes could lead to payment incentives for hospitals to report certain HCPCS codes for drugs instead of others. Making packaging determinations on a drug-specific basis eliminates these incentives and allows hospitals flexibility in choosing to report all HCPCS codes for different dosages of the same drug or only the lowest dosage HCPCS code. Therefore, we are proposing to continue our policy to make packaging determinations on a drug-specific basis, rather than a HCPCS code-specific basis, for those HCPCS codes that describe the same drug or biological but different dosages in CY 2011.

For CY 2011, in order to propose a packaging determination that is consistent across all HCPCS codes that describe different dosages of the same drug or biological, we aggregated both our CY 2009 claims data and our pricing information at ASP+6 percent across all of the HCPCS codes that describe each distinct drug or biological in order to determine the mean units per day of the drug or biological in terms of the HCPCS code with the lowest dosage descriptor. HCPCS codes J9093 (cyclophosphamide, lyophilized, 100 mg), J9094 (cyclophosphamide, lyophilized, 200 mg), J9095 (cyclophosphamide, lyophilized, 500 mg), J9096 (cyclophosphamide, lyophilized, 1g), and J9097 (cyclophosphamide, lyophilized, 2g) did not have pricing information available for the ASP methodology and, as is our current policy for determining the packaging status of other drugs, we used the mean unit cost available from fourth quarter CY 2009 claims data to make the packaging determinations for these drugs. For all other drugs and biologicals that have HCPCS codes describing different dosages, we then multiplied the weighted average ASP+6 percent or mean unit cost payment amount across all dosage levels of a specific drug or biological by the estimated units per day for all HCPCS codes that describe each drug or biological from our claims data to determine the estimated per day cost of each drug or biological at less than or equal to $70 (whereupon all HCPCS codes for the same drug or biological would be packaged) or greater than $70 (whereupon all HCPCS codes for the same drug or biological would be separately payable). The proposed packaging status of each drug and biological HCPCS code to which this methodology would apply is displayed in Table 24.

BILLING CODE 4120–01–P

TABLE 24.—HCPCS CODES TO WHICH THE PROPOSED CY 2011 DRUG-SPECFIFIC PACKAGING DETERMINATION METHODOLOGY APPLIES

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 SI
C9257	Injection, bevacizumab, 0.25 mg	K
J9035	Injection, bevacizumab, 10 mg	K
J1380	Injection, estradiol valerate, up to 10 mg	N
J0970	Injection, estradiol valerate, up to 40 mg	N
J1390	Injection, estradiol valerate, up to 20 mg	N
J1020	Injection, methylprednisolone acetate, 20 mg	N
J1030	Injection, methylprednisolone acetate, 40 mg	N
J1040	Injection, methylprednisolone acetate, 80 mg	N
J1070	Injection, testosterone cypionate, up to 100 mg	N
J1080	Injection, testosterone cypionate, 1 cc, 200 mg	N
J1440	Injection, filgrastim (g-csf), 300 mcg	K
J1441	Injection, filgrastim (g-csf), 480 mcg	K
J1460	Injection, gamma globulin, intramuscular, 1 cc	K
J1470	Injection, gamma globulin, intramuscular 2 cc	K
J1480	Injection, gamma globulin, intramuscular 3 cc	K
J1490	Injection, gamma globulin, intramuscular 4 cc	K
J1500	Injection, gamma globulin, intramuscular 5 cc	K
J1510	Injection, gamma globulin, intramuscular 6 cc	K
J1520	Injection, gamma globulin, intramuscular 7 cc	K
J1530	Injection, gamma globulin, intramuscular 8 cc	K
J1540	Injection, gamma globulin, intramuscular 9 cc	K
J1550	Injection, gamma globulin, intramuscular 10 cc	K
J1560	Injection, gamma globulin, intramuscular over 10 cc	K
J1642	Injection, heparin sodium, (heparin lock flush), per 10 units	N
J1644	Injection, heparin sodium, per 1000 units	N
J1850	Injection, kanamycin sulfate, up to 75 mg	N
J1840	Injection, kanamycin sulfate, up to 500 mg	N
J2270	Injection, morphine sulfate, up to 10 mg	N
J2271	Injection, morphine sulfate, 100mg	N
J2320	Injection, nandrolone decanoate, up to 50 mg	K
J2321	Injection, nandrolone decanoate, up to 100 mg	K
J2322	Injection, nandrolone decanoate, up to 200 mg	K
J2788	Injection, rho d immune globulin, human, minidose, 50 micrograms (250 i.u.)	K
J2790	Injection, rho d immune globulin, human, full dose, 300 micrograms (1500 i.u.)	K
J2920	Injection, methylprednisolone sodium succinate, up to 40 mg	N
J2930	Injection, methylprednisolone sodium succinate, up to 125 mg	N
J3120	Injection, testosterone enanthate, up to 100 mg	N

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 SI
J3130	Injection, testosterone enanthate, up to 200 mg	N
J3471	Injection, hyaluronidase, ovine, preservative free, per 1 usp unit (up to 999 usp units)	N
J3472	Injection, hyaluronidase, ovine, preservative free, per 1000 usp units	N
J7050	Infusion, normal saline solution , 250 cc	N
J7040	Infusion, normal saline solution, sterile (500 ml=1 unit)	N
J7030	Infusion, normal saline solution , 1000 cc	N
J7515	Cyclosporine, oral, 25 mg	N
J7502	Cyclosporine, oral, 100 mg	N
J8520	Capecitabine, oral, 150 mg	K
J8521	Capecitabine, oral, 500 mg	K
J9060	Cisplatin, powder or solution, per 10 mg	N
J9062	Cisplatin, 50 mg	N
J9070	Cyclophosphamide, 100 mg	N
J9080	Cyclophosphamide, 200 mg	N
J9090	Cyclophosphamide, 500 mg	N
J9091	Injection, cyclophosphamide, 1.0 gram	N
J9092	Cyclophosphamide, 2.0 gram	N
J9093	Cyclophosphamide, lyophilized, 100 mg	N
J9094	Cyclophosphamide, lyophilized, 200 mg	N
J9095	Cyclophosphamide, lyophilized, 500 mg	N
J9096	Cyclophosphamide, lyophilized, 1g	N
J9097	Cyclophosphamide, lyophilized, 2g	N
J9100	Injection, cytarabine, 100 mg	N
J9110	Injection, cytarabine, 500 mg	N
J9130	Dacarbazine, 100 mg	N
J9140	Injection, dacarbazine, 200 mg	N
J9250	Methotrexate sodium, 5 mg	N
J9260	Methotrexate sodium, 50 mg	N
J9280	Mitomycin, 5 mg	K
J9290	Mitomycin, 20 mg	K
J9291	Mitomycin, 40 mg	K
J9370	Vincristine sulfate, 1 mg	N
J9375	Vincristine sulfate, 2 mg	N
J9380	Vincristine sulfate, 5 mg	N
Q0164	Prochlorperazine maleate, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour doseage regimen	N
Q0165	Prochlorperazine maleate, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy	N

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 SI
	treatment, not to exceed a 48-hour doseage regimen	
Q0167	Dronabinol, 2.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anit0emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0168	Dronabinol, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anit0emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0169	Promethazine hydrochloride, 12.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0170	Promethazine hydrochloride, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0171	Chlorpromazine hydrochloride, 10 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0172	Chlorpromazine hydrochloride, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotheapy treatment, not to exceed a 48-hour dosage regimen	N
Q0175	Perphenazine, 4 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0176	Perphenazine, 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0177	Hydroxyzine pamoate, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0178	Hydroxyzine pamoate, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exeed a 48-hour dosage regimen	N

BILLING CODE 4120–01–C

d. Proposed Packaging of Payment for Diagnostic Radiopharmaceuticals, Contrast Agents, and Implantable Biologicals ("Policy-Packaged" Drugs and Devices)

Prior to CY 2008, the methodology of calculating a product's estimated per day cost and comparing it to the annual OPPS drug packaging threshold was used to determine the packaging status of drugs, biologicals, and radiopharmaceuticals under the OPPS (except for our CYs 2005 through 2009 exemption for 5–HT3 antiemetics). However, as established in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66766 through 66768), we began packaging payment for all diagnostic radiopharmaceuticals and contrast agents into the payment for the associated procedure, regardless of their per day costs. In addition, in CY 2009 we adopted a policy that packaged the payment for nonpass-through implantable biologicals into payment for the associated surgical procedure on the claim (73 FR 68633 through 68636). We refer to diagnostic radiopharmaceuticals and contrast agents collectively as "policy-packaged" drugs and to implantable biologicals as devices because, in CY 2010, we began to treat implantable biologicals as devices for all OPPS payment purposes.

According to our regulations at § 419.2(b), as a prospective payment system, the OPPS establishes a national payment rate that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis including, but not limited to, implantable prosthetics, implantable durable medical equipment, and medical and surgical supplies. Packaging costs into a single aggregate payment for a service, encounter, or episode-of-care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility.

Prior to CY 2008, we noted that the proportion of drugs, biologicals, and radiopharmaceuticals that were separately paid under the OPPS had increased in recent years, a pattern that we also observed for procedural services under the OPPS. Our final CY 2008 policy that packaged payment for all nonpass-through diagnostic radiopharmaceuticals and contrast agents, regardless of their per day costs, contributed significantly to expanding the size of the OPPS payment bundles and is consistent with the principles of a prospective payment system.

As discussed in more detail in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68645 through 68649), we presented several reasons supporting our initial policy to package payment of diagnostic radiopharmaceuticals and contrast agents into their associated procedures on a claim. Specifically, we stated that we believed packaging was appropriate because: (1) The statutory requirement that we must pay separately for drugs and biologicals for which the per day cost exceeds $50 under section 1833(t)(16)(B) of the Act has expired; (2) we believe that diagnostic radiopharmaceuticals and contrast agents function effectively as supplies that enable the provision of an independent service; and (3) section 1833(t)(14)(A)(iii) of the Act requires that payment for specified covered outpatient drugs (SCODs) be set prospectively based on a measure of average hospital acquisition cost. For these reasons, we believe it is appropriate to continue to treat diagnostic radiopharmaceuticals and contrast agents differently from other SCODs for CY 2011. Therefore, we are proposing to continue packaging payment for all contrast agents and diagnostic radiopharmaceuticals, collectively referred to as "policy-packaged" drugs, regardless of their per day costs, for CY 2011. We also are proposing to continue to package the payment for diagnostic radiopharmaceuticals into the payment for the associated nuclear medicine procedure and to package the payment for contrast agents into the payment of the associated echocardiography imaging procedure, regardless of whether the contrast agent met the OPPS drug packaging threshold. We refer readers to the CY 2010 OPPS/ASC final rule with comment period for a detailed discussion of nuclear medicine and echocardiography services (74 FR 35269 through 35277).

In CY 2009 (73 FR 68634), we began packaging the payment for all nonpass-through implantable biologicals into payment for the associated surgical procedure. Because implantable biologicals may sometimes substitute for nonbiological devices, we noted that if we were to provide separate payment for implantable biologicals without pass-through status, we would potentially be providing duplicate device payment, both through the packaged nonbiological device cost already included in the surgical procedure's payment and separate biological payment. We concluded that we saw no basis for treating implantable biological and nonbiological devices without pass-through status differently for OPPS payment purposes because both are integral to and supportive of the separately paid surgical procedures in which either may be used. Therefore, in CY 2009, we adopted a final policy to package payment for all nonpass-through implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice), like our longstanding policy that packages payment for all implantable nonbiological devices without pass-through status. We finalized a policy in CY 2010 to package payment for nonpass-through implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) into the body, known as devices. For CY 2011, we are proposing to continue to package payment for nonpass-through implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) into the body, referred to as devices. In accordance with this proposal, two of the products with expiring pass-through status for CY 2011 are biologicals that are solely surgically implanted according to their FDA-approved indications. These products are described by HCPCS codes C9356 (Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter) and C9359 (Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc). Like the two implantable biologicals with expiring pass-through status in CY 2010 that were discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60459 through 60499), we believe that the two biologicals specified above with expiring pass-through status for CY 2011 differ from other biologicals paid under the OPPS in that they specifically function as surgically implanted devices. As a result of the CY 2010 packaged payment methodology for all nonpass-through implantable biologicals, we are proposing to package payment for HCPCS codes C9356 and C9359 and assign them status indicator "N" for CY 2011. In addition, any new biologicals without pass-through status that are surgically inserted or implanted (through a surgical incision or a natural orifice) would be packaged in CY 2011.

Moreover, for nonpass-through biologicals that may sometimes be used as implantable devices, we continue to instruct hospitals to not bill separately for the HCPCS codes for the products when used as implantable devices. This reporting ensures that the costs of these products that may be, but are not always, used as implanted biologicals are appropriately packaged into payment for the associated implantation procedures.

3. Proposed Payment for Drugs and Biologicals without Pass-Through Status That Are Not Packaged

a. Proposed Payment for Specified Covered Outpatient Drugs (SCODs) and Other Separately Payable and Packaged Drugs and Biologicals

Section 1833(t)(14) of the Act defines certain separately payable radiopharmaceuticals, drugs, and biologicals and mandates specific payments for these items. Under section 1833(t)(14)(B)(i) of the Act, a "specified covered outpatient drug" is a covered outpatient drug, as defined in section 1927(k)(2) of the Act, for which a separate APC has been established and that either is a radiopharmaceutical agent or is a drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

Under section 1833(t)(14)(B)(ii) of the Act, certain drugs and biologicals are designated as exceptions and are not included in the definition of "specified covered outpatient drugs," known as SCODs. These exceptions are—

- A drug or biological for which payment is first made on or after January 1, 2003, under the transitional pass-through payment provision in section 1833(t)(6) of the Act.
- A drug or biological for which a temporary HCPCS code has not been assigned.
- During CYs 2004 and 2005, an orphan drug (as designated by the Secretary).

Section 1833(t)(14)(A)(iii) of the Act requires that payment for SCODs in CY 2006 and subsequent years be equal to the average acquisition cost for the drug for that year as determined by the Secretary, subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the Government Accountability Office (GAO) in CYs 2004 and 2005. If hospital acquisition cost data are not available, the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act, as calculated and adjusted by the Secretary as necessary. Most physician Part B drugs are paid pursuant to ASP+6 percent pursuant to section 1842(o) of the Act and section 1847A of the Act.

Section 1833(t)(14)(E) of the Act provides for an adjustment in OPPS payment rates for overhead and related expenses, such as pharmacy services and handling costs. Section 1833(t)(14)(E)(i) of the Act required MedPAC to study pharmacy overhead and to make recommendations to the Secretary regarding whether, and if so how, a payment adjustment should be made to compensate hospitals for them. Section 1833(t)(14)(E)(ii) of the Act authorizes the Secretary to adjust the weights for ambulatory procedure classifications for SCODs to take into account the findings of the MedPAC study.

In the CY 2006 OPPS proposed rule (70 FR 42728), we discussed the June 2005 report by MedPAC regarding pharmacy overhead costs in HOPDs and summarized the findings of that study:

- Handling costs for drugs, biologicals, and radiopharmaceuticals administered in the HOPD are not insignificant;
- Little information is available about the magnitude of pharmacy overhead costs;
- Hospitals set charges for drugs, biologicals, and radiopharmaceuticals at levels that reflect their respective handling costs; and
- Hospitals vary considerably in their likelihood of providing services which utilize drugs, biologicals, or radiopharmaceuticals with different handling costs.

As a result of these findings, MedPAC developed seven drug categories for pharmacy and nuclear medicine handling costs based on the estimated level of hospital resources used to prepare the products (70 FR 42729). Associated with these categories were two recommendations for accurate payment of pharmacy overhead under the OPPS.

1. CMS should establish separate, budget neutral payments to cover the costs hospitals incur for handling separately payable drugs, biologicals, and radiopharmaceuticals.

2. CMS should define a set of handling fee APCs that group drugs, biologicals, and radiopharmaceuticals based on attributes of the products that affect handling costs; CMS should instruct hospitals to submit charges for these APCs and base payment rates for the handling fee APCs on submitted charges reduced to costs.

In response to the MedPAC findings, in the CY 2006 OPPS proposed rule (70 FR 42729), we discussed our belief that, because of the varied handling resources required to prepare different forms of drugs, it would be impossible to exclusively and appropriately assign a drug to a certain overhead category that would apply to all hospital outpatient uses of the drug. Therefore, our CY 2006 OPPS proposal included a proposal to establish three distinct Level II HCPCS C-codes and three corresponding APCs for drug handling categories to differentiate overhead costs for drugs and biologicals (70 FR 42730). We also proposed: (1) To combine several overhead categories recommended by MedPAC; (2) to establish three drug handling categories, as we believed that larger groups would minimize the number of drugs that may fit into more than one category and would lessen any undesirable payment policy incentives to utilize particular forms of drugs or specific preparation methods; (3) to collect hospital charges for these HCPCS C-codes for 2 years; and (4) to ultimately base payment for the corresponding drug handling APCs on CY 2006 claims data available for the CY 2008 OPPS.

In the CY 2006 OPPS final rule with comment period (70 FR 68659 through 68665), we discussed the public comments we received on our proposal regarding pharmacy overhead. The overwhelming majority of commenters did not support our proposal and urged us not to finalize this policy, as it would be administratively burdensome for hospitals to establish charges for HCPCS codes for pharmacy overhead and to report them. Therefore, we did not finalize this proposal for CY 2006. Instead, we established payment for separately payable drugs and biologicals at ASP+6 percent, which we calculated by comparing the estimated aggregate cost of separately payable drugs and biologicals in our claims data to the estimated aggregate ASP dollars for separately payable drugs and biologicals, using the ASP as a proxy for average acquisition cost (70 FR 68642). Hereinafter, we refer to this methodology as our standard drug payment methodology. We concluded that payment for drugs and biologicals and pharmacy overhead at a combined ASP+6 percent rate would serve as the best proxy for the combined acquisition and overhead costs of each of these products.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68091), we finalized our proposed policy to provide a single payment of ASP+6 percent for the hospital's acquisition cost for the drug or biological and all associated pharmacy overhead and handling costs. The ASP+6 percent rate that we

finalized was higher than the equivalent average ASP-based amount calculated from claims of ASP+4 percent according to our standard drug payment methodology, but we adopted payment at ASP+6 percent for stability while we continued to examine the issue of the costs of pharmacy overhead in the HOPD.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42735), in response to ongoing discussions with interested parties, we proposed to continue our methodology of providing a combined payment rate for drug and biological acquisition and pharmacy overhead costs. We also proposed to instruct hospitals to remove the pharmacy overhead charge for both packaged and separately payable drugs and biologicals from the charge for the drug or biological and report the pharmacy overhead charge on an uncoded revenue code line on the claim. We believed that this would provide us with an avenue for collecting pharmacy handling cost data specific to drugs in order to package the overhead costs of these items into the associated procedures, most likely drug administration services. Similar to the public response to our CY 2006 pharmacy overhead proposal, the overwhelming majority of commenters did not support our CY 2008 proposal and urged us to not finalize this policy (72 FR 66761). At its September 2007 meeting, the APC Panel recommended that hospitals not be required to separately report charges for pharmacy overhead and handling and that payment for overhead be included as part of drug payment. The APC Panel also recommended that CMS continue to evaluate alternative methods to standardize the capture of pharmacy overhead costs in a manner that is simple to implement at the organizational level (72 FR 66761). Because of concerns expressed by the APC Panel and public commenters, we did not finalize the proposal to instruct hospitals to separately report pharmacy overhead charges for CY 2008. Instead, in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66763), we finalized a policy of providing payment for separately payable drugs and biologicals and their pharmacy overhead at ASP+5 percent as a transition from their CY 2007 payment of ASP+6 percent to payment based on the equivalent average ASP-based payment rate calculated from hospital claims according to our standard drug payment methodology, which was ASP+3 percent for the CY 2008 OPPS/ASC final rule with comment period. Hospitals continued to include charges for pharmacy overhead costs in the line-item charges for the associated drugs reported on claims.

For CY 2009, we proposed to pay separately payable drugs and biologicals at ASP+4 percent, including both SCODs and other drugs without CY 2009 OPPS pass-through status, based on our standard drug payment methodology, and we also proposed to split the "Drugs Charged to Patients" cost center into two cost centers: One for drugs with high pharmacy overhead costs and one for drugs with low pharmacy overhead costs (73 FR 41492). We noted that we expected that CCRs from the proposed new cost centers would be available in 2 to 3 years to refine OPPS drug cost estimates by accounting for differential hospital markup practices for drugs with high and low overhead costs. After consideration of the public comments received and the APC Panel recommendations, we finalized a CY 2009 policy (73 FR 68659) to provide payment for separately payable nonpass-through drugs and biologicals based on costs calculated from hospital claims at a 1-year transitional rate of ASP+4 percent, in the context of an equivalent average ASP-based payment rate of ASP+2 percent calculated according to our standard drug payment methodology from the final rule claims and cost report data. We did not finalize our proposal to split the single standard "Drugs Charged to Patients" cost center into two cost centers largely due to concerns raised to us by hospitals about the associated administrative burden. Instead, we indicated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68659) that we would continue to explore other potential approaches to improve our drug cost estimation methodology, thereby increasing payment accuracy for separately payable drugs and biologicals.

In response to the CMS proposals for the CY 2008 and CY 2009 OPPS, a group of pharmacy stakeholders (hereinafter referred to as the pharmacy stakeholders), including some cancer hospitals, some pharmaceutical manufacturers, and some hospital and professional associations, commented that CMS should pay an acquisition cost of ASP+6 percent for separately payable drugs, should substitute ASP+6 percent for the packaged cost of all packaged drugs and biologicals on procedure claims, and should redistribute the difference between the aggregate estimated packaged drug cost in claims and payment for all drugs, including packaged drugs at ASP+6 percent, as separate pharmacy overhead payments for separately payable drugs. They indicated that this approach would preserve the aggregate drug cost observed in the claims data, while significantly increasing payment accuracy for individual drugs and procedures by redistributing drug cost from packaged drugs. Their suggested approach would provide a separate overhead payment for each separately payable drug or biological at one of three different levels, depending on the pharmacy stakeholders' assessment of the complexity of pharmacy handling associated with each specific drug or biological (73 FR 68651 through 68652). Each separately payable drug or biological HCPCS code would be assigned to one of the three overhead categories, and the separate pharmacy overhead payment applicable to the category would be made when each of the separately payable drugs or biologicals was paid.

In the CY 2010 OPPS/ASC proposed rule (74 FR 35332), we proposed to redistribute between one-third and one-half of the estimated overhead cost associated with coded packaged drugs and biologicals with an ASP which resulted in our proposal to pay for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals that did not have pass-through payment status at ASP+4 percent. We calculated estimated overhead cost for coded packaged drugs and biologicals by determining the difference between the aggregate claims cost for coded packaged drugs and biologicals with an ASP and the ASP dollars (ASP multiplied by the drug's or biological's units in the claims data) for those same coded drugs and biologicals; this difference was our estimated overhead cost for coded packaged drugs and biologicals. In our rationale described in the CY 2010 OPPS/ASC proposed rule (74 FR 35326 through 35333), we stated that we believed that approximately $150 million of the estimated $395 million total in pharmacy overhead cost included in our claims data for coded packaged drugs and biologicals with reported ASP data should be attributed to separately payable drugs and biologicals and that the $150 million serves as the adjustment for the pharmacy overhead costs of separately payable drugs and biologicals. As a result, we also proposed to reduce the cost of coded drugs and biologicals that is packaged into payment for procedural APCs to offset the $150 million adjustment to payment for separately payable drugs and biologicals. In addition, we proposed that any redistribution of

pharmacy overhead cost that may arise from CY 2010 final rule data would occur only from coded packaged drugs and biologicals with an ASP to separately payable drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals.

Using our CY 2010 proposed rule data, and applying our longstanding methodology for calculating the total cost of separately payable drugs and biologicals in our claims compared to the ASP dollars for the same drugs and biologicals, without applying the proposed overhead cost redistribution, we determined that the estimated aggregate cost of separately payable drugs and biologicals (status indicators "K" and "G"), including acquisition and pharmacy overhead costs, was equivalent to ASP–2 percent. Therefore, under the standard methodology for establishing payment for separately payable drugs and biologicals, we would have paid for those drugs and biologicals at ASP–2 percent for CY 2010, their equivalent average ASP-based payment rate. We also determined that the estimated aggregate cost of coded packaged drugs and biologicals with an ASP (status indicator "N"), including acquisition and pharmacy overhead costs, was equivalent to ASP+247 percent.

While we had no way of assessing whether this current distribution of overhead cost to coded packaged drugs and biologicals with an ASP was appropriate, we acknowledged that the established method of converting billed charges to costs had the potential to "compress" the calculated costs to some degree. Further, we recognized that the attribution of pharmacy overhead costs to packaged or separately payable drugs and biologicals through our standard drug payment methodology of a combined payment for acquisition and pharmacy overhead costs depends, in part, on the treatment of all drugs and biologicals each year under our annual drug packaging threshold. Changes to the packaging threshold may result in changes to payment for the overhead cost of drugs and biologicals that do not reflect actual changes in hospital pharmacy overhead cost for those products. For these reasons, we stated that we believed some portion, but not all, of the total overhead cost that is associated with coded packaged drugs and biologicals (the difference between aggregate cost for those drugs on the claims and ASP for the same drugs), based on our standard drug payment methodology, should, at least for CY 2010, be attributed to separately payable drugs and biologicals.

We acknowledged that the observed combined payment for acquisition and pharmacy overhead costs of ASP–2 percent for separately payable drugs and biologicals may be too low and ASP+247 percent for coded packaged drugs and biologicals with reported ASP data in the CY 2010 claims data may be too high (74 FR 35328). We stated that a middle ground of approximately one-third to one-half of the total pharmacy overhead cost currently associated with coded packaged drugs and biologicals in the CY 2008 claims data would represent the most accurate redistribution of pharmacy overhead cost. We included a discussion of indirect overhead costs, such as administrative and general costs, capital costs, staff benefits, and other facility costs that do not vary across drugs, and direct overhead costs, including staff, supplies, and equipment that are directly attributable only to the storage, handling, preparation, and distribution of drugs and biologicals and which do vary, sometimes considerably, depending upon the drug being furnished. We presented analyses that modeled the redistribution of overhead costs in the packaged drugs to all drugs and biologicals based on overhead relative weights derived from industry and from MedPAC's recommended overhead relative weights and by assigning each drug, both packaged and separately paid, to a category of overhead complexity. Analyses relying on both sets of weights suggest that indirect costs are a sizable component of the overhead costs associated with all drugs and biologicals (74 FR 60505 to 60508).

Within the one-third to one-half parameters, we proposed that reallocating $150 million in drug and biological cost observed in the claims data from coded packaged drugs and biologicals with an ASP to separately payable drugs and biologicals for CY 2010 would more appropriately distribute pharmacy overhead cost among packaged and separately payable drugs and biologicals. Based on this redistribution, we proposed a payment rate for separately payable drugs and biologicals of ASP+4 percent. Thus, we proposed a pharmacy overhead adjustment for separately payable drugs and biologicals in CY 2010 that would result in their payment at ASP+4 percent. Redistributing $150 million represented a reduction in cost of coded packaged drug and biologicals with reported ASP data in the CY 2010 proposed rule claims data of 27 percent.

We also proposed that any redistribution of pharmacy overhead cost that may arise from CY 2010 final rule data would occur only from some drugs and biologicals to other drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals in our claims data (no redistribution of cost would occur from other services to drugs and biologicals or vice versa). We further proposed that the claims data for 340B hospitals be included in the calculation of payment for drugs and biologicals under the CY 2010 OPPS and that 340B hospitals would be paid the same amounts for separately payable drugs and biologicals as hospitals that do not participate in the 340B program. Finally, we proposed that, in accordance with our standard drug payment methodology, the estimated payments for separately payable drugs and biologicals would be taken into account in the calculation of the weight scaler that would apply to the relative weights for all procedural services (but would not apply to separately payable drugs and biologicals) paid under the OPPS, as required by section 1833(t)(14)(H) of the Act.

In the CY 2010 OPPS final rule with comment period, we adopted a transitional payment rate of ASP+4 percent based on a pharmacy overhead adjustment methodology for CY 2010 that redistributed $200 million from packaged drug cost to separately payable drug cost. This $200 million included the proposed $150 million redistribution from the pharmacy overhead cost of coded packaged drugs and biologicals for which an ASP is reported and an additional $50 million dollars from the total uncoded drug and biological cost to separately payable drugs and biologicals as a conservative estimate of the pharmacy overhead cost of uncoded packaged drugs and biologicals that should be appropriately associated with the cost of separately payable drugs and biologicals (74 FR 60517). We noted that our final CY 2010 payment policy for separately payable drugs and biologicals at ASP+4 percent fell within the range of ASP–3 percent, that would have resulted from no pharmacy overhead cost redistribution from packaged to separately payable drugs and biologicals, to ASP+7 percent, that would have resulted from redistribution of pharmacy overhead cost based on expansive assumptions about the nature of uncoded packaged drug and biological cost. We acknowledged that, to some unknown extent, there are pharmacy overhead costs being attributed to the items and services reported under the pharmacy revenue code without HCPCS codes that are likely pharmacy overhead for

separately payable drugs. With regard to uncoded packaged drug costs, we redistributed $50 million and stated that we could not know the amount of overhead associated with these drugs without making significant further assumptions about the amount of pharmacy overhead cost associated with the drugs and biologicals captured by these uncoded packaged drug costs. We finalized a policy of redistributing pharmacy overhead cost from some drugs and biologicals to other drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals in our claims data (no redistribution of cost would occur from other services to drugs and biologicals or vice versa).

b. Proposed Payment Policy

Section 1833(t)(14)(A)(iii) of the Act, as described above, continues to be applicable to determining payments for SCODs for CY 2011. This provision requires that payment for SCODs be equal to the average acquisition cost for the drug for that year as determined by the Secretary, subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the GAO in CYs 2004 and 2005. If hospital acquisition cost data are not available, section 1833(t)(14)(A)(iii)(II) of the Act requires that payment be equal to payment rates established under the methodology described in section 1842(o) of the Act, section 1847A of the Act (ASP+6 percent as paid for physician Part B drugs), or section 1847B of the Act (CAP), as the case may be, as calculated and adjusted by the Secretary as necessary. In accordance with sections 1842(o) and 1847A, payment for most Medicare Part B drugs furnished on or after January 1, 2005, are paid based on the ASP methodology. Medicare Part B drugs generally fall into three categories: Physician drugs (drugs furnished incident to a physician's service), DME drugs (drugs furnished under the durable medical equipment benefit), and drugs specifically covered by statute (certain oral anti-cancer and immunosuppressive drugs). In addition, section 1833(t)(14)(E)(ii) of the Act authorizes, but does not require, the Secretary to adjust APC weights to take into account the 2005 MedPAC report relating to overhead and related expenses, such as pharmacy services and handling costs. As discussed in V.B.3.a. of this proposed rule, since CY 2006, we have used ASP data and costs estimated from charges on hospital claims data as a proxy for both the average hospital acquisition cost that the statute requires for payment of SCODs and the associated pharmacy overhead cost to establish a combined payment rate for acquisition cost and pharmacy overhead. Until CY 2010, we applied this methodology to payment for all separately payable drugs and biologicals without pass-through status, including both SCODs and other drugs and biologicals that do not meet the statutory definition of SCODs.

However, for the CY 2010 OPPS, we revised the standard methodology to include an adjustment for pharmacy overhead. We acknowledged that the established method of converting billed charges to costs had the potential to "compress" the calculated costs to some degree. We recognized that the attribution of pharmacy overhead costs to packaged or separately payable drugs and biologicals through our standard drug payment methodology of a combined payment for acquisition and pharmacy overhead costs depends, in part, on the treatment of all drugs and biologicals each year under our annual drug packaging threshold. To some unknown extent, we believe that some pharmacy overhead costs are being attributed to packaged drugs and biologicals that are likely pharmacy overhead costs for separately payable drugs.

For this CY 2011 OPPS/ASC proposed rule, using our standard methodology for determining the total cost of separately payable drugs in our CY 2009 claims data and comparing these costs to the ASP dollars (April 2010 ASP quarterly payment rates multiplied by units for the separately payable drugs and biologicals in the claims data) for the same drugs, we determined that the total payment for separately payable drugs (status indicators "K" and "G"), including acquisition and pharmacy overhead costs, is ASP+0 percent, which also would be the ASP-based payment rate under the standard methodology that we established in CY 2006. Additionally, we determined that the total aggregate cost for packaged drugs with a HCPCS code for which manufacturers report ASP data (status indicator "N"), including acquisition and pharmacy overhead costs, is equivalent to ASP+283 percent. Finally, we determined that the total cost for both packaged drugs with a HCPCS code and separately payable drugs (status indicators "N", "K" and "G") for which we also have ASP data, including acquisition and pharmacy overhead costs, is ASP+14 percent. Table 25 below displays our findings with regard to the percentage of ASP in comparison to the cost for packaged coded drugs and for separately payable coded drugs before application of the overhead adjustment methodology.

TABLE 25.—CY 2011 PROPOSED RULE DATA: ASP+X CALCULATION UNDER STANDARD METHODOLOGY

	Total ASP Dollars for Drugs and Biologicals in Claims Data (in millions)*	Total Cost of Drugs and Biologicals in Claims Data (in millions)**	Ratio of Cost to ASP (column C /column B)	ASP+X Percent
Uncoded packaged pharmacy revenue code costs	Unknown	$623	NA	NA
Coded Packaged Drugs and Biologicals with a reported ASP	$155	$593	3.83	ASP+283
Separately Payable Drugs and Biologicals with a reported ASP	$2,951	$2,939	1.00	ASP+0
All Coded Drugs and Biologicals with a reported ASP	$3,105	$3,532	1.14	ASP+14

*Total April 2010 ASP dollars (ASP multiplied by drug or biological units in CY 2009 claims) for drugs and biologicals with a HCPCS code and ASP information.
**Total cost in the CY 2009 claims data for drugs and biologicals.

We believe that the combined payment for average acquisition and pharmacy overhead costs under our standard methodology may understate the cost of separately payable drugs and biologicals and related pharmacy overhead for those drugs and biologicals. Specifically, we believe payment at ASP+0 percent for such costs may not be sufficient. We also acknowledge that ASP+283 percent may overstate the combined acquisition and pharmacy overhead cost of packaged drugs and biologicals. Therefore, for CY 2011, we are proposing to continue our CY 2010 pharmacy overhead adjustment methodology. We are proposing to redistribute $150 million from the pharmacy overhead cost of coded packaged drugs and biologicals with reported ASP data and to redistribute $50 million from the cost of uncoded packaged drugs and biologicals without an ASP, for a total redistribution of $200 million in drug cost from the cost of coded and uncoded packaged drugs to the cost of separately payable drugs, as we did for the CY 2010 final rule. We estimate the overhead cost for coded packaged drugs to be $438 million ($593 million in total cost for coded packaged drugs and biologicals with a reported ASP less $155 million in total ASP dollars for coded packaged drugs and biologicals with a reported ASP). Similar to the CY 2010 proposal, we are proposing that any redistribution of pharmacy overhead cost would occur only among drugs and biologicals in our claims data, that no redistribution of cost would occur from other services to drugs and biologicals or vice versa. We continue to believe that redistributing $200 million from packaged to separately payable drugs and biologicals is an appropriate redistribution of pharmacy overhead costs to address any charge compression in the standard methodology. This would result in a proposed CY 2011 payment rate for separately payable drugs and biologicals of ASP+6 percent. We emphasize that we are proposing a pharmacy overhead adjustment methodology based on a redistribution of overhead cost and that our proposal for payment at ASP+6 percent is a coincidental outcome of the proposed methodology to redistribute $200 million from packaged drugs to separately payable drugs. We are not proposing payment of ASP+6 percent for separately payable drugs as an alternative to payment of average acquisition costs based on a survey under section 1833(t)(14)(A)(iii)(I) of the Act. We continue to believe that the average sales price information collected under section 1847A (b)(1)(A) of the Act and our hospital claims data is a suitable proxy for the acquisition cost data. For a full explanation of our rationale for using ASP data and our hospital claims data as a suitable proxy for acquisition cost data we refer readers to the CY2010 OPPS/ASC final rule with comment period (74 FR 60515). We further note that, in past years, the proposed ASP+X amount decreased by at least 1 percentage point when we updated the ASP data, claims data, and cost report data between the proposed rule and the final rule with comment period, from ASP+5 to ASP+4 for example. Therefore, it is possible that this proposed methodology would result in an ASP+X amount that is different from ASP+6.

As indicated in Table 25 above, if we were to propose to establish payment for separately payable drugs and biologicals under the standard methodology established in CY 2006 without applying a pharmacy overhead adjustment, we would propose to pay for separately payable drugs and biologicals at ASP+0 percent. However, because we are concerned about underpaying separately payable drugs and biologicals, we believe a pharmacy overhead adjustment using a redistribution methodology for determining the amount of payment for drugs and biologicals as we did for CY 2010 is appropriate. We believe the observed ASP+0 percent reflects some amount of charge compression and variability attributable to choice of a packaging threshold.

We continue to believe that the methodology to redistribute $200 million in drug overhead cost from packaged coded and uncoded drugs to separately payable drugs, while keeping the total cost of drugs in the claims data constant, continues to be appropriate for the reasons set forth in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60501 through 60517). Therefore, we are proposing to redistribute $200 million in drug overhead costs from coded and uncoded packaged drugs to separately payable drugs while keeping the total cost of drugs in the claims data constant. Table 26 presents the ASP+X amount after redistribution of $150 million from the estimated overhead of $438 million for coded packaged drugs with reported ASP data to separately payable drugs and biologicals and $50 million from uncoded packaged drug cost for which an estimate of overhead cannot be calculated, resulting in a total redistribution of $200 million in cost from packaged drugs and biologicals to separately payable drugs and biologicals.

TABLE 26.— PROPOSED CY 2011 PHARMACY OVERHEAD ADJUSTMENT PAYMENT METHODOLOGY: ASP+X CALCULATION

	Total ASP Dollars for Drugs and Biologicals in Claims Data (in millions)*	Total Cost of Drugs and Biologicals in Claims Data *after Adjustment* (in millions)**	Ratio of Cost to ASP (column C /column B)	ASP+X Percent
Uncoded packaged pharmacy revenue code costs	Unknown	$548	NA	NA
Coded Packaged Drugs and Biologicals with a reported ASP	$155	$443	2.86	ASP+186
Separately Payable Drugs and Biologicals with a reported ASP	$2,951	$3,139	1.06	ASP+6
All Coded Drugs and Biologicals with a reported ASP	$3,105	$3,532	1.14	ASP+14

*Total April 2010 ASP dollars (ASP multiplied by drug or biological units in CY 2009 claims) for drugs and biologicals with a HCPCS code and ASP information.
**Total cost in the CY 2009 claims data for drugs and biologicals.

We generally received positive comments on our CY 2010 proposal to redistribute $150 million of drug cost from packaged drugs and biologicals to separately payable drugs and biologicals to establish their final combined payment level. The general comment we received on our pharmacy overhead adjustment methodology was that the amount of drug cost that should be redistributed should be greater, a sentiment reiterated at the February 2010 APC Panel meeting and discussed in greater detail below. Commenters and presenters to the APC Panel specifically argued that our CY 2010 proposal had not acknowledged the potential overhead cost available for redistribution in the uncoded packaged drugs.

We explain below our rationale for why we are not proposing to redistribute more cost from uncoded packaged drugs. Conversations with stakeholders and hospitals over the past year suggest that hospitals do not always report HCPCS codes for drugs for a variety of reasons including an internal practice not to code for packaged drugs, building the cost of the drugs into the associated procedure charge, lack of a HCPCS code for some drugs and biologicals, and purchased

vendor billing software functionality that removes codes. A key premise of our pharmacy overhead adjustment redistribution methodology was our assessment of the amount of drug cost in the claims data above aggregate ASP available as "overhead" for redistribution. Knowing the specific HCPCS codes for packaged drugs and their associated ASP allows us to assess the differential between aggregate ASP and claim cost for packaged drugs and to assess the intensity of pharmacy overhead associated with these drugs. The inability to know which drugs are captured by uncoded drug charges on a claim is challenging because we cannot know what is being charged or what the overhead complexity might be. Further, we understand that there is wide variation in how hospitals set charges for items and services in their chargemasters, sometimes charging separately for overhead (for example, paper cups, gloves, transportation, staff consultations) and sometimes including charges for those supplies in the charge for drugs. Therefore, we cannot be certain that the amount of uncoded pharmacy overhead cost is as high as the public has suggested or that hospitals mark up these uncoded drugs and biologicals in the same way as packaged drugs and biologicals with HCPCS codes.

In addition, at its February 2010 meeting, the APC Panel recommended that CMS reallocate a larger portion of the pharmacy overhead costs from packaged drugs to separately payable drugs for CY 2011. We do not accept the APC Panel's recommendation to redistribute a larger portion of the pharmacy overhead costs from packaged drugs to separately payable drugs because we also believe the analysis provided by the presenters at the February 2010 APC Panel meeting is insufficient to determine that it is appropriate to propose to redistribute more payment from uncoded packaged drugs and biologicals to separately paid drugs and biologicals. Although presenters at the APC Panel meeting acknowledged that CMS could not know the ASP for these uncoded drug costs, they provided analyses examining the proportion of estimated coded packaged drug cost relative to estimated uncoded packaged drug cost out of all packaged drug cost (both coded and uncoded) and concluded that uncoded and coded packaged drugs are probably the same drugs because hospitals tend to have roughly the same amount of estimated packaged drug cost in their claims data but wide variation on the proportion of coded packaged drugs. They also presented analyses stating that the relationship between pharmacy overhead and handling costs and the cost of drugs in the cost report data can be interpreted as providing a relationship between cost and overhead comparable to the ASP+X calculated for all drug cost in the claims data, if an aggregate ASP amount is assumed to be the same for uncoded drugs and biologicals as it is for coded packaged drugs. The presenters concluded that the uncoded packaged drug and biological cost accounts for exactly the same drugs and biologicals as those in the coded packaged drug and biological cost and that CMS could assume the same proportional amount of overhead cost that appears in the uncoded packaged drug and biological cost as observed in the coded packaged drug cost. They asked that CMS assume that uncoded packaged drugs and biologicals resemble coded packaged drugs and biologicals and treat them comparably for purposes of estimating "overhead." We reviewed the presenters' analyses, but we believe the information they provided is insufficient in order to enable us to isolate the portion of the uncoded packaged drug and biological cost that is pharmacy overhead cost. In order to isolate the portion of uncoded packaged drug and biological cost that is pharmacy overhead cost, we believe that we would need more drug-specific information reported to us by hospitals, either through more reporting of packaged drugs on claims or through more granular cost centers on the cost report. We note that we investigated uncoded drugs further. We evaluated the services with which uncoded packaged drug cost appears in the claims data in an effort to assess how much uncoded drugs resemble coded packaged drugs. We found that most uncoded packaged drug costs appear with surgical services and that most coded packaged drug costs appear with medical services. In light of this information, we are not confident that the drugs captured by uncoded drug cost are the same drugs captured by coded packaged drug cost. Therefore, we do not believe we can assume that they are the same drugs, with comparable overhead and handling costs. Without being able to calculate an ASP for these drugs and without being able to gauge the magnitude of the overhead complexity associated with these drugs, we do not believe we should assume that the same amount of proportional overhead is available for redistribution for this proposed rule. We are not convinced that the same proportionate amount of overhead cost should be redistributed from the packaged uncoded drugs as the amount of overhead cost that is appropriate to redistribute for packaged coded drugs. In addition, we remain committed to using hospital claims data reported to us by hospitals to set the OPPS payment rates because it provides more specificity about the provided drugs and biologicals and would allow us to assess an overhead amount for those drugs.and biologicals. Therefore, we continue to propose to redistribute a conservative estimate, $50 million, in cost from uncoded packaged drugs to separately payable drugs and biologicals.

Based on the reasons set forth above, and consistent with our rationale outlined in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60511 through 60512), we cannot be certain that we know what portion of the uncoded drugs and biologicals cost is acquisition cost versus pharmacy overhead costs, and we have no compelling reason to redistribute a greater amount of drug cost. Therefore, our proposal to redistribute $200 million in drug cost from packaged drugs to separately payable drugs, while maintaining the total cost of drugs in our claims data, consists of redistributing $150 million in "overhead" cost from packaged coded drugs and biologicals with reported ASP data to separately payable drugs and biologicals and redistributing $50 million in drug cost from uncoded packaged drugs and biologicals to separately payable drugs and biologicals as a conservative estimate of potential overhead cost appearing in uncoded packaged drugs that should have been associated with separately payable drugs and biologicals.

We have indicated that the basis for this CY 2011 proposal to redistribute $150 million dollars from packaged coded drugs and biologicals to separately payable drugs and biologicals as a pharmacy overhead adjustment is the same as our CY 2010 final policy. The CY 2010 policy was based on our assessment that between one-third and one-half of the overhead cost in coded packaged drugs could be attributable to charge compression due to our cost estimation methodology and our choice of a packaging threshold. We continue to believe that a precise amount of drug cost attributable to charge compression cannot be known precisely, but that $150 million is an appropriate adjustment. The current proposal for $150 million falls within the approximate one-third to one-half range established in CY 2010 with updated CY 2009 claim and cost report data, and we anticipate that the $150 million would

continue to roughly approximate one-third to one-half or thereabouts of overhead cost in the coded packaged drugs with updated ASP data, and claim and cost report data for the final rule. In order to redistribute the $150 million in pharmacy overhead from packaged costs of drugs and biologicals for which a HCPCS code was reported, we reduced the costs attributable to these items and services by multiplying the costs derived from the revenue center charges for packaged HCPCs codes by 0.75 (a 25 percent reduction).

To redistribute the $50 million in total cost from packaged costs of drugs and biologicals for which no HCPCS code was reported, we reduced the costs attributable to these items and services by multiplying the costs derived from revenue center charges for pharmacy by 0.92 (an 8 percent reduction). We note that for this CY 2011 OPPS/ASC proposed rule, the $50 million in drug overhead cost that we propose to redistribute from packaged uncoded drugs and biologicals to separately payable drugs and biologicals is 8 percent, comparable to the CY 2010 final rule amount. We note that $50 million as a percent of uncoded drug cost may be close to the 8 percent range or thereabouts of uncoded drug and biological cost in the final rule with updated claim and cost data. In addition, although we have arrived at a proposed payment rate of ASP+6 percent, we emphasize that the ASP+6 percent amount may change when ASP+X is recalculated using updated ASP data and claims and cost report data for the CY 2011 OPPS/ASC final rule with comment period.

We also note that, although it is CMS' longstanding policy under the OPPS to refrain from instructing hospitals on the appropriate revenue code to use to charge for specific services, we continue to encourage hospitals to bill all drugs and biologicals with HCPCS codes, regardless of whether they are separately payable or packaged. We believe that a practice of billing all drugs and biologicals with HCPCS codes under revenue code 0636 (Pharmacy—Extension of 025X; Drugs Requiring Detailed Coding) would be consistent with NUBC billing guidelines and would provide us with the most complete and detailed information for ratesetting. We note that we make packaging determinations for drugs annually based on cost information reported under HCPCS codes, and the OPPS ratesetting is best served when hospitals report charges for all items and services with HCPCS codes when they are available, whether or not Medicare makes separate payment for the items and services.

The APC Panel also recommended that CMS evaluate the impact of changes in its drug payment policy on hospitals (categorized by type and size) of such a reallocation and present this analysis to the APC Panel at its next meeting. We accept this recommendation and will present this analysis to the APC Panel at its next meeting.

The APC Panel also recommended that CMS continue to evaluate the impact of its drugs and biologicals overhead payment policy on hospitals. We accept this recommendation. We note that our regulatory impact analysis presented in section XXIII of this proposed rule includes some of the analysis requested in these last two recommendations.

In conclusion, we are proposing for CY 2011 to continue our CY 2010 redistribution methodology, to redistribute $150 million from the pharmacy overhead cost of coded packaged drugs and biologicals with an ASP and to redistribute $50 million from the cost of uncoded packaged drugs and biologicals for a total of $200 million from cost in coded and uncoded packaged drugs to separately payable drugs. We are proposing to redistribute pharmacy overhead cost among drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals in our claims data (no redistribution of cost would occur from other services to drugs and biologicals or vice versa). The result of the proposed methodology when applied using April 2010 ASPs, data for claims for services furnished during CY 2009 and processed through the common working file before January 1, 2010, and the most current submitted cost reports as of January 1, 2010, is a proposed ASP+6 percent amount for CY 2011. We are further proposing to continue to include the claims data for 340B hospitals in the calculation of payment for drugs and biologicals under the CY 2011 OPPS because excluding data from hospitals that participate in the 340B program from our ASP+X calculation, but paying those hospitals at that derived payment amount, would effectively redistribute payment to drugs or biologicals from payment for other services under the OPPS, and we do not believe this redistribution would be appropriate (74 FR 35332). In addition, we are proposing that 340B hospitals continue to be paid the same amounts for separately payable drugs and biologicals as hospitals that do not participate in the 340B program for CY 2011 because commenters have generally opposed differential payment for hospitals based on their 340B participation status. In addition, we are proposing to include claims from 340B hospitals in our assessment of average acquisition cost under section 1833(t)(14)(A)(iii) of the Act. We are proposing that the estimated payments for separately payable drugs and biologicals be taken into account in the calculation of the weight scaler that would apply to the relative weights for all procedural services (but would not apply to separately payable drugs and biologicals) paid under the OPPS, as required by section 1833(t)(14)(H) of the Act.

Finally, we note that we continue to pursue the most appropriate methodology for establishing payment for drugs and biologicals under the OPPS and that we will continue to evaluate the appropriateness of this methodology in future years.

c. Proposed Payment Policy for Therapeutic Radiopharmaceuticals

From the implementation of the collection of ASP information in CY 2005, CMS exempted radiopharmaceutical manufacturers from reporting ASP data for all radiopharmaceuticals for payment purposes under the OPPS. (For more information, we refer readers to the CY 2005 OPPS final rule with comment period (69 FR 65811) and the CY 2006 OPPS final rule with comment period (70 FR 68655).) Consequently, we did not have ASP data for radiopharmaceuticals for consideration for OPPS ratesetting until we began collecting ASP for therapeutic radiopharmaceuticals for CY 2010. In accordance with section 1833(t)(14)(B)(i)(I) of the Act, we have classified radiopharmaceuticals under the OPPS as SCODs. As such, we have paid for radiopharmaceuticals at average acquisition cost as determined by the Secretary and subject to any adjustment for overhead costs. For CYs 2006 and 2007, we used mean unit cost data from hospital claims to determine each radiopharmaceutical's packaging status and implemented a temporary policy to pay for separately payable radiopharmaceuticals based on the hospital's charge for each radiopharmaceutical adjusted to cost using the hospital's overall CCR. The methodology of providing separate radiopharmaceutical payment based on charges adjusted to cost through application of an individual hospital's overall CCR for CYs 2006 and 2007 was finalized as an interim proxy for average acquisition cost.

In CY 2008, we packaged payment for all diagnostic radiopharmaceuticals and

we proposed and finalized a methodology to provide prospective payment for therapeutic radiopharmaceuticals (defined as those Level II HCPCS codes that include the term "therapeutic" along with a radiopharmaceutical in their long code descriptors) using mean costs derived from the CY 2006 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 (72 FR 66772). Following issuance of the CY 2009 OPPS/ASC proposed rule, section 142 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) amended section 1833(t)(16)(C) of the Act, as amended by section 106(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173), to further extend the payment period for therapeutic radiopharmaceuticals based on hospital's charges adjusted to cost through December 31, 2009. Therefore, for CY 2009, we finalized a policy to continue to pay hospitals for therapeutic radiopharmaceuticals at charges adjusted to cost through the end of CY 2009.

For CY 2010, we proposed and finalized a policy to pay for separately paid therapeutic radiopharmaceuticals under the ASP methodology adopted for separately payable drugs and biologicals. We allowed manufacturers to submit the ASP data in a patient-specific dose or patient-ready form in order to properly calculate the ASP amount for a given HCPCS code. This resulted in payment for therapeutic radiopharmaceuticals at ASP+4 percent for CY 2010 for products for which the manufacturer submitted ASP. We also finalized a policy to base therapeutic radiopharmaceutical payment on CY 2008 mean unit cost data derived from hospital claims if ASP information was unavailable.

We believe that the rationale outlined in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60524 through 60525) continues to be appropriate in for nonpass-through separately payable therapeutic radiopharmaceuticals in CY 2011. Therefore, we are proposing to continue to pay all nonpass-through, separately payable therapeutic radiopharmaceuticals under the ASP+X payment level established using the proposed pharmacy overhead adjustment based on a redistribution methodology to set payment for separately payable drugs and biologicals (as discussed in section V.B.3.b.) based on ASP information, if available, for a "patient ready" dose and updated on a quarterly basis for products for which manufacturers report ASP data. For a full discussion of how a "patient ready" dose is defined, we refer readers to the CY 2010 OPPS/ASC final rule with comment period, 74 FR 60520 through 60521. We also are proposing to rely on CY 2009 mean unit cost data derived from hospital claims data for payment rates for therapeutic radiopharmaceuticals for which ASP data are unavailable and to update the payment rates for separately payable therapeutic radiopharmaceuticals, according to our usual process for updating the payment rates for separately payable drugs and biologicals, on a quarterly basis if updated ASP information is available.

4. Proposed Payment for Blood Clotting Factors

For CY 2010, we provided payment for blood clotting factors under the same methodology as other nonpass-through separately payable drugs and biologicals under the OPPS and continued paying an updated furnishing fee. That is, for CY 2010, we provided payment for blood clotting factors under the OPPS at ASP+4 percent, plus an additional payment for the furnishing fee. We note that when blood clotting factors are provided in physicians' offices under Medicare Part B and in other Medicare settings, a furnishing fee is also applied to the payment. The CY 2010 updated furnishing fee is $0.170 per unit.

For CY 2011, we are proposing to pay for blood clotting factors at ASP+6 percent, consistent with our proposed payment policy for other nonpass-through separately payable drugs and biologicals, and to continue our policy for payment of the furnishing fee using an updated amount. Because the furnishing fee update is based on the percentage increase in the Consumer Price Index (CPI) for medical care for the 12-month period ending with June of the previous year and the Bureau of Labor Statistics releases the applicable CPI data after the MPFS and OPPS/ASC proposed rules are published, we are not able to include the actual updated furnishing fee in this proposed rule. Therefore, in accordance with our policy as finalized in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66765), we would announce the actual figure for the percent change in the applicable CPI and the updated furnishing fee calculated based on that figure through applicable program instructions and posting on the CMS Web site at: *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.*

5. Proposed Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without OPPS Hospital Claims Data

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173) does not address the OPPS payment in CY 2005 and after for drugs, biologicals, and radiopharmaceuticals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals. Because there is no statutory provision that dictated payment for such drugs, biologicals, and radiopharmaceuticals 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 to 2007, we implemented a policy to provide separate payment for new drugs, biologicals, and radiopharmaceuticals with HCPCS codes (specifically those new drug, biological, and radiopharmaceutical HCPCS codes in each of those calendar years that did not crosswalk to predecessor HCPCS codes) but which did not have pass-through status, at a rate that was equivalent to the payment they received in the physician's office setting, established in accordance with the ASP methodology for drugs and biologicals, and based on charges adjusted to cost for radiopharmaceuticals. For CYs 2008 and 2009, we finalized a policy to provide payment for new drugs (excluding contrast agents and diagnostic radiopharmaceuticals) and biologicals (excluding implantable biologicals for CY 2009) with HCPCS codes, but which did not have pass-through status and were without OPPS hospital claims data, at ASP+5 percent and ASP+4 percent, respectively, consistent with the final OPPS payment methodology for other separately payable drugs and biologicals. New therapeutic radiopharmaceuticals were paid at charges adjusted to cost based on the statutory requirement for CY 2008 and CY 2009 and payment for new diagnostic radiopharmaceuticals was packaged in both years. For CY 2010, we continued to provide payment for new drugs (excluding contrast agents), and nonimplantable biologicals with HCPCS codes that do not have pass-through status and are without OPPS hospital

claims data, at ASP+4 percent, consistent with the CY 2010 payment methodology for other separately payable nonpass-through drugs, and nonimplantable biologicals. We also finalized a policy to extend the CY 2009 payment methodology to new therapeutic radiopharmaceutical HCPCS codes, consistent with our final policy providing separate payment for therapeutic radiopharmaceuticals in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60581 through 60526), that do not crosswalk to CY 2009 HCPCS codes, do not have pass-through status, and are without OPPS hospital claims data, at ASP+4 percent.

For CY 2011, we are proposing to continue the CY 2010 payment methodology for new drugs (excluding contrast agents and diagnostic radiopharmaceuticals), nonimplantable biologicals, and therapeutic radiopharmaceuticals that meet the following conditions: those drugs, biologicals and therapeutic radiopharmaceuticals that have HCPCS codes that do not crosswalk to CY 2010 HCPCS codes, those that do not have pass-through status, and those that are without OPPS hospital claims data. We are proposing to provide payment for new CY 2011 drugs (excluding contrast agents and diagnostic radiopharmaceuticals), nonimplantable biologicals, and therapeutic radiopharmaceuticals, at ASP+6 percent, consistent with the proposed CY 2011 payment methodology for other separately payable nonpass-through drugs, nonimplantable biololgicals, and therapeutic radiopharmaceuticals. We believe this proposed policy would ensure that new nonpass-through drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals would be treated like other drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals under the OPPS, unless they are granted pass-through status. Only if they are pass-through drugs, nonimplantable biologicals, or therapeutic radiopharmaceuticals would they receive a different payment for CY 2011, generally equivalent to the payment these drug and biologicals would receive in the physician's office setting, consistent with the requirements of the statute.

We are proposing to continue our CY 2010 policy of packaging payment for all new nonpass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals with HCPCS codes but without claims data (those new CY 2011 diagnostic radiopharmaceutical, contrast agent, and implantable biological HCPCS codes that do not crosswalk to predecessor HCPCS codes), consistent with the proposed packaging of all existing nonpass-through diagnostic radiopharmaceuticals, contrast agents and implantable biologicals, as discussed in more detail in section V.B.2.d and IV.A.2. of this proposed rule.

In accordance with the OPPS ASP methodology, in the absence of ASP data, for CY 2011, we are proposing to continue the policy we implemented beginning in CY 2005 of using the WAC for the product to establish the initial payment rate for new nonpass-through drugs and biologicals with HCPCS codes, but which are without OPPS claims data. However, we note that if the WAC is also unavailable, we would make payment at 95 percent of the product's most recent AWP. We also are proposing to assign status indicator "K" to HCPCS codes for new drugs and nonimplantable biologicals without OPPS claims data and for which we have not granted pass-through status. We further note that, with respect to new items for which we do not have ASP data, once their ASP data become available in later quarter submissions, their payment rates under the OPPS would be adjusted so that the rates would be based on the ASP methodology and set to the finalized ASP-based amount (proposed for CY 2011 at ASP+6 percent) for items that have not been granted pass-through status. This proposed policy would ensure that new nonpass-through drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals would be treated like other drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals under the OPPS, unless they are granted pass-through status. Only if they are pass-through drugs, nonimplantable biologicals, or therapeutic radiopharmaceuticals would they receive a different payment for CY 2010, generally equivalent to the payment these drugs and biologicals would receive in the physician's office setting, consistent with the requirements of the statute.

We also are proposing to continue our CY 2010 policy to base payment for new therapeutic radiopharmaceuticals with HCPCS codes, but which do not have pass-through status and are without claims data, on the WACs for these products if ASP data for these therapeutic radiopharmaceuticals are not available. If the WACs are also unavailable, we are proposing to make payment for a new therapeutic radiopharmaceutical at 95 percent of the product's most recent AWP because we would not have mean costs from hospital claims data upon which to base payment. Analogous to new drugs and biologicals, we are proposing to continue our policy of assigning status indicator "K" to HCPCS codes for new therapeutic radiopharmaceuticals without OPPS claims data for which we have not granted pass-through status.

Consistent with other ASP-based payments, for CY 2011, we are proposing to announce any changes to the payment amounts for new drugs and biologicals in the CY 2011 OPPS/ASC final rule with comment period and also on a quarterly basis on the CMS Web site during CY 2011 if later quarter ASP submissions (or more recent WACs or AWPs) indicate that changes to the payment rates for these drugs and biologicals are necessary. The payment rates for new therapeutic radiopharmaceuticals would also be changed accordingly, based on later quarter ASP submissions. We note that the new CY 2011 HCPCS codes for drugs, biologicals, and therapeutic radiopharmaceuticals are not available at the time of development of this proposed rule. However, they will be included in Addendum B to the CY 2011 OPPS/ASC final rule with comment period. They will be assigned comment indicator "NI" in Addendum B to reflect that their interim final OPPS treatment is open to public comment on the CY 2011 OPPS/ASC final rule with comment period.

There are several nonpass-through drugs and biologicals that were payable in CY 2009 and/or CY 2010, for which we do not have CY 2009 hospital claims data available for this proposed rule and for which there are no other HCPCS codes that describe different doses of the same drug. These drugs and biologicals do have pricing information available for the ASP methodology. We note that there are currently no therapeutic radiopharmaceuticals in this category. In order to determine the packaging status of these products for CY 2011, we calculated an estimate of the per day cost of each of these items by multiplying the payment rate for each product based on ASP+6 percent, similar to other nonpass-through drugs and biologicals paid separately under the OPPS, by an estimated average number of units of each product that would typically be furnished to a patient during one administration in the hospital outpatient setting. We are proposing to package items for which we estimated the per administration cost to be less than or equal to $70, which is the general packaging threshold that we are proposing for drugs, nonimplantable biologicals, and

therapeutic radiopharmaceuticals in CY 2011. We are proposing to pay separately for items with an estimated per day cost greater than $70 (with the exception of diagnostic radiopharmaceuticals, contrast agents and implantable biologicals, which we are proposing to continue to package regardless of cost (as discussed in more detail in section V.B.2.d of this proposed rule) in CY 2011. We are proposing that the CY 2011 payment for separately payable items without CY 2009 claims data would be ASP+6 percent, similar to payment for other separately payable nonpass-through drugs and biologicals under the OPPS. In accordance with the ASP methodology used in the physician's office setting, in the absence of ASP data, we are proposing to use the WAC for the product to establish the initial payment rate. However, we note that if the WAC is also unavailable, we would make payment at 95 percent of the most recent AWP available.

The proposed estimated units per day and status indicators for these items are displayed in Table 27 below.

TABLE 27.—DRUGS AND BIOLOGICALS WITHOUT CY 2009 CLAIMS DATA

CY 2011 HCPCS Code	CY 2011 Long Descriptor	Estimated Average Number of Units Per Administration	Proposed CY 2011 SI	Proposed CY 2011 APC
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	1	K	1239
90725	cholera vaccine for injectable use	1	K	1271
J0205	injection, alglucerase, per 10 units	420	K	0900
J0364	Injection, apomorphine hydrochloride, 1 mg	12	N	
J1835	Injection, itraconazole, 50 mg	8	K	1303
J2724	Injection, protein c concentrate, intravenous, human, 10 iu	2240	K	1139
J3355	Injection, urofollitropin, 75 IU	2	K	1741
J3485	Injection, zidovudine, 10 mg	42	N	
J7185	Injection, factor viii (antihemophilic factor, recombinant) (xyntha), per i.u.	1750	K	1268
J9215	Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 iu	5	K	0865
J9226	Histrelin implant (supprelin la), 50 mg	1	K	1142
J9357	Injection, valrubicin, intravesical, 200 mg	4	K	1235
Q0515	Injection, sermorelin acetate, 1 microgram	70	K	3050
Q2017	Injection ,teniposide, 50 mg	9.35	K	7035

Finally, there were five drugs and biologicals, shown in Table 28 below, that were payable in CY 2009, but for which we lacked CY 2009 claims data and any other pricing information for the ASP methodology for this proposed rule. In CY 2009, for similar items without CY 2007 claims data and without pricing information for the ASP methodology, we previously stated that we were unable to determine their per day cost and we packaged these items for the year, assigning these items status indicator "N."

For CY 2010, we finalized a policy to change the status indicator for drugs and biologicals to status indicator "E" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) that we understood were not currently sold or had been identified as obsolete. In addition, we noted that we would provide separate payment for these drugs and biologicals if pricing information reflecting recent sales becomes available mid-year in CY 2010 for the ASP methodology. If pricing information became available, we would assign the products status indicator "K" and pay for them separately for the remainder of CY 2010.

For CY 2011, we are proposing to continue our CY 2010 policy to assign status indicator "E" to drugs and biologicals that lack CY 2009 claims data and pricing information for the ASP methodology. All drugs and biologicals without CY 2009 hospital claims data and data based on the ASP methodology that are assigned status indicator "E" on this basis at the time of this proposed rule for CY 2011 are displayed in Table 26 below. If pricing information becomes available, we are proposing to assign the products status indicator "K" and pay for them separately for the remainder of CY 2011.

TABLE 28.—DRUGS AND BIOLOGICALS WITHOUT CY 2009 CLAIMS DATA AND WITHOUT PRICING INFORMATION FOR THE ASP METHODOLOGY

CY 2011 HCPCS Code	CY 2011 Long Descriptor	Proposed CY 2011 SI
J0190	Injection, biperiden lactate, per 5 mg	E
J1435	Injection, estrone, per 1 mg	E
J3320	Injection, spectinomycin dihydrochloride, up to 2 gm	E
J3400	Injection, triflupromazine hcl, up to 20 mg	E
Q0174	Thiethylperazine maleate, 10 mg, oral, fda approved prescription anti-emetic, for use as a compl	E

VI. Proposed Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices

A. Background

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" (defined below) of total program payments estimated to be made under section 1833(t) of the Act for all covered services furnished for that year under the hospital OPPS. For a year (or portion of a year) before CY 2004, the applicable percentage means 2.5 percent; for CY 2004 and subsequent years, the applicable percentage means a percentage specified by the Secretary up to (but not to exceed) 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 in order to ensure that total estimated pass-through spending for the prospective payment year is budget neutral as required by section 1883(t)(6)(E) of the Act.

For devices, developing an estimate of pass-through spending in CY 2011 entails estimating spending for two groups of items. The first group of items consists of device categories that were recently made eligible for pass-through payment and that would continue to be eligible for pass-through payment in CY 2011. The CY 2008 OPPS/ASC final rule with comment period (72 FR 66778) describes the methodology we have used in previous years to develop the pass-through spending estimate for known device categories continuing into the applicable update year. The second group contains items that we know are newly eligible, or project would be newly eligible, for device pass-through payment in the remaining quarters of CY 2010 or beginning in CY 2011. As discussed in section V.A.4. of the CY 2010 final rule with comment period (74 FR 60529), beginning in CY 2010, the pass-through evaluation process and pass-through payment for implantable biologicals newly approved for pass-through payment beginning on or after January 1, 2010, that are always surgically inserted or implanted (through a surgical incision or a natural orifice) is the device pass-through process and payment methodology only. Therefore, we are proposing that the estimate of pass-through spending for implantable biologicals newly eligible for pass-through payment beginning in CY 2011 be included in the pass-through spending estimate for this second group of device categories. The sum of the proposed CY 2011 pass-through estimates for these two groups of device categories equals the total proposed CY 2011 pass-through spending estimate for device categories with pass-through status.

For devices eligible for pass-through payment, section 1833(t)(6)(D)(ii) of the Act establishes the pass-through payment amount as the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the device. As discussed in section IV.A.2. of this proposed rule, we deduct from the pass-through payment for an identified device category eligible for pass-through payment an amount that reflects the portion of the APC payment amount that we determine is associated with the cost of the device, defined as the device APC offset amount, when we believe that predecessor device costs for the device category newly approved for pass-through payment are already packaged into the existing APC structure. For each device category that becomes newly eligible for device pass-through payment, including implantable biologicals from CY 2010 forward, we estimate pass-through spending to be the difference between payment for the device category and the device APC offset amount, if applicable, for the procedures that would use the device. If we determine that predecessor device costs for the new device category are not already included in the existing APC structure, the pass-through spending estimate for the device category would be the full payment at charges adjusted to cost.

For drugs and biologicals eligible for pass-through payment, section 1833(t)(6)(D)(i) of the Act establishes the pass-through payment amount as the amount by which the amount authorized under section 1842(o) of the Act (or, if the drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary) exceeds the portion of the otherwise applicable fee schedule amount that the Secretary determines is associated with the drug or biological. Because we are proposing to pay for most nonpass-through separately payable drugs and nonimplantable biologicals under the CY 2011 OPPS at ASP+6 percent, which represents the otherwise applicable fee schedule amount associated with most pass-through drugs and biologicals, and

because we are proposing to pay for CY 2011 pass-through drugs and nonimplantable biologicals at ASP+6 percent or the Part B drug CAP rate, if applicable, our proposed estimate of drug and nonimplantable biological pass-through payment for CY 2011 would be zero. Furthermore, payment for certain drugs, specifically diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals without pass-through status, would always be packaged into payment for the associated procedures because these products would never be separately paid. However, all pass-through diagnostic radiopharmaceuticals, contrast agents, and those implantable biologicals with pass-through status approved prior to CY 2010 would be paid at ASP+6 percent or the Part B drug CAP rate, if applicable, like other pass-through drugs and biologicals. Therefore, our proposed estimate of pass-through payment for all diagnostic radiopharmaceuticals and contrast agents and those implantable biologicals with pass-through status approved prior to CY 2011 is not zero.

In section V.A.4. of this proposed rule, we discuss our policy to determine if the cost of certain "policy-packaged" drugs, including diagnostic radiopharmaceuticals and contrast agents, are already packaged into the existing APC structure. If we determine that a "policy-packaged" drug approved for pass-through payment resembles predecessor diagnostic radiopharmaceuticals or contrast agents already included in the costs of the APCs that would be associated with the drug receiving pass-through payment, we are proposing to offset the amount of pass-through payment for diagnostic radiopharmaceuticals and contrast agents. For these drugs, the APC offset amount would be the portion of the APC payment for the specific procedure performed with the pass-through diagnostic radiopharmaceutical or contrast agent that is attributable to diagnostic radiopharmaceuticals or contrast agents, which we refer to as the "policy-packaged" drug APC offset amount. If we determine that an offset is appropriate for a specific diagnostic radiopharmaceutical or contrast agent receiving pass-through payment, we would reduce our estimate of pass-through payment for these drugs by this amount. We have not established a policy to offset pass-through payment for implantable biologicals when approved for pass-through payment as a drug or biological, that is, for CY 2009 and earlier, so we would consider full payment at ASP+6 percent for these implantable biologicals receiving biological pass-through payment as of CY 2011 in our proposed estimate of CY 2011 pass-through spending for drugs and biologicals.

We note that the Part B drug CAP program has been suspended beginning January 1, 2009. We refer readers to the Medicare Learning Network (MLN) Matters Special Edition article SE0833 for more information on this suspension. As of the publication of this proposed rule, the Part B drug CAP program has not been reinstituted. Therefore, for this proposed rule, we are proposing to continue to not have an effective Part B drug CAP rate for pass-through drugs and biologicals. Similar to pass-through estimates for devices, the first group of drugs and biologicals requiring a pass-through payment estimate consists of those products that were recently made eligible for pass-through payment and that would continue to be eligible for pass-through payment in CY 2011. The second group contains drugs and nonimplantable biologicals that we know are newly eligible, or project would be newly eligible, in the remaining quarters of CY 2010 or beginning in CY 2011. The sum of the CY 2011 pass-through estimates for these two groups of drugs and biologicals would equal the total CY 2010 pass-through spending estimate for drugs and biologicals with pass-through status.

B. Proposed Estimate of Pass-Through Spending

We are proposing to set the applicable pass-through payment percentage limit at 2.0 percent of the total projected OPPS payments for CY 2011, consistent with our OPPS policy from CY 2004 through CY 2010 (74 FR 60530).

For the first group of devices for pass-through payment estimate purposes, there currently are no device categories receiving pass-through payment in CY 2010 that would continue for payment during CY 2011. Therefore, we are proposing a device pass-through payment estimate for the first group of pass-through device categories of $0.

We also are proposing for CY 2011 to continue to employ the device pass-through process and payment methodology for implantable biologicals that are always surgically inserted or implanted (through a surgical incision or a natural orifice) that we used for CY 2010. We are proposing to consider existing implantable biologicals approved for pass-through payment under the drugs and biologicals pass-through provision prior to CY 2010 as drugs and biologicals for pass-through payment estimate purposes until they expire from pass-through status. Therefore, the proposed pass-through spending estimate for the first group of pass-through devices does not include implantable biologicals that were granted pass-through status prior to CY 2010. Finally, we are proposing to continue to provide payment for implantable biologicals newly eligible for pass-through payment beginning in CY 2010 or CY 2011 based on hospital charges adjusted to cost that is applicable for pass-through device categories, rather than the ASP methodology that is applicable to pass-through drugs and biologicals. Therefore, we are proposing that the estimate of pass-through spending for implantable biologicals first paid as pass-through devices in CY 2011 would be based on the payment methodology for pass-through devices and would be included in the device pass-through spending estimate.

In estimating our proposed CY 2011 pass-through spending for device categories in the second group, that is, device categories that we knew at the time of the development of the proposed rule would be newly eligible for pass-through payment in CY 2011 (of which there are none), additional device categories (including categories that describe implantable biologicals) that we estimated could be approved for pass-through status subsequent to the development of the proposed rule and before January 1, 2011, and contingent projections for new categories (including categories that describe implantable biologicals in the second through fourth quarters of CY 2011), we are proposing to use the general methodology described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66778), while also taking into account recent OPPS experience in approving new pass-through device categories. While there are no new device categories (including categories that describe implantable biologicals) for CY 2011 of which we are aware at the time of development of this proposed rule, there are possible new device categories for pass-through payment based on current applications. Therefore, the estimate of CY 2011 pass-through spending for this second group of device categories is $72.1 million.

Employing our established methodology that the estimate of pass-through device spending in CY 2011 incorporates CY 2011 estimates of pass-through spending for known device categories continuing in CY 2011, those known or projected to be first effective January 1, 2011, and those device categories projected to be approved during subsequent quarters of CY 2010

or CY 2011, our proposed CY 2011 estimate of total pass-through spending for device categories is $72.1 million.

To estimate CY 2011 proposed pass-through spending for drugs and biologicals in the first group, specifically those drugs (including radiopharmaceuticals and contrast agents) and biologicals (including implantable biologicals) recently made eligible for pass-through payment and continuing on pass-through status for CY 2011, we are proposing to utilize the most recent Medicare physician's office data regarding their utilization, information provided in the respective pass-through applications, historical hospital claims data, pharmaceutical industry information, and clinical information regarding those drugs or biologicals, in order to project the CY 2011 OPPS utilization of the products.

For the known drugs and biologicals (excluding diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals) that would be continuing on pass-through status in CY 2011, we then estimate the proposed pass-through payment amount as the difference between ASP+6 percent or the Part B drug CAP rate, as applicable, and ASP+6 percent, aggregated across the projected CY 2011 OPPS utilization of these products, which is zero for this group of drugs and biologicals. Because payment for a diagnostic radiopharmaceutical or contrast agent would be packaged if the product were not paid separately due to its pass-through status, we include in the pass-through estimate the difference between payment for the drug or biological at ASP+6 percent (or WAC+6 percent, or 95 percent of AWP, if ASP information is not available) and the "policy-packaged" drug APC offset amount, if we determined that the diagnostic radiopharmaceutical or contrast agent approved for pass-through payment resembles predecessor diagnostic radiopharmaceuticals or contrast agents already included in the costs of the APCs that would be associated with the drug receiving pass-through payment. Because payment for an implantable biological eligible for pass-through payment in CY 2009 and continuing on pass-through status in CY 2011 would be packaged if the product were not paid separately due to its pass-through status and because we had not established a pass-through payment offset policy for implantable biologicals when approved for pass-through payment as biologicals, that is, for CY 2009 and earlier, we are including in the proposed pass-through spending estimate the full payment for these implantable biologicals at ASP+6 percent (or WAC+6 percent or 95 percent of AWP, if ASP information is not available). Based on these results, we are proposing the spending estimate for this first group of drugs and biologicals to be $9 million, while we are proposing our spending estimate for the second group of drugs and biologicals to be $5.8 million.

To estimate CY 2011 pass-through spending for drugs and nonimplantable biologicals in the second group (that is, drugs and nonimplantable biologicals that we knew at the time of development of this proposed rule would be newly eligible for pass-through payment in CY 2011, additional drugs and nonimplantable biologicals that we estimated could be approved for pass-through status subsequent to the development of this proposed rule and before January 1, 2011, and projections for new drugs and nonimplantable biologicals that could be initially eligible for pass-through payment in the second through fourth quarters of CY 2011), we are proposing to use utilization estimates from pass-through applicants, pharmaceutical industry data, clinical information, recent trends in the per unit ASPs of hospital outpatient drugs, and projected annual changes in service volume and intensity as our basis for making the CY 2011 proposed pass-through payment estimate. We also are considering the most recent OPPS experience in approving new pass-through drugs and nonimplantable biologicals. Consistent with our policy established in CY 2010 (74 FR 60531 through 60532), we also are proposing to include new implantable biologicals that we expect to be approved for pass-through status as devices beginning in CY 2011 in the second group of items considered for device pass-through estimate purposes. Therefore, we are not proposing to include implantable biologicals in the second group of items in the proposed drug and biological pass-through spending estimate.

Based on the results of these analyses, we are proposing that the spending estimate for this second group of drugs and biologicals to be $5.8 million.

As described in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60476), under our current policy, beginning in CY 2010, implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) and that were not receiving pass-through payment as biologicals prior to January 1, 2010, will be evaluated under the device pass-through process and paid according to the device payment methodology. We are proposing to continue to consider implantable biologicals approved for pass-through payment under the drug and biological pass-through provision prior to CY 2010 as drugs and biologicals for pass-through payment estimate purposes. These implantable biologicals that have been approved for pass-through status prior to CY 2010 continue to be considered drugs and biologicals until they expire from pass-through status. Therefore, the pass-through spending estimate for the first group of pass-through device categories does not include implantable biologicals that have been granted pass-through status prior to CY 2010.

Consistent with the current policy established in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60476), we are proposing to continue to provide that payment for implantable biologicals newly eligible for pass-through payment beginning in CY 2011 is based on hospital charges adjusted to cost, rather than the ASP methodology that is applicable to pass-through drugs and biologicals. Therefore, we are proposing that the estimate of pass-through spending for implantable biologicals first paid as pass-through devices in CY 2011 would be based on the payment methodology for pass-through devices, and would be included in the proposed CY 2011 device pass-through spending estimate for the second group of pass-through device categories.

The proposed CY 2011 pass-through spending estimate for the first group of pass-through device categories is $0. The proposed estimate of CY 2010 pass-through spending for the second group of pass-through device categories is $72.1 million. Our proposed CY 2011 estimate of total pass-through spending for device categories is $72.1 million.

The estimate for pass-through spending for the first group of drugs and biologicals is $9.0 million for CY 2011. The estimate for pass-through spending for the second group of drugs and biologicals is $5.8 million for CY 2011. As discussed in section V.A. of this proposed rule, radiopharmaceuticals are considered drugs for pass-through purposes. Therefore, we have included radiopharmaceuticals in our proposed CY 2011 pass-through spending estimate for drugs and biologicals. Our proposed CY 2011 estimate of total pass-through spending for drugs and biologicals is $14.8 million.

In summary, in accordance with the methodology described above in this section, we estimate that total pass-through spending for the device categories and the drugs and biologicals that are continuing to receive pass-through payment in CY 2011 and those

device categories, drugs, and nonimplantable biologicals that first become eligible for pass-through payment during CY 2011 would be approximately $86.9 million, which represents 0.20 percent of total OPPS projected total payments for CY 2011. We estimate that pass-through spending in CY 2011 would not amount to 2.0 percent of total projected OPPS CY 2011 program spending.

VII. Proposed OPPS Payment for Brachytherapy Sources

A. Background

Section 1833(t)(2)(H) of the Act, as added by section 621(b)(2)(C) of Public Law 108–173 (MMA), mandated the creation of additional groups of covered OPD services that classify devices of brachytherapy consisting of a seed or seeds (or radioactive source) ("brachytherapy sources") separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the brachytherapy sources furnished and include separate groups for palladium-103 and iodine-125 sources.

Section 1833(t)(16)(C) of the Act, as added by section 621(b)(1) of Public Law 108–173, established payment for brachytherapy sources furnished from January 1, 2004 through December 31, 2006, based on a hospital's charges for each brachytherapy source furnished adjusted to cost. Under section 1833(t)(16)(C) of the Act, charges for the brachytherapy sources may not be used in determining any outlier payments under the OPPS for that period in which payment is based on charges adjusted to cost. Consistent with our practice under the OPPS to exclude items paid at cost from budget neutrality consideration, these items were excluded from budget neutrality for that time period as well.

In our CY 2007 annual OPPS rulemaking, we proposed and finalized a policy of prospective payment based on median costs for the 11 brachytherapy sources for which we had claims data. We based the prospective payment rates on median costs for each source from our CY 2005 claims data (71 FR 68102 through 71 FR 68115).

Subsequent to publication of the CY 2007 OPPS/ASC final rule with comment period, section 107 of Public Law 109–432 (MIEA–TRHCA) amended section 1833 of the Act. Specifically, section 107(a) of Public Law 109–432 amended section 1833(t)(16)(C) of the Act by extending the payment period for brachytherapy sources based on a hospital's charges adjusted to cost for one additional year, through December 31, 2007. Therefore, we continued to pay for brachytherapy sources based on charges adjusted to cost for CY 2007.

Section 107(b)(1) of Public Law 109–432 amended section 1833(t)(2)(H) of the Act by adding a requirement for the establishment of separate payment groups for "stranded and non-stranded" brachytherapy sources furnished on or after July 1, 2007, in addition to the existing requirements for separate payment groups based on the number, isotope, and radioactive intensity of brachytherapy sources under section 1833(t)(2)(H) of the Act. Section 107(b)(2) of Public Law 109–432 authorized the Secretary to implement this requirement by "program instruction or otherwise." We note that public commenters who responded to the CY 2007 OPPS/ASC proposed rule asserted that stranded sources, which they described as embedded into the stranded suture material and separated within the strand by material of an absorbable nature at specified intervals, had greater production costs than non-stranded sources (71 FR 68113 through 68114).

As a result of the statutory requirement to create separate groups for stranded and non-stranded sources as of July 1, 2007, we established several coding changes through a transmittal, effective July 1, 2007 (Transmittal 1259, dated June 1, 2007). Based on public comments received on the CY 2007 OPPS/ASC proposed rule and industry input, we were aware of three sources available in stranded and non-stranded forms at that time: iodine-125; palladium-103; and cesium-131 (72 FR 42746). We created six new HCPCS codes to differentiate the stranded and non-stranded versions of iodine, palladium, and cesium sources.

In Transmittal 1259, we indicated that if we receive information that any of the other sources now designated as non-stranded are also FDA-approved and marketed as a stranded source, we would create a code for the stranded source. We also established two "Not Otherwise Specified" (NOS) codes for billing stranded and non-stranded sources that are not yet known to us and for which we do not have source-specific codes. We established HCPCS code C2698 (Brachytherapy source, stranded, not otherwise specified, per source) for stranded NOS sources and HCPCS code C2699 (Brachytherapy source, non-stranded, not otherwise specified, per source) for non-stranded NOS sources.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66784), we again finalized prospective payment for brachytherapy sources, beginning in CY 2008, with payment rates determined using the CY 2006 claims-based costs per source for each brachytherapy source. Consistent with our policy regarding APC payments made on a prospective basis, we finalized the policy in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66686) to subject the cost of brachytherapy sources to the outlier provision of section 1833(t)(5) of the Act, and also to subject brachytherapy source payment weights to scaling for purposes of budget neutrality. Therefore, brachytherapy sources could receive outlier payments if the costs of furnishing brachytherapy sources met the criteria for outlier payment, that is, if brachytherapy sources are paid prospectively. In addition, as noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66683), implementation of prospective payment for brachytherapy sources would provide opportunities for hospitals to receive additional payments under certain circumstances through the 7.1 percent rural SCH adjustment (discussed in section II.E. of this proposed rule).

For CY 2008, we also proposed and finalized a policy regarding payment for new brachytherapy sources for which we have no claims data (72 FR 42749 and 72 FR 66786, respectively). We indicated 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. Finally, we proposed and finalized our policy to discontinue using status indicator "H" (Pass-Through Device Categories. Separate cost based pass-through payment; not subject to copayment) because we would not be paying charges adjusted to costs after December 31, 2007, and instead adopted a policy of using status indicator "K" (which includes, among others, "Brachytherapy Sources. Paid under OPPS; separate APC payment") for CY 2008 (72 FR 42749 and 72 FR 66785, respectively).

After we finalized these policies for CY 2008, section 106(a) of Public Law 110–173 (MMSEA) extended the charges-adjusted-to-cost payment methodology for brachytherapy sources for an additional 6 months, through June 30, 2008. Because our final CY 2008 policies paid for brachytherapy sources at prospective rates based on median costs, we were unable to implement these policies during this extension.

In the CY 2009 OPPS/ASC proposed rule (73 FR 41502), we again proposed prospective payment rates for brachytherapy sources for CY 2009. We proposed to pay for brachytherapy sources at prospective rates based on their source-specific median costs as calculated from CY 2007 claims data available for CY 2009 ratesetting. Subsequent to issuance of the CY 2009 OPPS/ASC proposed rule, Public Law 110–275 (MIPPA) was enacted on July 15, 2008. Section 142 of Public Law 110–275 amended section 1833(t)(16)(C) of the Act, as amended by section 106(a) of Public Law 110–173 (MMSEA), to further extend the payment period for brachytherapy sources based on a hospital's charges adjusted to cost from July 1, 2008 through December 31, 2009. Therefore, we continued to pay for brachytherapy sources at charges adjusted to cost in CY 2008 from July 1 through December 31, and we maintained the assignment of status indicator "H" to brachytherapy sources for claims processing purposes in CY 2008. For CY 2009, we continued to pay for all separately payable brachytherapy sources based on a hospital's charges adjusted to cost. Because brachytherapy sources are paid at charges adjusted to cost, we did not subject them to outlier payments under section 1833(t)(5) of the Act, or subject brachytherapy source payment weights to scaling for purposes of budget neutrality. Moreover, during the CY 2009 period of payment at charges adjusted to cost, brachytherapy sources were not eligible for the 7.1 percent rural SCH adjustment (as discussed in detail in section II.E. of this proposed rule).

Furthermore, for CY 2009, we did not adopt the policy we established in the CY 2008 OPPS/ASC final rule with comment period of paying stranded and non-stranded NOS codes for brachytherapy sources, HCPCS codes C2698 and C2699, based on a rate equal to the lowest stranded or non-stranded prospective payment for such sources. Also, for CY 2009, we did not adopt the policy we established in the CY 2008 OPPS/ASC final rule with comment period regarding payment for new brachytherapy sources for which we have no claims data. NOS HCPCS codes C2698 and C2699 and newly established specific source codes were paid at charges adjusted to cost through December 31, 2009, consistent with the provisions of section 142 of Public Law 110–275.

For CY 2009, we finalized our proposal to create new status indicator "U" (Brachytherapy Sources. Paid under OPPS; separate APC payment) for brachytherapy source payment, instead of using status indicator "K" as proposed and finalized for CY 2008 for prospective payment, or status indicator "H," used during the period of charges adjusted to cost payment. As noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68670), assigning a status indicator, such as status indicator "K," to several types of items and services with potentially differing payment policies added unnecessary complexity to our operations. Status indicator "U" is used only for brachytherapy sources, regardless of their specific payment methodology for any period of time.

Under section 142 of Public Law 110–275, payment for brachytherapy sources was mandated at charges adjusted to cost only through CY 2009. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60533 through 60537), we adopted for CY 2010 the general OPPS prospective payment methodology for brachytherapy sources, consistent with section 1833(t)(2)(C) of the Act.

B. Proposed OPPS Payment Policy

As we have previously stated (72 FR 66780, 73 FR 41502, and 74 FR 60533 and 60534), we believe that adopting the general OPPS prospective payment methodology for brachytherapy sources is appropriate for a number of reasons. The general OPPS payment methodology uses median costs based on claims data to set the relative payment weights for hospital outpatient services. This payment methodology results in more consistent, predictable, and equitable payment amounts per source across hospitals by eliminating some of the extremely high and low payment amounts resulting from payment based on hospitals' charges adjusted to cost. We believe the OPPS prospective payment methodology would also provide hospitals with incentives for efficiency in the provision of brachytherapy services to Medicare beneficiaries. Moreover, this approach is consistent with our payment methodology for the vast majority of items and services paid under the OPPS.

We are proposing to use the median costs from CY 2009 claims data for setting the proposed CY 2011 payment rates for brachytherapy sources, as we are proposing for most other items and services that will be paid under the CY 2011 OPPS. We are proposing to continue the other payment policies for brachytherapy sources we finalized in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60537). We are proposing to pay for the stranded and non-stranded NOS codes, HCPCS codes C2698 and C2699, at a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively, on a per source basis (as opposed, for example, to a per mCi), which is based on the policy we established in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66785). The proposed payment methodology for NOS sources would provide payment to a hospital for new sources, and at the same time encourage interested parties to quickly bring new sources to our attention so that specific coding and payment could be established.

We also are proposing to continue the policy we implemented in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60537) regarding payment for new brachytherapy sources for which we have no claims data, based on the same reasons we discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66786; which was superseded by section 142 of Pub. L. 110–275). That policy is intended to enable us to assign future new HCPCS codes for new brachytherapy sources to their own APCs, with prospective payment rates set based on our consideration of external data and other relevant information regarding the expected costs of the sources to hospitals.

Consistent with our policy regarding APC payments made on a prospective basis, as we did for CY 2010, we are proposing to subject brachytherapy sources to outlier payments under section 1833(t)(5) of the Act, and also to subject brachytherapy source payment weights to scaling for purposes of budget neutrality. Therefore, brachytherapy sources could receive outlier payments if the costs of furnishing brachytherapy sources meet the criteria for outlier payment, that is, if they are prospectively paid. In addition, as noted in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60534), implementation of prospective payments for brachytherapy sources would provide opportunities for hospitals to receive additional payments in CY 2010 under certain circumstances through the 7.1 percent rural adjustment, as described in section II.E. of this proposed rule.

Therefore, we are proposing to pay for brachytherapy sources at prospective payment rates based on their source-specific median costs for CY 2011. The separately payable brachytherapy source HCPCS codes, long descriptors, APCs, status indicators, and approximate APC median costs that we are proposing for CY 2011 are presented in Table 29 below.

BILLING CODE 4120–01–P

TABLE 29.—PROPOSED SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2011

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 APC	Proposed CY 2011 SI	Proposed CY 2011 Approximate APC Median Cost
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	2632	U	$21
C1716	Brachytherapy source, non-stranded, Gold-198, per source	1716	U	$188
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	1717	U	$225
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	1719	U	$23
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	2616	U	$17,108
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	2634	U	$53
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	2635	U	$30
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	2636	U	$37
C2638	Brachytherapy source, stranded, Iodine-125, per source	2638	U	$39
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	2639	U	$37
C2640	Brachytherapy source, stranded, Palladium-103, per source	2640	U	$65
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	2641	U	$64
C2642	Brachytherapy source, stranded, Cesium-131, per source	2642	U	$117
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	2643	U	$64
C2698	Brachytherapy source, stranded, not otherwise specified, per source	2698	U	*$39

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 APC	Proposed CY 2011 SI	Proposed CY 2011 Approximate APC Median Cost
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	2699	U	*$23

*Median cost is that of the lowest cost stranded or non-stranded source upon which proposed CY 2011 payment for the NOS HCPCS code is based.

BILLING CODE 4120–01–C

We continue to invite hospitals and other parties to submit recommendations to us for new HCPCS codes to describe new brachytherapy sources consisting of a radioactive isotope, including a detailed rationale to support recommended new sources. Such recommendations should be directed to the Division of Outpatient Care, Mail Stop C4–05–17, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244. We will continue to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly basis.

VIII. Proposed OPPS Payment for Drug Administration Services

A. Background

In CY 2005, in response to the recommendations made by public commenters and the hospital industry, OPPS transitioned from Level II HCPCS Q-codes to the use of CPT codes for drug administration services. These CPT codes allowed specific reporting of services regarding the number of hours for an infusion and provided consistency in coding between Medicare and other payers. (For a discussion regarding coding and payment for drug administration services prior to CY 2005, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66787).)

While hospitals began adopting CPT codes for outpatient drug administration services in CY 2005, physicians paid under the MPFS were using HCPCS G-codes in CY 2005 to report office-based drug administration services. These HCPCS 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 and incorporated new concepts, such as initial, sequential, and concurrent services, into a structure that previously distinguished services based on type of administration (chemotherapy/nonchemotherapy), method of administration (injection/infusion/push), and for infusion services, first hour and additional hours. For CY 2006, we implemented the CY 2006 drug administration CPT codes that did not reflect the concepts of initial, sequential, and concurrent services under the OPPS, and we created HCPCS C-codes that generally paralleled the CY 2005 CPT codes for reporting these other services.

For CY 2007, as a result of public comments on the proposed rule and feedback from the hospital community and the APC Panel, we implemented the full set of CPT codes for drug administration services, including codes incorporating the concepts of initial, sequential, and concurrent services. In addition, the CY 2007 update process offered us the first opportunity to consider data gathered from the use of CY 2005 CPT codes for purposes of ratesetting. For CY 2007, we used CY 2005 claims data to implement a six-level APC structure for drug administration services. In CY 2008, we continued to use the full set of CPT codes for drug administration services and continued our assignment of drug administration services to this six-level APC structure.

For CY 2009, we continued to allow hospitals to use the full set of CPT codes for drug administration services but moved from a six-level APC structure to a five-level APC structure. We note that, while there were changes in the CPT numerical coding for nonchemotherapy drug administration services in CY 2009, the existing CPT codes were only renumbered, and there were no significant changes to the code descriptors themselves. As we discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68672), the CY 2009 ratesetting process afforded us the first opportunity to examine hospital claims data for the full set of CPT codes that reflected the concepts of initial, sequential, and concurrent services. For CY 2009, we performed our standard annual OPPS review of the clinical and resource characteristics of the drug administration CPT codes assigned to the six-level CY 2008 APC structure based on the CY 2007 claims data available for the CY 2009 OPPS/ASC proposed rule. As a result of our hospital cost analysis and detailed clinical review, we adopted a five-level APC structure for CY 2009 drug administration services to more appropriately reflect their resource utilization in APCs that also group clinically similar services. As we noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68671), these APCs generally demonstrated the clinically expected and actually observed comparative relationships between the median costs of different types of drug administration services, including initial and additional services; chemotherapy and other diagnostic, prophylactic, or therapeutic services; injections and infusions; and simple and complex methods of drug administration.

After analyzing the assignment of CPT codes for drug administration into the five-level APC structure by utilizing our standard annual OPPS review for clinical cohesiveness and resource homogeneity, we continued our five-level APC structure for payment for drug administration services in the HOPD for CY 2010. In addition, we used the full set of CPT codes for drug administration and included all separately payable drug administration add-on codes on the CY 2010 bypass list in order to create pseudo single claims for these codes that would enable us to use the claims data to set payment rates for them. As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60538) since CY 2007, we continue to update the bypass methodology to reflect changing drug administration HCPCS codes that are recognized under the OPPS.

B. Proposed Coding and Payment for Drug Administration Services

For CY 2011, we are proposing to continue to use the full set of CPT codes for reporting drug administration services and to continue to pay separately for the same set of drug administration codes under the CY 2011 OPPS as were paid separate in the CY 2010 OPPS. As a part of our standard annual review, we analyzed the CY 2009 claims data that reflect assignments of CPT codes for drug administration into the five-level APC structure and have found that the assignment of separately paid drug administration codes to five APCs continues to appropriately reflect the relative resources required to furnish these services. In addition, as has been our standard policy since the CY 2007 OPPS (71 FR 68117), we are proposing to continue to include all separately payable drug administration add-on codes on the bypass list so that we can use the cost data we derive from claims for these codes to establish payment rates for them.

Since this approach was first adopted for CY 2007, we have updated and expanded the bypass methodology to reflect changing drug administration HCPCS codes that are recognized under the OPPS. We placed all of the add-on CPT codes for drug administration services, including the sequential infusion and intravenous push codes, on the bypass list in CY 2009 (73 FR 68513) in order to continue this framework for transforming these otherwise unusable multiple bills into "pseudo" single claims that can be used for OPPS ratesetting purposes. We believe that this longstanding methodology results in appropriate payment rates for the add-on CPT codes for drug administration; therefore, we are proposing to continue to use this methodology for the CY 2011 OPPS because we believe this methodology takes into account all of the packaging on claims for drug administration services and therefore provides a reasonable framework for developing median costs for drug administration services that are often provided in combination with one another (74 FR 60539).

At its February 2010 meeting, the APC Panel recommended that CMS make CPT code 96368 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) and CPT code 93676 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary, separately payable procedure) separately payable for the CY 2011 OPPS at an appropriate payment rate as determined by CMS. We are not proposing to accept this APC Panel recommendation because these two codes each describe services that, by definition, are always provided in conjunction with an initial drug administration code and therefore are appropriately packaged into the payment for the separately payable services that they usually accompany. These services have been packaged since the inception of the OPPS, and we continue to believe they are appropriately packaged into the payment for the separately payable services without which, under CPT guidelines and definitions, they cannot be appropriately reported. We refer readers to section II.A.3. of this proposed rule for a more detailed discussion of payment for packaged services.

Table 30 below displays the proposed configuration of the five drug administration APCs for CY 2011 and the proposed median cost for each of the proposed drug administration APCs. We believe the updated CY 2009 claims data and the most recent cost report data for the drug administration CPT show that these codes share sufficiently similar clinical and resource characteristics to justify their continued placement in the five levels of drug administration APCs that were in effect in the CY 2010 OPPS. The median cost for each of the separately paid drug administration CPT codes is contained in the CPT median cost file that is provided as supporting documentation to this proposed rule at the Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/.* The proposed CY 2011 payment rate for each of the proposed drug administration APCs is contained in Addendum B of this proposed rule.

BILLING CODE 4120–01–P

TABLE 30.—PROPOSED CY 2011 DRUG ADMINISTRATION APCs

CY 2011 HCPCS Code	Proposed CY 2011 APC	Proposed CY 2011 Approximate APC Median Cost	CY 2010 Long Descriptor
90471	0436	$27	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular \injections); one vaccine (single or combination vaccine/toxoid)
90472			Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90473			Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90474			Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
95115			Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
95117			Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections
95165			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)
96361			Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
96366			Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96371			Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)
96372			Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

CY 2011 HCPCS Code	Proposed CY 2011 APC	Proposed CY 2011 Approximate APC Median Cost	CY 2010 Long Descriptor
96379			Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion
96549			Unlisted chemotherapy procedure
95144	0437	$38	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)
95145			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom
95148			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms
95149			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 5 single stinging insect venoms
95170			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses)
96367			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)
96370			Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96373			Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial
96374			Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
96375			Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in additional to code for primary procedure)
96401			Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
96402			Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic
96405			Chemotherapy administration; intralesional, up to and including 7 lesions

CY 2011 HCPCS Code	Proposed CY 2011 APC	Proposed CY 2011 Approximate APC Median Cost	CY 2010 Long Descriptor
96415			Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)
95146	0438	$78	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 2 single stinging insect venoms
95147			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 3 single stinging insect venoms
96360			Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96411			Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)
96417			Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)
96420			Chemotherapy administration, intra-arterial; push technique
96423			Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure)
96542			Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents
95990	0439	$129	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular);
95991			Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician
96365			Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96369			Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)

CY 2011 HCPCS Code	Proposed CY 2011 APC	Proposed CY 2011 Approximate APC Median Cost	CY 2010 Long Descriptor
96406			Chemotherapy administration; intralesional, more than 7 lesions
96409			Chemotherapy administration; intravenous, push technique, single or initial substance/drug
96440			Chemotherapy administration into pleural cavity, requiring and including thoracentesis
96521			Refilling and maintenance of portable pump
96522			Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)
96413	0440	$208	Chemotherapy administration; intravenous infusion technique; up to 1 hour, single or initial substance/drug
96416			Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump
96422			Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour
96425			Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
96445			Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis
96450			Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture
C8957			Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than eight hours), requiring use of portable or implantable pump

BILLING CODE 4120–01–C

IX. Proposed OPPS Payment for Hospital Outpatient Visits

A. Background

Currently, hospitals report visit HCPCS codes to describe three types of OPPS services: clinic visits; emergency department visits; and critical care services. For OPPS purposes, we recognize clinic visit codes as those codes defined in the CPT code book to report evaluation and management (E/M) services provided in the physician's office or in an outpatient or other ambulatory facility. We recognize emergency department visit codes as those codes used to report E/M services provided in the emergency department. Emergency department visit codes consist of five CPT codes that apply to Type A emergency departments and five Level II HCPCS codes that apply to Type B emergency departments. For OPPS purposes, we recognize critical care codes as those CPT codes used by hospitals to report critical care services that involve the "direct delivery by a physician(s) of medical care for a critically ill or critically injured patient," as defined by the CPT code book. In Transmittal 1139, Change Request 5438, dated December 22, 2006, we stated that, under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. Under the OPPS, we also recognize HCPCS code G0390 (Trauma response team associated with hospital critical care service) for the reporting of a trauma response in association with critical care services.

We are proposing to continue to recognize these CPT and HCPCS codes describing clinic visits, Type A and Type B emergency department visits, critical care services, and trauma team activation provided in association with critical care services for CY 2011. These codes are listed below in Table 31.

BILLING CODE 4120–01–P

TABLE 31.—PROPOSED HCPCS CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS AND CRITICAL CARE SERVICES

CY 2010 HCPCS Code	CY 2010 Descriptor
Clinic Visit HCPCS Codes	
99201	Office or other outpatient visit for the evaluation and management of a new patient (Level 1)
99202	Office or other outpatient visit for the evaluation and management of a new patient (Level 2)
99203	Office or other outpatient visit for the evaluation and management of a new patient (Level 3)
99204	Office or other outpatient visit for the evaluation and management of a new patient (Level 4)
99205	Office or other outpatient visit for the evaluation and management of a new patient (Level 5)
99211	Office or other outpatient visit for the evaluation and management of an established patient (Level 1)
99212	Office or other outpatient visit for the evaluation and management of an established patient (Level 2)
99213	Office or other outpatient visit for the evaluation and management of an established patient (Level 3)
99214	Office or other outpatient visit for the evaluation and management of an established patient (Level 4)
99215	Office or other outpatient visit for the evaluation and management of an established patient (Level 5)
Emergency Department Visit HCPCS Codes	
99281	Emergency department visit for the evaluation and management of a patient (Level 1)
99282	Emergency department visit for the evaluation and management of a patient (Level 2)
99283	Emergency department visit for the evaluation and management of a patient (Level 3)
99284	Emergency department visit for the evaluation and management of a patient (Level 4)
99285	Emergency department visit for the evaluation and management of a patient (Level 5)
G0380	Type B emergency department visit (Level 1)
G0381	Type B emergency department visit (Level 2)
G0382	Type B emergency department visit (Level 3)
G0383	Type B emergency department visit (Level 4)
G0384	Type B emergency department visit (Level 5)
Critical Care Services HCPCS Codes	
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes
G0390	Trauma response associated with hospital critical care service

BILLING CODE 4120–01–C

During the February 2010 APC Panel meeting, the APC Panel recommended that CMS continue to report on clinic and emergency department visits and observation services in the claims data, and that if CMS identifies changes in patterns of utilization or cost, it bring those issues before the Visits and Observation Subcommittee for future consideration. The APC Panel also recommended that the work of the Visits and Observation Subcommittee continue. We are adopting these recommendations and plan to provide the requested data and analyses to the APC Panel at an upcoming meeting.

B. Proposed Policies for Hospital Outpatient Visits

1. Clinic Visits: New and Established Patient Visits

As reflected in Table 31, hospitals use different CPT codes for clinic visits based on whether the patient being treated is a new patient or an established patient. Beginning in CY 2009, we refined the definitions of a new patient and an established patient to reflect whether or not the patient has been registered as an inpatient or outpatient of the hospital within the past 3 years. A patient who has been registered as an inpatient or outpatient of the hospital within the 3 years prior to a visit would be considered to be an established patient for that visit, while a patient who has not been registered as an inpatient or outpatient of the hospital within the 3 years prior to a visit would be considered to be a new patient for that visit. We refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68677 through 68680) for a full discussion of the refined definitions.

We continue to believe that defining new or established patient status based on whether the patient has been registered as an inpatient or outpatient of the hospital within the 3 years prior to a visit will reduce hospitals' administrative burden associated with reporting appropriate clinic visit CPT codes. For CY 2011, we are proposing to continue recognizing the refined definitions of a new patient and an established patient, and applying our policy of calculating median costs for clinic visits under the OPPS using historical hospital claims data. As discussed in section II.A.2.e.(1) of this proposed rule and consistent with our CY 2010 policy, when calculating the median costs for the clinic visit APCs (0604 through 0608), we would utilize our methodology that excludes those claims for visits that are eligible for payment through the extended assessment and management composite APC 8002 (Level I Extended Assessment and Management Composite). We continue to believe that this approach results in the most accurate cost estimates for APCs 0604 through 0608 for CY 2011.

2. Emergency Department Visits

Since CY 2007, we have recognized two different types of emergency departments for payment purposes under the OPPS—Type A emergency departments and Type B emergency departments. As described in greater detail below, by providing payment for two types of emergency departments, we recognize, for OPPS payment purposes, both the CPT definition of an emergency department, which requires the facility to be available 24 hours, and the requirements for emergency departments specified in the provisions of the Emergency Medical Treatment and Labor Act (EMTALA) (Pub. L. 99–272), which do not stipulate 24-hour availability but do specify other obligations for hospitals that offer emergency services. For more detailed information on the EMTALA provisions, we refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68680).

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68132), we finalized the definition of a Type A emergency department to distinguish it from a Type B emergency department. A Type A emergency department must be available to provide services 24 hours a day, 7 days a week, and meet one or both of the following requirements related to the EMTALA definition of a dedicated emergency department specified at 42 CFR 489.24(b), 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. For CY 2007 (71 FR 68140), we assigned the five CPT E/M emergency department visit codes for services provided in Type A emergency departments to five created Emergency Visit APCs, specifically APC 0609 (Level 1 Emergency Visits), APC 0613 (Level 2 Emergency Visits), APC 0614 (Level 3 Emergency Visits), APC 0615 (Level 4 Emergency Visits), and APC 0616 (Level 5 Emergency Visits). We defined a Type B emergency department as any dedicated emergency department that incurred EMTALA obligations but did not meet the CPT definition of an emergency department. For example, a hospital department that may be characterized as a Type B emergency department would meet the definition of a dedicated emergency department but may not be available 24 hours a day, 7 days a week. Hospitals with such dedicated emergency departments incur EMTALA obligations with respect to an individual who presents to the department and requests, or has a request made on his or her behalf, examination or treatment for a medical condition.

To determine whether visits to Type B emergency departments have different resource costs than visits to either clinics or Type A emergency departments, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68132), we finalized a set of five HCPCS G-codes for use by hospitals to report visits to all entities that meet the definition of a dedicated emergency department under the EMTALA regulations but that are not Type A emergency departments. These codes are called "Type B emergency department visit codes." In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68132), we explained that these new HCPCS G-codes would serve as a vehicle to capture median cost and resource differences among visits provided by Type A emergency departments, Type B emergency departments, and clinics. We stated that the reporting of specific HCPCS G-codes for emergency department visits provided in Type B emergency departments would permit us to specifically collect and analyze the hospital resource costs of visits to these facilities in order to determine if, in the future, a proposal for an alternative payment policy might be warranted. We expected hospitals to adjust their charges appropriately to reflect differences in Type A and Type B emergency department visit costs.

As we noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68681), the CY 2007 claims data used for that rulemaking were from the first year of claims data available for analysis that included hospitals' cost data for these new Type B emergency department HCPCS visit codes. Based on our analysis of the CY 2007 claims data, we confirmed that the median costs of Type B emergency department visits were less than the median costs of Type A emergency department visits for all but the level 5 visit. In other words, the median costs from the CY 2007 hospital claims represented real differences in the hospital resource costs for the same level of visits in a

Type A or Type B emergency department. Therefore, for CY 2009, we adopted the August 2008 APC Panel recommendation to assign levels 1 through 4 Type B emergency department visits to their own APCs and to assign the level 5 Type B emergency department visit to the same APC as the level 5 Type A emergency department visit.

As discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60548 through 60551), analyses of CY 2008 hospitals' cost data from claims data used for CY 2010 ratesetting for the emergency department HCPCS G-codes demonstrated that the pattern of relative cost differences between Type A and Type B emergency department visits was largely consistent with the distributions we observed in the CY 2007 data, with the exception that, in the CY 2008 data, we observed a relatively lower HCPCS code-specific median cost associated with level 5 Type B emergency department visits compared to the HCPCS code-specific median cost of level 5 Type A emergency department visits. As a result, for CY 2010, we finalized a policy to continue to pay levels 1 through 4 Type B emergency department visits through four levels of APCs, and to pay for level 5 Type B emergency department visits through new APC 0630 (Level 5 Type B Emergency Department Visit), to which the level 5 Type B emergency department visit HCPCS code is the only service assigned.

Based on the CY 2009 claims data available for this proposed rule, we note that the pattern of relative cost differences between Type A and Type B emergency department visits is consistent with the distributions we observed in the CY 2008 claims data, as demonstrated in Table 32 below. Therefore, we are proposing to continue to pay for Type B emergency department visits in CY 2011 based on their median costs through five levels of APCs: APC 0626 (Level 1 Type B Emergency Department Visit), APC 0627 (Level 2 Type B Emergency Department Visit), APC 0628 (Level 3 Type B Emergency Department Visit), APC 0629 (Level 4 Type B Emergency Department Visit), and APC 0630. As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60550), we continue to believe that this configuration pays appropriately for each level of Type B emergency department visits based on estimated resource costs from more recent claims data. We also note that, as discussed in section II.A.2.e.(1) of this proposed rule and consistent with our CY 2010 policy, when calculating the median costs for the emergency department visit and critical care APCs (0609 through 0617 and 0626 through 0630), we are proposing to utilize our methodology that excludes those claims for visits that are eligible for payment through the extended assessment and management composite APC 8002. We believe that this approach will result in the most accurate cost estimates for APCs 0604 through 0608 for CY 2011.

Table 32 below displays the proposed median costs for each level of Type B emergency department visit APCs under the proposed CY 2011 configuration, compared to the proposed median costs for each level of clinic visit APCs and each level of Type A emergency department visit APCs.

TABLE 32.—COMPARISON OF PROPOSED MEDIAN COSTS FOR CLINIC VISIT APCs, TYPE B EMERGENCY DEPARTMENT VISIT APCs, AND TYPE A EMERGENCY DEPARTMENT VISIT APCs

Visit Level	Proposed CY 2011 Clinic Visit Approximate APC Median Cost	Proposed CY 2011 Type B Emergency Department Approximate APC Median Cost	Proposed CY 2011 Type A Emergency Visit Approximate APC Median Cost
Level 1	$52	$44	$54
Level 2	$74	$65	$92
Level 3	$95	$104	$146
Level 4	$125	$169	$234
Level 5	$172	$270	$347

During the February 2010 APC Panel meeting, the APC Panel requested that CMS provide information about the common diagnoses and services furnished with critical care services. We are accepting the APC Panel's recommendation and will provide the requested information at an upcoming meeting of the APC Panel.

3. Visit Reporting Guidelines

Since April 7, 2000, we have instructed hospitals to report facility resources for clinic and emergency department hospital outpatient visits using the CPT E/M codes and to develop internal hospital guidelines for reporting the appropriate visit level. Because a national set of hospital-specific codes and guidelines do not currently exist, we have advised hospitals that each hospital's internal guidelines that determine the levels of clinic and emergency department visits to be reported 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.

As noted in detail in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66802 through 66805), we observed a normal and stable distribution of clinic and emergency department visit levels in hospital claims over the past several years. The data indicated that hospitals, on average, were billing all five levels of visit codes with varying frequency, in a consistent pattern over time. Overall, both the clinic and emergency department visit distributions indicated that hospitals were billing consistently over time and in a manner that distinguished between visit levels, resulting in relatively normal distributions nationally for the OPPS, as well as for specific classes of hospitals. The results of these analyses were generally consistent with our

understanding of the clinical and resource characteristics of different levels of hospital outpatient clinic and emergency department visits. In the CY 2008 OPPS/ASC proposed rule (72 FR 42764 through 42765), we specifically invited public comment as to whether a pressing need for national guidelines continued at this point in the maturation of the OPPS, or if the current system where hospitals create and apply their own internal guidelines to report visits was currently more practical and appropriately flexible for hospitals. We explained that, although we have reiterated our goal since CY 2000 of creating national guidelines, this complex undertaking for these important and common hospital services was proving more challenging than we initially anticipated as we received new and expanded information from the public on current hospital reporting practices that led to appropriate payment for the hospital resources associated with clinic and emergency department visits. We stated our belief that many hospitals had worked diligently and carefully to develop and implement their own internal guidelines that reflected the scope and types of services they provided throughout the hospital outpatient system. Based on public comments, as well as our own knowledge of how clinics operate, it seemed unlikely that one set of straightforward national guidelines could apply to the reporting of visits in all hospitals and specialty clinics. In addition, the stable distribution of clinic and emergency department visits reported under the OPPS over the past several years indicated that hospitals, both nationally in the aggregate and grouped by specific hospital classes, were generally billing in an appropriate and consistent manner as we would expect in a system that accurately distinguished among different levels of service based on the associated hospital resources.

Therefore, we did not propose to implement national visit guidelines for clinic or emergency department visits for CY 2008. Since publication of the CY 2008 OPPS/ASC final rule with comment period, we have again examined the distribution of clinic and Type A emergency department visit levels based upon updated CY 2009 claims data available for this CY 2011 proposed rule and confirmed that we continue to observe a normal and stable distribution of clinic and emergency department visit levels in hospital claims. We continue to believe that, based on the use of their own internal guidelines, hospitals are generally billing in an appropriate and consistent manner that distinguishes among different levels of visits based on their required hospital resources. As a result of our updated analyses, we are encouraging hospitals to continue to report visits during CY 2011 according to their own internal hospital guidelines. In the absence of national guidelines, we will continue to regularly reevaluate patterns of hospital outpatient visit reporting at varying levels of disaggregation below the national level to ensure that hospitals continue to bill appropriately and differentially for these services. As originally noted in detail in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66648), we continue to expect that hospitals will not purposely change their visit guidelines or otherwise upcode clinic and emergency department visits for purposes of extended assessment and management composite APC payment.

In addition, we note our continued expectation that hospitals' internal guidelines will comport with the principles listed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66805). We encourage hospitals with more specific questions related to the creation of internal guidelines to contact their servicing fiscal intermediary or MAC.

We appreciate all of the comments we have received in the past from the public on visit guidelines, and we encourage continued submission of comments throughout the year that would assist us and other stakeholders interested in the development of national guidelines. Until national guidelines are established, hospitals should continue using their own internal guidelines to determine the appropriate reporting of different levels of clinic and emergency department visits. While we understand the interest of some hospitals in having us move quickly to promulgate national guidelines that would ensure standardized reporting of hospital outpatient visit levels, we believe that the issues and concerns identified both by us and others are important and require serious consideration prior to the implementation of national guidelines.

Because of our commitment to provide hospitals with 6 to 12 months notice prior to implementation of national guidelines, we would not implement national guidelines prior to CY 2012. Our goal is to ensure that OPPS national or hospital-specific visit guidelines continue to facilitate consistent and accurate reporting of hospital outpatient visits in a manner that is resource-based and supportive of appropriate OPPS payments for the efficient and effective provision of services to beneficiaries during visits in hospital outpatient settings.

X. Proposed Payment for Partial Hospitalization Services

A. Background

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for individuals who have an acute mental illness. Sections 1861(ff)(1) and (ff)(2) of the Act specify the items and services that are defined as partial hospitalization services and the conditions under which Medicare payment for the items and services will be made. Section 1861(ff)(3) of the Act specifies that a partial hospitalization program (PHP) is one that is furnished by a hospital or community mental health center (CMHC) that meets the requirements specified under that subsection of the Act.

Section 1301(a) of the recently enacted Health Care and Education Reconciliation Act of 2010 (HCERA 2010) (Pub. L. 111–152, enacted on March 30, 2010) revised the definition of a CMHC set forth at section 1861(ff)(3)(B) of the Act by adding a provision that the CMHC, effective on the first day of the first calendar quarter that begins at least 12 months after the date of enactment (that is, April 1, 2011), must provide at least 40 percent of its services to individuals who are not eligible for benefits under Title XVIII of the Act (Medicare). Section 1301(b) of HCERA 2010 amended the description of a PHP to specify that the program must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care "other than in an individual's home or in an inpatient or residential setting." We discuss our proposal to incorporate these two provisions of HCERA 2010 in our regulations under section X.C. of this proposed rule.

Section 1833(t)(1)(B)(i) of the Act provides the Secretary with the authority to designate the HOPD services to be covered under the OPPS. The existing Medicare regulations at 42 CFR 419.21 that implement this provision specify that payments under the OPPS will be made for partial hospitalization services furnished by CMHCs as well as those services furnished by hospitals to their outpatients. Section 1833(t)(2)(C) of the Act requires the Secretary to establish relative payment weights for covered

HOPD services (and any APCs) based on median (or mean, at the election of the Secretary) hospital costs using data on claims from 1996 and data from the most recent available cost reports. 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 APCs, effective for services furnished on or after August 1, 2000 (65 FR 18452 through 18455).

From CY 2003 through CY 2006, the median per diem cost for CMHCs fluctuated significantly from year to year (from a high of $685 in CY 2003 to a low of $154 in CY 2006), while the median per diem cost for hospital-based PHPs remained relatively constant ($177–$225). We believe that CMHCs may have increased and decreased their charges in response to Medicare payment policies.

Due to these significant fluctuations and declines in CMHC PHP median per diem costs, in developing the CY 2008 update, we began an effort to strengthen the PHP benefit through extensive data analysis and policy and payment changes (72 FR 66670 through 66676). Specifically, we proposed and finalized two refinements to the methodology for computing the PHP median. First, we remapped 10 revenue codes that are common among hospital-based PHP claims to the most appropriate cost centers. Secondly, we refined our methodology for calculating PHP per diem costs by computing the median using a per day methodology. A complete discussion of these refinements can be found in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66671 through 66672).

In CY 2009, we implemented several regulatory, policy, and payment changes, including a two-tiered payment approach for PHP services under which we pay one amount for days with 3 services (APC 0172 (Level I Partial Hospitalization)) and a higher amount for days with 4 or more services (APC 0173 (Level II Partial Hospitalization)). We refer readers to section X.C.2. of the CY 2009 OPPS/ASC final rule with comment period (73 FR 68688 through 68693) for a full discussion of the two-tiered payment system. In addition, for CY 2009, we finalized our policy to deny payment for any PHP claims for days when fewer than 3 units of therapeutic services are provided. As noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68694), we believe that 3 services should be the minimum number of services allowed in a PHP day because a day with 1 or 2 services does not meet the statutory intent of a PHP. Three services are a minimum threshold that will take into consideration unforeseen circumstances, such as medical appointments, while maintaining the integrity of the PHP benefit.

Furthermore, for CY 2009, we revised the regulations at 42 CFR 410.43 to codify existing basic PHP patient eligibility criteria and to add a reference to current physician certification requirements at 42 CFR 424.24 to conform our regulations to our longstanding policy (73 FR 68694 through 68695). We believe these changes have helped to strengthen the PHP benefit. We also revised the partial hospitalization benefit to include several coding updates. We refer readers to section X.C.2. of the CY 2009 OPPS/ASC final rule with comment period (73 FR 68694 through 68697) for a full discussion of these requirements.

For CY 2010, we retained the two-tiered payment approach for PHP services and used only hospital-based PHP data in computing the per diem payment rates. We used only hospital-based PHP data because we were concerned about further reducing both PHP APC per diem payment rates without knowing the impact of the policy and payment changes we made in CY 2009. Because of the 2-year lag between data collection and rulemaking, the changes we made in CY 2009 are reflected for the first time in the claims data that we are using to determine proposed payment rates for this CY 2011 rulemaking.

B. Proposed PHP APC Update for CY 2011

For CY 2011, we used CY 2009 claims data and computed median per diem costs in the following three categories: (1) All days; (2) days with 3 services; and (3) days with 4 or more services. These proposed median per diem costs were computed separately for CMHC PHPs and hospital-based PHPs and are shown in Table 33 below.

TABLE 33.—PHP MEDIAN PER DIEM COSTS FOR CMHC AND HOSPITAL-BASED PHPs, BY CATEGORY, BASED ON CY 2009 CLAIMS DATA

Category	CMHC PHPs	Hospital-Based PHPs	Combined
All Days	$123.17	$235.58	$132.28
Days with 3 services	$118.19	$184.47	$140.96
Days with 4 or more services	$123.35	$235.58	$131.56

Using CY 2009 data and the refined methodology for computing PHP per diem costs that we adopted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66672), we computed a median per diem cost from all claims for CY 2011 of $132.28. The data indicate that, although CMHCs provided more days with 4 or more services in CY 2009 than in CY 2008, their median per diem cost for 4 or more services ($123.35) is substantially lower than the median per diem cost for the same units of service provided in hospital-based PHPs ($235.58). The median per diem cost for claims containing 4 or more services for all PHP claims, regardless of site of service, is $131.56. Medians for claims containing 3 services is $118.19 for CMHC PHPs, $184.47 for hospital-based PHPs, and $140.96 for all PHP service claims, regardless of site of service.

These data, along with data from previous years, show the shift in cost and utilization for CMHCs and hospital-based PHPs under the two-tiered

payment system. Since CY 2009 (using 2007 data), CMHC costs decreased from $139 in CY 2009 to $118 in CY 2011 for Level I services (3 services) and from $172 in CY 2009 to $123 in CY 2011 for Level II services (4 or more services). For hospital-based PHPs, costs increased from $157 in CY 2009 to $184 in CY 2011 for Level I services (3 services) and from $200 in CY 2009 to $236 in CY 2011 for Level II services (4 or more services). For the past two years, we have based the PHP APC per diem payment rates on only hospital-based PHP data because including the CMHC data would have lowered the PHP APC per diem rates and raised concerns about appropriate payment for PHP services. Specifically, we were concerned about paying hospital-based PHP programs a rate that is lower than what their cost structure reflects, which in turn could lead to hospital-based program closures and possible access problems. We also were concerned about further reducing the payment rates without knowing the impact of the policy and payment changes we made in CY 2009.

Because the CMHC cost data has significantly decreased again this year, we believe that we can no longer ignore the pattern and continue to base the PHP payment rates using only hospital-based data. We are confident that the CY 2009 claims data reflect that CMHCs continue to have a lower cost structure than hospitals and not the impact of CY 2009 policies. Therefore, we believe that we cannot continue to treat these two provider types the same in terms of payment, particularly because their cost differences continue to be so disparate. We also believe that we need to continue to protect hospital-based PHPs from receiving inadequate payments, given that they offer the widest access to PHP services because they are located across the country. We believe that the results of our analysis of the claims data indicate a need to establish payment rates for each provider type based on its own unique cost structures.

Therefore, for CY 2011, we are proposing to compute four separate PHP APC per diem payment rates, two for CMHC PHPs (for Level I and Level II services using only CMHC data) and two for hospital-based PHPs (Level I and Level II services using only hospital-based PHP data). Creating the proposed four payment rates (two for CMHC PHPs and two for hospital-based PHPs) would support continued access to the PHP benefit, including a more intensive level of care, while also providing appropriate payment based on the unique cost structures of CMHC PHPs and hospital-based PHPs. We request public comments on our proposal to provide four separate PHP APC per diem payment rates, two for CMHC PHPs and two for hospital-based PHPs.

The proposed APCs median per diem costs for PHP services for CY 2011 are as follows:

TABLE 34.—PROPOSED CY 2011 MEDIAN PER DIEM COSTS FOR CMHC PHP SERVICES

Proposed APC	Group Title	Proposed Median Per Diem Costs
0172	Level 1 Partial Hospitalization (3 services) for CMHCs	$118.19
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	$123.35

TABLE 35.—PROPOSED CY 2011 MEDIAN PER DIEM COSTS FOR HOSPITAL-BASED PHP SERVICES

Proposed APC	Group Title	Proposed Median
0175	Level 1 Partial Hospitalization (3 services) for hospital-based PHPs	$184.47
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	$235.58

We note that this proposal is consistent with the recommendation by several commenters in the CY 2010 OPPS/ASC final rule with comment period that CMS adopt two additional payment rates that are site specific APCs for PHP services, where the hospital-based PHP APCs for Level I services (3 services) and Level II services (4 or more services) would be established using only hospital-based data and the CMHC PHP APCs for Level I services (3 services) and Level II services (4 or more services) would be established using only CMHC data (74 FR 60557).

C. Proposed Changes to Regulations To Incorporate Provisions of HCERA 2010

As stated in section X.A. of this proposed rule, section 1301 of HCERA 2010 made a change to the statutory definition of a CMHC and a change to the description of what constitutes a PHP. Specifically, section 1301(a) of HCERA 2010 revised the definition of a CMHC set forth at section 1861(ff)(3)(B) of the Act by adding a provision to the existing provisions under which a CMHC, effective on the first day of the first calendar quarter that begins at least 12 months after the date of enactment (that is, April 1, 2011), must provide at least 40 percent of its services to individuals who are not eligible for benefits under Title XVIII of the Act (Medicare). Section 1301(b) of HCERA 2010 amended the description of a PHP to specify that the program must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care "other than

in an individual's home or in an inpatient or residential setting."

Our existing regulations at 42 CFR 410.2 incorporate the statutory definitions of "Community mental health center (CMHC)" and "Partial hospitalization services." We are proposing to revise the definition of a CMHC in § 410.2 to include the additional requirement provided for under the amendment made by section 1301(a) of HCERA 2010. Under existing § 410.2, we define "partial hospitalization services" to mean "a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care and furnishes the services described in § 410.43." We are proposing to revise this definition to incorporate the amendment made by section 1301(b) of HCERA 2010 to describe partial hospitalization services as a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care "other than in an individual's home or in an inpatient residential setting" and furnishes the services described in § 410.43.

D. Proposed Separate Threshold for Outlier Payments to CMHCs

In the November 7, 2003 final rule with comment period (68 FR 63469 through 63470), 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. Prior to that time, there was a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP services. In addition, further analysis indicated that using the same OPPS outlier threshold for both hospitals and CMHCs did not limit outlier payments to high cost cases and resulted in excessive outlier payments to CMHCs. Therefore, beginning in CY 2004, we established a separate outlier threshold for CMHCs. The separate outlier threshold for CMHCs has resulted in more commensurate outlier payments.

In CY 2004, the separate outlier threshold for CMHCs resulted in $1.8 million in outlier payments to CMHCs. In CY 2005, the separate outlier threshold for CMHCs resulted in $0.5 million in outlier payments to CMHCs. In contrast, in CY 2003, more than $30 million was paid to CMHCs in outlier payments. We believe this difference in outlier payments indicates that the separate outlier threshold for CMHCs has been successful in keeping outlier payments to CMHCs in line with the percentage of OPPS payments made to CMHCs.

As noted in section II.F. of this proposed rule, we are proposing to continue our policy of identifying 1.0 percent of the aggregate total payments under the OPPS for outlier payments for CY 2011. We are proposing that a portion of that 1.0 percent, an amount equal to 0.04 percent of outlier payments (or 0.0004 percent of total OPPS payments), would be allocated to CMHCs for PHP outliers. As discussed in section II.F. of this proposed rule, we are proposing to set a dollar threshold in addition to an APC multiplier threshold for OPPS outlier payments. However, because the PHP APC is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we are not proposing to set a dollar threshold for CMHC outliers. As noted in section II.F. of this proposed rule, we are proposing to set the outlier threshold for CMHCs for CY 2011 at 3.40 times the APC payment amount and the CY 2011 outlier payment percentage applicable to costs in excess of the threshold at 50 percent. Specifically, we are proposing to establish that if a CMHC's cost for partial hospitalization services, paid under either APC 0172 or APC 0173, exceeds 3.40 times the payment for APC 0173, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate.

XI. Proposed 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 HOPD. 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 our 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 (65 FR 18455), we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS. These procedures comprise what is referred to as the "inpatient list." The inpatient list specifies those services for which the hospital will be paid only when provided in the inpatient setting because of the nature of the procedure, the underlying physical condition of the patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged. As we discussed in that rule and in the November 30, 2001 final rule with comment period (66 FR 59856), we may use any of a number of criteria we have specified when reviewing procedures to determine whether or not they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS when provided in the hospital outpatient setting. Those criteria include the following:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule with comment period (67 FR 66741), we added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- A determination is made that the procedure is being performed in numerous hospitals on an outpatient basis; or
- A determination is made that the procedure can be appropriately and safely performed in an ASC, and is on the list of approved ASC procedures or has been proposed by us for addition to the ASC list.

The list of codes that we are proposing to be paid by Medicare in CY 2011 only as inpatient procedures is included as Addendum E to this proposed rule.

B. Proposed Changes to the Inpatient List

For the CY 2011 OPPS, we are proposing to use 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 performed a significant amount of the time on an outpatient basis. Using this methodology, we identified three procedures that met the criteria for potential removal from the inpatient list. We then clinically reviewed these three potential procedures for possible

removal from the inpatient list and found them to be appropriate candidates for removal from the inpatient list. During the February 2010 meeting of the APC Panel, we solicited the APC Panel's input on the appropriateness of removing the following three procedures from the CY 2011 inpatient list: CPT codes 21193 (Reconstruction of mandibular rami; horizontal, vertical, C, or L osteotomy; without bone graft); 21395 (Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)); and 25909 (Amputation, forearm, through radius and ulna; reamputation). Following the discussion at its February 2010 meeting, the APC Panel recommended that CMS remove from the CY 2011 inpatient list the three CPT codes that we had identified: CPT codes 21193, 21395, and 25909.

For the CY 2011 OPPS, we are proposing to accept the APC Panel's recommendations to remove the procedures described by CPT codes 21193, 21395, and 25909 from the inpatient list because we agree with the APC Panel that the procedures may be appropriately provided as hospital outpatient procedures for some Medicare beneficiaries. The three procedures that we are proposing to remove from the inpatient list for CY 2011 and their CPT codes, long descriptors, and proposed APC assignments are displayed in Table 36 below.

TABLE 36.—PROCEDURES PROPOSED FOR REMOVAL FROM THE INPATIENT LIST AND THEIR PROPOSED APC ASSIGNMENTS FOR CY 2011

CPT Code	Long Descriptor	Proposed CY 2011 APC Assignment	Proposed CY 2011 Status Indicator
21193	Reconstruction of mandibular rami; horizontal, vertical, C, or L osteotomy; without bone graft	0256	T
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft	0256	T
25909	Amputation, forearm, through radius and ulna; reamputation	0049	T

XII. Proposed OPPS Nonrecurring Technical and Policy Changes and Clarifications

A. Physician Supervision

1. Background

In the CY 2000 OPPS final rule with comment period (65 FR 18524–18526), we amended our regulations to establish, as a condition of payment, the requirements for physician supervision of diagnostic and therapeutic services provided to hospital outpatients incident to a physician's service. We adopted physician supervision policies as a condition of payment to ensure that Medicare pays for high quality hospital outpatient services provided to beneficiaries in a safe and effective manner and consistent with Medicare requirements. We clarified and restated the various payment requirements for physician supervision of therapeutic and diagnostic services through notice and comment rulemaking in the CY 2009 OPPS/ASC proposed rule and final rule with comment period (73 FR 41518 through 41519 and 73 FR 68702 through 68704, respectively). In response to concerns about our policy restatement that were expressed following the publication of the CY 2009 final rule with comment period, we met with stakeholders and further delineated our physician supervision policies for both therapeutic and diagnostic services in the CY 2010 OPPS/ASC proposed rule and final rule with comment period (74 FR 35365 and 74 FR 60679 through 60680, respectively).

While we received and responded to many comments in the course of the CY 2010 rulemaking, addressing supervision for both diagnostic and therapeutic services, it was not until after publication of the CY 2010 OPPS/ASC final rule with comment period that we received substantial comments from the CAH community in response to a technical correction we made to codify our long standing view that CAHs are subject to the supervision policy for payment of therapeutic services in the regulations at 42 CFR 410.27. In addition, the broader hospital community continues to indicate that it would prefer that we modify the current supervision policy to permit a lower level of supervision for therapeutic services.

By way of introduction, we have defined supervision in the hospital outpatient setting by drawing on the three levels of supervision that we defined for the physician office setting at § 410.32(b): general, direct and personal supervision. Over time, we have tailored these definitions to apply them in the hospital outpatient setting, but we have maintained the following premises. General supervision means that a service is furnished under the overall direction and control of the physician, but his or her physical presence is not required during the performance of the procedure. Direct supervision means that the physician is physically present on site and is immediately available to furnish assistance and direction throughout the performance of the procedure. However, it does not mean the physician must be present in the same room when the procedure is being performed. Personal supervision means the physician is present in the room when the service is being performed.

a. Outpatient Therapeutic Services

As set forth in the CY 2000 OPPS final rule with comment period establishing the hospital outpatient prospective payment system, direct supervision is the standard for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider based departments (PBDs) of hospitals. In that rule, we defined "direct supervision" to mean that "the

physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed." In the CY 2000 OPPS final rule with comment period, we finalized regulation text in § 410.27(f) specifying that direct supervision is required in PBDs of hospitals. In the preamble discussion we emphasized the importance of the direct supervision requirement for off-campus provider based departments. We also stated that the language of § 410.27(f) "applies to services furnished at an entity that is located off the campus of a hospital that we designate as having provider-based status as a department of a hospital in accordance with § 413.65." We disagreed with commenters that the requirement for direct supervision in the off campus provider-based hospital department was more stringent than that required on the hospital campus. We noted that section 1861(s)(2)(B) of the Act authorizes payment for hospital services incident to physicians' services furnished to outpatients. We stated that "we require that hospital services and supplies furnished to outpatients that are incident to physician services be furnished on a physician's order by hospital personnel and under a physician's supervision" (65 FR 18525). We further stated that "we assume the physician supervision requirement is met on hospital premises because staff physicians would always be nearby within the hospital."

In manual guidance, we have clarified that we expect services incident to physicians' services to be performed under direct supervision. We provide in Section 20.5.1, Chapter 6, of the Medicare Benefit Policy Manual (Pub. 100–04) that services and supplies must be furnished on a physician's order and delivered under supervision. Section 20.5.1 indicates further that each occasion of a service by a nonphysician does not need to also be the occasion of the actual rendition of a personal professional service by the physician responsible for the care of the patient. Nevertheless, as stipulated in that same section of the Manual "during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often enough to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen."

In the CY 2009 OPPS/ASC proposed rule and final rule with comment period, we provided a restatement and clarification of the requirements for physician supervision of hospital outpatient diagnostic and therapeutic services that were set forth in the CY 2000 OPPS final rule with comment period. We chose to restate the existing physician supervision policy for hospital outpatient therapeutic services in part because we were concerned that some stakeholders may have misunderstood our use of the term "assume" in the following statement, "We assume the physician requirement is met on hospital premises because staff physicians would always be nearby within the hospital. The effect of the regulations in this final rule is to extend this assumption to a department of a hospital that is located on the campus of the hospital" (65 FR 18525). We were concerned that stakeholders might believe that this statement meant that we do not require any supervision in the hospital or in an on-campus PBD for hospital outpatient therapeutic services, or that we only require general supervision for those services.

In our policy restatement in the CY 2009 OPPS/ASC rulemaking, we reiterated that direct supervision is the standard for physician supervision, as set forth in the CY 2000 OPPS final rule with comment period, for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and PBDs of hospitals. We stated clearly that we expect direct physician supervision of all hospital outpatient therapeutic services, regardless of their on-campus or off-campus location, but indicated that we would continue to emphasize the physician supervision requirements in off-campus PBDs as we did in the CY 2000 OPPS final rule with comment period. We noted that if there were problems with outpatient care in a hospital or in an on-campus PBD where direct supervision was not in place (that is, the expectation of direct supervision was not met), we would consider that to be a quality concern.

After we published the CY 2009 OPPS/ASC final rule with comment period, we received significantly more public feedback than during the rulemaking cycle about our restatement of our supervision policy for both diagnostic and therapeutic services. We met with stakeholders in the early part of 2009 as we prepared for the CY 2010 rulemaking cycle, as well as reviewed all public input that we received, to craft a response to these concerns regarding the supervision requirements. For therapeutic services, we considered the concerns of various stakeholders along with our position that direct supervision for therapeutic services is appropriate and aligned with the statutory requirement that Medicare only makes payment for therapeutic services in the hospital outpatient setting that are "incident to" physician services.

In the CY 2010 OPPS/ASC final rule with comment period, we finalized our proposal to allow, in addition to clinical psychologists, certain other nonphysician practitioners to directly supervise services that they may perform themselves under their State license and scope of practice and hospital-granted or CAH-granted privileges. The nonphysician practitioners that were permitted to provide direct supervision of therapeutic services under the CY 2010 OPPS/ASC final rule with comment period are physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, and licensed clinical social workers. These nonphysician practitioners may directly supervise outpatient therapeutic services that they may personally furnish in accordance with State law and all additional requirements, including the Medicare coverage rules relating to their services specified in our regulations at 42 CFR 410.71, 410.73, 410.74, 410.75, 410.76, and 410.77 (for example, requirements for collaboration with, or general supervision by, a physician). In implementing the new benefits for pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation added by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Pub. L. 110–275), we required that direct supervision of services furnished in the hospital outpatient department must be provided by a doctor of medicine or osteopathy as required by statute.

For services furnished on a hospital's main campus, we finalized a modification of our proposed definition of "direct supervision" in new paragraph (a)(1)(iv)(A) of § 410.27 that allows for the supervisory physician or nonphysician practitioner to be anywhere on the hospital campus. Therefore, as of CY 2010, direct supervision on the hospital or CAH campus or in an on-campus PBD means that "the supervisory physician or nonphysician practitioner must be present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure." Because the term "in the hospital or CAH" applies broadly to "incident to" requirements such as the site-of-service requirement for therapeutic services provided by the hospital directly and under arrangement, we also established

a definition of "in the hospital" in new paragraph § 410.27(g) as meaning areas in the main building(s) of a hospital or CAH that are under the ownership, financial, and administrative control of the hospital or CAH; that are operated as part of the hospital; and for which the hospital bills the services furnished under the hospital's or CAH's CMS Certification Number (CCN). In the preamble to the CY 2010 OPPS/ASC final rule with comment period, as part of the discussion of various public comments on the definition of the hospital campus, and on the supervision requirement specifically, we stated that we would recognize other areas or structures of the hospital's campus that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare to be part of the hospital's campus.

In the CY 2010 OPPS/ASC final rule with comment period, we also finalized our proposal to add paragraph (a)(1)(iv)(B) to § 410.27. This paragraph updated our previous regulation at § 410.27(f) to reflect that, for off-campus PBDs of hospitals, the physician or nonphysician practitioner must be present in the off-campus PBD, as defined in § 413.65, and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician or nonphysician practitioner must be in the room when the procedure is performed. In addition, we finalized the proposed technical change to clarify the language in § 410.27(f) by removing the phrase "present and on the premises of the location" and replacing it with the phrase "present in the off-campus provider-based department."

Finally, we finalized a technical correction to the title of § 410.27 to read "Outpatient hospital or CAH services and supplies incident to a physician service: Conditions," to clarify in the title that the requirements for payment of hospital outpatient therapeutic services incident to a physician or nonphysician practitioner service in that section apply to both hospitals and CAHs. Similarly, we included the phrase "hospital or CAH" throughout the text of § 410.27 wherever the text referred only to "hospital." We viewed this as a technical correction because the statute applies the same regulations to hospitals and CAHs when appropriate. Specifically, the definition of "hospital" in section 1861(e) of the Act expressly excludes CAHs "unless the context otherwise requires." Accordingly, we do not believe it is necessary for a regulation to reference specifically the applicability to CAHs for those regulations to be appropriate given the "context" for CAHs. Although payment to CAHs is authorized under section 1834(g) of the Act, many of the payment rules applicable to hospitals paid under sections 1886(d) and 1833(t) of the Act apply to CAHs.

We believe that the supervision requirements should apply in the context of CAHs because they represent appropriate safety and quality requirements for Medicare payment of outpatient services. In the early part of this year, the CAH community asserted that the CAH CoPs offer more flexibility in staffing requirements than the rule requiring direct supervision, and that the CAH CoPs address the general availability of physician and nonphysician practitioners on the CAH campus. The hospital CoPs at 42 CFR 482.22 require hospital medical staff to be composed of doctors of medicine or osteopathy and, in accordance with State law, may also be composed of other practitioners appointed by the governing body. They also require 24 hour nursing services that are provided by or supervised by a registered nurse. Under section 1820(c)(2)(B) of the Act, among other criteria, a CAH must meet the same staffing requirements as would apply under section 1861(e) of the Act to a hospital located in a rural area. However, there are some exceptions to these staffing requirements. Section 1820(c)(2)(B)(iv) of the Act specifies that the CAH need not meet hospital staffing requirements under section 1861(e) of the Act regarding the days and hours in which it is open and fully staffed; the facility may provide certain services under arrangement at an off-site location; that inpatient care may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician, who need not be present in the facility.

The CAH CoPs in 42 CFR 485.631 are specific in recognizing the statutory authority to be staffed by nonphysician practitioners rather than physicians, provided a doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates. The requirement that the practitioner "be available" in § 485.631 has been interpreted to mean that the nonphysician practitioner or physician is available by phone, but not necessarily physically present on the CAH campus. The CAH CoPs also specify standards for emergency personnel under § 485.618, requiring that a doctor of medicine or osteopathy, or a nonphysician practitioner such as a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care, be on call and immediately available by telephone or radio contact, and available on site within 30 minutes, on a 24-hour a day basis in most areas.

However, in the Medicare program, payment requirements are frequently different from those identified in the CoPs because the two sets of rules serve very separate and distinct purposes. CoPs apply largely at the facility level, while payment regulations apply at the service level. Payment regulations, such as requirements for how contracted entities providing services to hospital patients, support program goals of appropriate and accurate payment for quality services. In contrast, for all providers including CAHs, the CoPs authorize hospitals to participate in the Medicare program. We establish CoPs as minimum standards for patient health and safety, and CoPs focus on creating a foundation to ensure quality and safe care for beneficiaries throughout a given facility, irrespective of the payment system or service provided. CoPs do not ensure that payment is appropriate for specific types of purchased services nor can they substitute for payment requirements since that is not their function.

In summary, requirements established for purposes of payment frequently differ from the requirements established by the CoPs for many providers, including hospitals and CAHs. Whereas payment regulations establish basic parameters defining the services being purchased, CoPs (including both the hospital CoPs and the CAH CoPs) establish standards to ensure a minimum level of quality and safety for operating as a hospital or a CAH. The minimum standards established as CoPs are not always adequate to address the particular quality, safety and other requirements for payment for a service or group of services.

b. Outpatient Diagnostic Services

As we stated in the CY 2009 OPPS/ASC and CY 2000 OPPS proposed rules and final rules with comment period, section 1861(s)(2)(C) of the Act authorizes payment for diagnostic services that are furnished to a hospital outpatient for the purpose of diagnostic study. We have further defined the requirements for diagnostic services furnished to hospital outpatients, including requirements for physician supervision of diagnostic services, in §§ 410.28 and 410.32 of our regulations. For CY 2010, we finalized a proposal to require that all hospital outpatient

diagnostic services provided directly or under arrangement, whether provided in the hospital, in a PBD of a hospital, or at a nonhospital location, follow the physician supervision requirements for individual tests as listed in the MPFS Relative Value File in order to receive payment. The existing definitions of general and personal supervision as defined in §§ 410.32(b)(3)(i) and (b)(3)(iii) also apply. For services furnished directly or under arrangement in the hospital or on-campus PBD, "direct supervision" means that the physician must be present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure. For the purposes of § 410.28, as for the general purposes of § 410.27, the definition of "in the hospital" as incorporated in § 410.27(g) applies.

These policies are an extension of the supervision requirements for outpatient diagnostic tests performed in a provider-based department that were adopted at the inception of the OPPS in the CY 2000 OPPS final rule with comment period. The MPFS Relative Value File is updated quarterly and is available on the CMS Web site at: *http://www.cms.gov/PhysicianFeeSched/*. For diagnostic services not listed in the MPFS, we have indicated that Medicare contractors, in consultation with their medical directors, would define appropriate supervision levels in order to determine whether claims for these services are reasonable and necessary.

We note that the current requirement in §§ 410.28(e)(1) and (e)(2) that physician supervision of diagnostic services provided in the hospital or in any provider-based department follow the levels for diagnostic services established under the MPFS explicitly applies to hospitals that are paid pursuant to section 1833(t) of the Act, which is the statutory authority for the OPPS. Because Medicare makes payments to CAHs pursuant to section 1834(g) of the Act, at this time, CAHs are not subject to this supervision requirement.

2. Issues Regarding the Supervision of Hospital Outpatient Services Raised by Hospitals and Other Stakeholders

Following the adoption of our policies in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60575 through 60591), beginning in January 2010, we began to receive a sizable amount of correspondence, as well as numerous phone calls, and questions through other public avenues, including the regular open door forum calls, from the rural hospital and CAH community indicating its belief that the requirement for direct supervision for therapeutic services finalized in that rule is at odds with longstanding and prevailing practice in rural communities. These hospitals and their representatives stated that they generally function with a reduced level of supervision for the provision of therapeutic services and that while they furnish services under a physician's or appropriate nonphysician practitioner's order, frequently no physician or nonphysician practitioner is physically present anywhere in the CAH or small rural hospital while the therapeutic services are being furnished. CAHs, in particular, noted that the provisions in their CoPs allow a CAH to operate under the reduced staffing requirements specified above. Specifically, under the CoPs, CAHs must have a physician or one of several types of nonphysician practitioners available by phone at all times, but not on campus, and in most areas of the country, for emergencies, the CAH must have a physician or certain other nonphysician practitioners with training or experience in emergency care physically available onsite within 30 minutes.

Both CAHs and rural hospitals have stated that the flexibility to allow nonphysician practitioners to supervise services that we authorized in the CY 2010 OPPS/ASC final rule with comment period is helpful for meeting the direct supervision requirement for all therapeutic services, but that a shortage of qualified practitioners in rural areas continues to make it difficult to staff a physician or nonphysician practitioner for supervision purposes. They also noted that a practitioner retained on the campus of a small rural hospital or CAH to meet supervision requirements may not have other patients or medical activities to complete. In an urban or large urban hospital, a practitioner would be able to see other patients or engage in other activities so long as those activities could be interrupted, such that they would be immediately available to supervise.

In a series of questions and answers about supervision on the CMS Web site (*http://www.cms.gov/HospitalOutpatientPPS/05_OPPSGuidance.asp#TopOfPage*), we provided additional guidance regarding our regulations about who can supervise services in order to explain to CAHs and small rural hospitals the flexibility we believe exists within our requirement for direct supervision. For example, in that document, we state that we believe the emergency physician or non-physician practitioner, who would be the most likely practitioners staffing a small rural hospital or CAH, can directly supervise outpatient services so long as the emergency physician in the emergency department of the campus meets the other requirements of direct supervision. That is, the individual needs to be immediately available, so that, if needed, he or she could reasonably be interrupted to furnish assistance and direction in the delivery of therapeutic services provided elsewhere in the hospital. We believe that most emergency physicians can appropriately supervise many services within the scope of their knowledge, skills, licensure, and hospital-granted privileges, including observation services. With regard to whether an emergency physician or a nonphysician practitioner could be interrupted, such that the individual could be immediately available, we have stated that each hospital would need to assess the level of activity in their emergency department and determine whether at least one emergency physician or nonphysician practitioner could be interrupted to furnish assistance and direction in the treatment of outpatients.

In their correspondence and discussion in public forums, CAHs and small rural hospitals explicitly have raised concerns about services that extend after regular operating hours, especially observation services. They also asserted that direct supervision is not clinically necessary for some services that have a significant monitoring component that is typically performed by nursing or other auxiliary staff typically, including IV hydration, blood transfusions, and chemotherapy. They stated that their facilities have protocols to safely deliver all of these services, including chemotherapy, relying on nursing or other hospital staff to provide the service and having a physician or non-physician practitioner available by phone to furnish assistance and direction throughout the duration of the therapeutic service.

In the early part of this year, small rural hospitals and CAHs indicated that, regulations notwithstanding, many of them did not have appropriate staff arrangements to provide the required supervision of some services, particularly services being provided after hours or consisting of a significant monitoring component that lasted for an extended period of time. In response to rising concerns among the rural community about these rules and the inability of some hospitals to meet the direct supervision requirement, we issued a statement on March 15, 2010, indicating that we would not enforce the rules for supervision of hospital outpatient therapeutic procedures

furnished in CAHs in CY 2010 (*http://www.cms.gov/HospitalOutpatientPPS/01_overview.asp#TopOfPage*). We also stated that we would proactively revisit the rules surrounding the supervision of services furnished by CAHs in the CY 2011 OPPS/ASC proposed rule.

With regard to diagnostic services, unlike supervision of therapeutic services, we have had only limited dialogue with various stakeholders about our CY 2010 policy to recognize the supervision levels for diagnostic services under the MPFS for the provision of diagnostic services in the hospital. Individual stakeholders have asked about supervision of specific diagnostic services and have noted that our requirement that the hospitals follow the supervision levels for diagnostic services in the hospital identified in the MPFS Relative Value Unit file has required some modest changes in hospital staffing practices. We also have received questions requesting clarification about related supervision requirements for nonphysician practitioners. We note that adopting the supervision levels defined under the MPFS for diagnostic services in 42 CFR 410.32 means that nonphysician practitioners that are not specifically excluded under § 410.32(b) from the level of supervision required by the MPFS are subject to supervision by a physician at the level of supervision required by the diagnostic test. We also discussed in our CY 2010 OPPS/ASC final rule with comment period that diagnostic X-ray and other diagnostic tests must be furnished under the appropriate level of supervision by a physician as defined in section 1861(r) of the Act (74 FR 60588 through 60590).

3. Proposed Policies for Supervision of Outpatient Therapeutic Services in Hospitals and CAHs

As indicated in our March 15, 2010 statement, we are revisiting the issue of supervision of outpatient therapeutic services in CAHs to ensure a robust public discussion about supervision requirements for payment in hospital outpatient departments, including those located in rural communities, and CAH outpatient departments. In this proposed rule, we are proposing modest changes to our supervision policy for therapeutic services that reflect our continuing commitment to require direct supervision for the provision of therapeutic services in the hospital outpatient setting as a requirement for payment. We are proposing these changes for all hospitals, including CAHs, because we believe that Medicare should purchase a basic quality of service for all Medicare beneficiaries. Specifically, we are proposing to identify a limited set of services with a significant monitoring component that can extend for a sizable period of time, that are not surgical, and that typically have a low risk of complication after assessment at the beginning of the service, as "nonsurgical extended duration therapeutic services." We are proposing for these services that there would be a requirement for direct supervision for the initiation of the service followed by general supervision for the remainder of the service. We are proposing to adopt the definition of "general supervision" in § 410.32(b)(3)(i), which is the same definition of general supervision that we already recognize as appropriate for diagnostic services with a general supervision level requirement under the MPFS. Finally, at the end of this proposal, we include several discussion points designed to focus public comments and generate sufficient detail to assist us in crafting a final policy.

In the CY 2010 OPPS/ASC final rule with comment period, we affirmed our belief that direct supervision is the appropriate supervision requirement for therapeutic services provided in the hospital outpatient setting. In that rule, we finalized a definition of direct supervision in the hospital or in an on-campus department of the hospital to mean that the physician or nonphysician practitioner is present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure (74 FR 60591).

In considering the significant correspondence from CAHs and rural communities, as well as public discussion on the issue of supervision through the open door forum and calls with individual hospitals and other hospital representatives, we sought to identify some means of offering flexibility within the supervision requirement to hospitals and CAHs, while continuing to ensure that Medicare purchases services delivered with a basic level of quality and safety and also fulfills the statutory requirement for payment of therapeutic outpatient services in the hospital that are provided "incident to" physician services. We recognize the concerns of CAHs and rural hospitals that it could be difficult to staff a physician or nonphysician practitioner on the campus of the CAH or small rural hospital to supervise services that have a significant monitoring component and lack an active component being performed by the physician or nonphysician practitioner, especially when these services extend into after business hours or overnight. CAHs and rural hospitals explicitly identified observation services, IV hydration, chemotherapy, and blood transfusions as the services that are particularly challenging to provide under direct supervision. Observation services, in particular, can extend for a significant period of time. Data from the 85X claims indicate that most observation care lasts longer than 12 hours and almost all such care ends within 48 hours, suggesting that observation care frequently extends after business hours and through the night.

We recognize that any service with an extended duration and a significant monitoring component could challenge hospitals' ability to ensure direct supervision, and we decided to concentrate on these services. We set out to identify services with a significant monitoring component extending after business hours as identified by the CAHs and hospitals in rural communities and for which we could offer some flexibility in meeting the requirement for direct supervision of therapeutic services without compromising the quality and safety of services for which Medicare makes payment. One way to provide flexibility would be to allow a reduced level of supervision for part of these services. CAHs have already stated that their longstanding practice has been to provide therapeutic services under general supervision, which comports with the minimum requirements set forth in their CoPs to participate in the Medicare program that a physician or certain nonphysician practitioner must be available by phone but not physically present on the CAH campus. As defined in § 410.32(b)(3)(i), "general supervision" means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. We have established a requirement for direct supervision for all hospital outpatient services in our CY 2000 and CY 2010 rulemaking processes. However, we reasoned that, for certain extended duration services, we could adopt a general supervision requirement for some portion of the service, as long as we believed that such flexibility would not undermine the quality and safety of purchased services. Therefore, we are proposing to require, for a limited set of nonsurgical extended duration therapeutic services, direct supervision during the initiation of the service followed by general supervision for the remainder of the service.

We are proposing to define "initiation of the service" as the beginning portion

of a service ending when the patient is stable and the supervising physician or appropriate nonphysician practitioner believes the remainder of the service can be delivered safely under their general direction and control without their physical presence on the hospital campus or in the PBD of the hospital. We considered further defining the term "stable" in this definition as there is an established definition in the EMTALA regulations at section 489.24(b). In those regulations, "stabilized" with respect to an emergency medical condition means "that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer for the individual from a facility * * *". However, this language is set within the context of emergency services, not hospital outpatient therapeutic services generally, and we have been clear that supervision is more than emergency response. Ultimately, we were not certain that this definition would be appropriate for a payment requirement for supervision of outpatient therapeutic services.

We also are not proposing to further define the term "initiation" or to set time limits on this portion of the service because we believe that the determination that a patient is sufficiently stable to transfer from direct supervision to general supervision, and the timing of that decision, are clinical judgments. Because some of the services identified for this proposed policy have the potential for shorter durations, such as an hour, we believe it is best to leave the determination of when to move from direct to general supervision to the discretion of the supervising physician or nonphysician practitioner. However, we are considering whether the point of transfer from direct supervision to general supervision should be documented in the medical record or identified in a hospital protocol, and we invite public comment on how CMS might review the physician or nonphysician practitioner's decision to move from direct to general supervision to monitor for proper billing should an adverse event occur.

We considered four criteria when identifying the list of services to which this new policy of direct supervision during the initiation of the service followed by general supervision for the remainder of the service would apply. We first accepted the two criteria identified in correspondence and discussion with CAHs and rural hospitals, that the service be of extended duration, frequently extending beyond normal business hours, and that the service largely consist of a significant monitoring component typically conducted by nursing or other auxiliary staff. We added a third criterion that the service must be of sufficiently low risk, such that the service typically would not require direct supervision often during the service. We believe this criterion is appropriate because, as we have previously discussed, our requirement for direct supervision is grounded in the statutory "incident to" payment authority, as well as the need to ensure that Medicare purchases services that represent a basic level of quality and safety. We have noted that, unlike an inpatient admission, the provision of outpatient services lacks certain safeguards such as a detailed medical history and a plan of care (74 FR 60578 through 60588). Finally, we excluded all surgical services including recovery time from potential inclusion because, although monitoring of any patient in recovery is a key component of surgery, it is not the focus or a substantial component of the service and because we believe the surgeon should personally evaluate the patient's medical status during the recovery period.

Using these four criteria, we identified a list of nonsurgical therapeutic services that have a tendency to last for a long period of time, that largely consist of monitoring, and that have a low risk that the physician's physical presence will be needed once the patient is stable. To identify this list of potential services, we reviewed all medical services, including the services and procedures specifically identified by CAHs and rural hospitals in their correspondence and public discussion. The proposed list of nonsurgical extended duration therapeutic services appears in Table 37 below. We explicitly did not include chemotherapy or blood transfusions in our proposed list of nonsurgical extended duration therapeutic services because we believe that these services require the physician's or nonphysician practitioner's recurrent physical presence in order to evaluate the patient's condition in the event it is necessary to redirect the service.

We included observation services on the proposed list of nonsurgical extended duration services. In Section 20.6 of Chapter 2 of the Medicare Benefit Policy Manual (Pub. 100–02), we define observation care as "a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital." Therefore, the acuity of patients receiving observation services and the amount of recurrent supervisory review that may be necessary for these services can vary significantly. Observation services can be of low acuity and can have a low probability that the supervising physician or nonphysician practitioner's physical presence would be needed to step in and perform the service or otherwise furnish assistance. We do note in Section 290.5.1 of Chapter 4 of the Medicare Claims Processing Manual (Pub. 100–04) that, for observation services, (a) "the beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician, and (b) the medical record also must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation services." We would continue to expect hospitals and CAHs to fulfill these specific requirements associated with observation care, so the supervising physician or appropriate nonphysician practitioner must continue to evaluate the patient periodically and include written notes in the medical record.

BILLING CODE 4120–01–P

TABLE 37.--PROPOSED LIST OF NONSURGICAL EXTENDED DURATION THERAPEUTIC SERVICES

HCPCS Code	Long Description
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump
G0378	Hospital observation service, per hour
G0379	Direct admission of patient for hospital observation care
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96367	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)
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)
96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
96375	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)
96376	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)

BILLING CODE 4120–01–C

In summary, we are proposing to require direct supervision as defined in § 410.27(a)(1)(iv) during an initiation period, followed by a minimum standard of general supervision as defined in § 410.32(b)(3)(i) for the duration of the service, for a limited set of "nonsurgical extended duration therapeutic services" identified in Table 37 above. We are proposing to add a new paragraph (a)(1)(v) to § 410.27 for this provision. In new § 410.27(a)(1)(v)(A), we are proposing to define "nonsurgical extended duration therapeutic services" as services that can last a significant period of time, have a substantial monitoring component, have a low risk of requiring the physician's or appropriate nonphysician practitioner's physical presence to furnish assistance and direction after the initiation of the service, and are not primarily surgical in nature. In new § 410.27(a)(1)(v)(B), we are proposing to define "initiation of the service" as the beginning portion of a service ending when the patient is stable and the supervising physician or appropriate nonphysician practitioner believes the remainder of the service can be delivered safely under his or her general direction and control without needing his or her physical presence on the hospital campus or in the PBD of the hospital. We note that in the CY 2010 OPPS/ASC final rule with comment period, in presenting the regulation text changes for § 410.27, paragraph (a)(2) (relating to PHP services) was inadvertently deleted from the Code of Federal Regulations. We are proposing to restore paragraph (a)(2) as it originally appeared in the regulations.

In crafting this proposal, we considered other avenues to offer flexibility within our requirement for direct supervision. We summarize below the alternatives we considered in order to focus public comments and generate sufficient detail to assist us in developing the final policy. In addition to considering the proposed policy to permit general supervision after an initial period of direct supervision for a limited subset of services, we also considered offering hospitals the flexibility to broaden the list to include chemotherapy and blood transfusions, which some stakeholders also maintain do not require direct supervision. Because we were concerned that these services had a high probability of needing a physician or nonphysician practitioner to redirect the service, we reasoned that we would have to require hospitals to create internal guidelines specifying a supervision level and protocols for staffing that supervision level for every nonsurgical extended duration therapeutic service. We considered proposing minimum requirements for these internal supervision guidelines, including annual review and approval by a governing committee, periodic internal evaluation of implementation, and the ability to make these guidelines available to Medicare program auditors if requested. Further, these guidelines would be reviewed thoroughly by CMS should a quality issue arise. Given the complexity of services such as chemotherapy and blood transfusions, and the probability that the physician's or nonphysician practitioner's physical presence will be required during the service, we decided to propose a policy to ensure greater safety for these higher acuity services. We also chose not to pursue this internal guidelines option because we believed that hospitals would find these requirements onerous and that the policy would not necessarily provide the flexibility that CAHs and rural hospitals desire. We are seeking public comment on whether hospitals agree with our assessment about the challenge of crafting, maintaining, and implementing internal guidelines about supervision and whether general supervision is clinically appropriate and safe for chemotherapy, blood transfusions, and similar services.

We also considered whether for payment purposes we should explicitly exclude outpatient CAH services from all supervision requirements. As discussed above, one of the grounds for applying the direct supervision requirement to outpatient therapeutic services furnished in hospitals is that these services are outpatient hospital services furnished "incident to" physicians' services under section 1861(s)(2)(B) of the Act and paid under the OPPS pursuant to section 1833(t) of the Act. In contrast, "outpatient critical access hospital services" are defined under section 1861(mm)(3) of the Act, and CAHs are reimbursed for outpatient CAH services based on their reasonable costs pursuant to section 1834(g) of the Act. We believe that outpatient CAH services are correctly viewed as being furnished "incident to" physicians' services. Section 1861(mm)(3) of the Act defines "outpatient critical access hospital services" as "medical and other health services furnished by a critical access hospital on an outpatient basis." The term "medical and other health services" is defined at section 1861(s) of the Act as including "hospital services * * * incident to physicians' services rendered to outpatients." Furthermore, the same considerations regarding the need to ensure that services furnished to Medicare beneficiaries represent a basic level of quality and safety that apply to outpatient hospital services are equally applicable to outpatient CAH services. As a result, we believe it is appropriate to apply the same supervision requirements to outpatient therapeutic services furnished in hospitals and CAHs. We acknowledge that statutory provisions allow CAHs some flexibility in their staffing requirements to operate with more nursing staff and nonphysician practitioners rather than physicians if those are the practitioners that are available, and that our regulations recognize those reduced staffing requirements in the CoPs by establishing that, at a minimum, the physician or nonphysician practitioner must be available, but not necessarily on the CAH campus. Some have suggested, however, that these regulations which establish only minimal requirements reduce the quality and safety of CAH services and that CAHs should be required to disclose their reduced staffing levels to patients prior to providing services. Accordingly, we have elected not to propose to exempt CAHs from all direct supervision requirements because we believe that Medicare should purchase from CAHs services that are of the same basic level of safety and quality as from other hospitals, and because we also believe that both small rural hospitals paid under the OPPS through section 1833(t) of the Act and CAHs paid at reasonable cost under section 1834(g) of the Act have similar staffing and resource constraints. In fact, given that CAHs are reimbursed based on their reasonable costs, we reasoned that CAHs might be better able to hire staff to provide direct supervision. We welcome public comment on the topic of exempting CAHs from a direct supervision requirement for outpatient therapeutic services, including comments in response to our concerns about making such a proposal.

4. Supervision of Hospital Outpatient Diagnostic Services

We have received limited correspondence and questions on our policy finalized in the CY 2010 OPPS/ASC final rule with comment period to adopt for outpatient hospital diagnostic services the physician supervision levels in § 410.32(b)(3) established under the MPFS and indicated on the Practice Expense Relative Value Unit file. As discussed above, the CY 2010 policy applies to hospitals and not to CAHs. However, we have received questions asking whether nonphysician

practitioners previously performing diagnostic tests without physician supervision, within their State scope of practice and hospital-granted privileges, can continue to perform those tests without physician supervision. The CY 2010 policy now requires physician supervision of those services, unless the nonphysician practitioner is specifically exempted under § 410.32(b)(2) or there is some other provision addressing supervision for that type of nonphysician practitioner. As part of a broader proposal addressing clinical nurse-midwives as defined in § 410.77(b)(2) of the regulations, we are making a clarifying proposal in the CY 2011 MPFS proposed rule that clinical nurse-midwives should be excepted from requiring physician supervision for the diagnostic tests that they are authorized to perform under applicable State laws. Comments on that proposal should be submitted through the comment process for that proposed rule (CMS–1503–P).

B. Proposed Payment for Preventive Services

1. Definition of "Preventive Services"

Section 4104(a) of the Affordable Care Act revised section 1861(ddd) of the Act by adding a new paragraph (3), which defines the term "preventive services." Preventive services are defined as:

- Screening and preventive services currently described in section 1861(ww)(2) of the Act, except for electrocardiograms described in section 1861(ww)(2)(M) of the Act;
- An initial preventive physical examination (IPPE) as defined in section 1861(ww) of the Act; and
- Personalized prevention plan services (PPPS), also known as the "Annual Wellness Visit," as defined in section 1861(hhh) of the Act (which was added by section 4103 of the Affordable Care Act).

The services specified in the definition of "preventive services" at section 1861(ddd)(3)(A) of the Act, as cross-referenced to section 1861(ww)(2) of the Act, excluding electrocardiograms, include the following:

- Pneumococcal, influenza, and hepatitis B vaccine and administration.
- Screening mammography.
- Screening pap smear and screening pelvic examination.
- Prostate cancer screening tests.
- Colorectal cancer screening tests.
- Diabetes outpatient self-management training (DSMT).
- Bone mass measurement.
- Screening for glaucoma.
- Medical nutrition therapy (MNT) services.
- Cardiovascular screening blood tests.
- Diabetes screening tests.
- Ultrasound screening for abdominal aortic aneurysm (AAA).
- Additional preventive services identified for coverage through the national coverage determination (NCD) process.

We note that currently the only additional preventive service identified for coverage through the NCD process is HIV testing. A proposed national coverage determination for smoking cessation services for asymptomatic patients (CAG–00420N, "Proposed Coverage Decision Memorandum for Counseling to Prevent Tobacco Use"), was released in May 2010 on the CMS Web site at: *http://www.cms.gov/mcd/index_list.asp?list_type=nca.* We will address the applicability of section 4104 of the Affordable Care Act to these services if an NCD establishing them as additional preventive services is finalized before the CY 2011 OPPS/ASC final rule with comment period is issued.

We are specifying our proposals to implement the coverage and payment provisions for PPPS in the CY 2011 Medicare Physician Fee Schedule (MPFS) proposed rule. Therefore, public comments on the proposed coverage of and payment for PPPS under the provisions of the Affordable Care Act should be submitted in response to the CY 2011 MPFS proposed rule. The implementing regulations regarding coverage of the IPPE are already established under existing 42 CFR 410.16 and remain unchanged by the Affordable Care Act. As discussed below in section XII.B.2. of this proposed rule, we are presenting our proposals for the application or waiver of the coinsurance requirements and the deductible for preventive services as provided for under sections 4104(b) and (c) of the Affordable Care Act.

2. Coinsurance and Deductible for Preventive Services

Sections 4104(b) and 10406 of the Affordable Care Act amended section 1833(a)(1) of the Act to require 100 percent payment for the IPPE and for those preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual. This requirement waives any coinsurance or copayment that would otherwise be applicable under section 1833(a)(1) of the Act for those items and services listed in section 1861(ww)(2) of the Act (excluding electrocardiograms) to which the USPSTF has given a grade of A or B. In addition, section 4103(c) of the Affordable Care Act waives the coinsurance or copayment for the annual wellness visit providing PPPS. The coinsurance or copayment represents the beneficiary's share of the payment to the provider or supplier for furnished services. Coinsurance generally refers to a percentage (for example, 20 percent) of the Medicare payment rate for which the beneficiary is liable and is applicable under the MPFS and ASC payment system, while copayment generally refers to an established amount that the beneficiary must pay that is not necessarily related to a particular percentage of the Medicare payment rate, and is applicable under the OPPS. We refer readers to the CY 2011 MPFS proposed rule for the proposed provisions related to payment for preventive services, including waiver of the deductible and copayment, under the MPFS, and to section XV.D.1.d. of this proposed rule for our proposals to implement the provisions related to payment for preventive services under the ASC payment system.

Section 4104(c) of the Affordable Care Act amended section 1833(b)(1) of the Act to waive the Part B deductible for preventive services described in section 1861(ddd)(3)(A) of the Act that have a grade of A or B from the USPSTF. In addition, section 4103(c)(4) of the Affordable Care Act waives the Part B deductible for the annual wellness visit providing PPPS. These provisions are effective for services furnished on and after January 1, 2011. We note that section 101(b)(2) of the MIPPA previously amended section 1833(b) of the Act to waive the deductible for the IPPE, effective January 1, 2009.

Not all preventive services described in paragraph (A) of section 1861(ddd)(3) of the Act are recommended by the USPSTF with a grade of A or B, and therefore, some of the preventive services do not meet the criteria in sections 1833(a)(1) and 1833(b)(1) of the Act for the waiver of deductible and coinsurance. However, the changes made by section 4104 of the Affordable Care Act do not affect most of the pre-existing specific provisions listed in existing § 410.160(b) and § 410.152 of the regulations (which reflect the provisions found in sections 1833(a) and 1833(b) of the Act) that waive the deductible and coinsurance for specific services. For example, section 1833(a)(1)(D) of the Act waives the coinsurance and section 1833(b)(3) of the Act waives the deductible for clinical laboratory tests (including those furnished for screening purposes).

Section 4104 of the Affordable Care Act does not change this provision and the waiver for both the deductible and coinsurance remains in place for all laboratory tests, regardless of whether the particular clinical laboratory test meets the criteria of section 4104 for waiver of deductible and coinsurance as a preventive service.

The following preventive services listed in section 1833(ddd)(3)(A) of the Act are not recommended by the USPSTF with a grade of A or B for any indication or population: digital rectal examination provided as a prostate cancer screening service; glaucoma screening; diabetes outpatient self-management training; and barium enema provided as a colorectal cancer screening service.

Specifically, HCPCS code G0102 (Prostate cancer screening; digital rectal exam), which does not have a grade of A or B from the USPSTF for any indication or population, will continue to be subject to the deductible and coinsurance. However, the deductible and coinsurance for HCPCS code G0103 (Prostate cancer screening; prostate specific antigen test (PSA)) will continue to be waived under section 1833(a)(1)(D) of the Act as a clinical laboratory test, even though it also does not have a grade of A or B from the USPSTF.

Glaucoma screening services, described by HCPCS codes G0117 (Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist) and G0118 (Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist), will continue to be subject to the deductible and coinsurance requirements because these services are not recommended with a grade of A or B by the USPSTF for any indication or population. Similarly, diabetes outpatient self-management training is currently not rated by the USPSTF; therefore, the deductible and coinsurance requirements will continue to apply.

Barium enemas provided as colorectal cancer screening tests, described by HCPCS codes G0106 (Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema) and G0120 (Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema) do not have a grade of A or B from the USPSTF for any indication or population. However, the deductible does not apply to barium enemas provided as colorectal cancer screening tests, because colorectal cancer screening tests are explicitly excluded from the deductible under section 1833(b)(8) of the Act. However, there is no specific exclusion of barium enemas from the coinsurance requirement at section 1833(b)(1) of the Act. Therefore, this requirement, as applicable, continues to apply to barium enemas. We note that the USPSTF has given a grade of A to colonoscopy, flexible sigmoidoscopy, and fecal occult blood screening tests, and that, as a result, these services qualify for the statutory waiver of both the deductible and coinsurance.

We also note that the USPSTF ceased to make recommendations with regard to vaccines and vaccine administration after CY 1996, so as not to conflict with the recommendations of the CDC's Advisory Committee on Immunization Practices. However, the USPSTF's most recent vaccine recommendations, which were never withdrawn by the USPSTF, gave a grade of B to the influenza and pneumococcal vaccines and their administration and a grade of A to the hepatitis B vaccine and its administration. While sections 1833(a)(1) and 1833(b)(1) of the Act require that the preventive services receive a grade of A or B from the USPSTF for the coinsurance and deductible to be waived, the statute does not specify that the recommended grade must be furnished within any given timeframe. The USPSTF grades for these preventive services are the most current USPSTF grade and have never been withdrawn. Therefore, we believe that these preventive services meet the requirements of the statute for the waiver of the deductible and coinsurance. We also note that the CDC's Advisory Committee on Immunization Practices currently recommends influenza, pneumococcal, and hepatitis B vaccines.

Table 38 below displays the HCPCS codes (paid under the OPPS or at reasonable cost) that we are proposing as "preventive services" under section 1861(ddd)(3)(A) of the Act. Table 38 also provides the most recent USPSTF grade, if any, that is the basis for our proposed policy with regard to waiver of the deductible and coinsurance, as applicable. In developing recommendations regarding preventive services, we recognize that the USPSTF may make recommendations that are specific to an indication or population, at times including characteristics such as gender and age in its recommendations. While we are proposing to waive the deductible and coinsurance for any Medicare covered preventive service recommended with a grade of A or B for any indication or population, with no limits on the indication or population as long as the USPSTF has recommended the preventive service for at least one indication and/or population with a grade of A or B, we note that all existing Medicare coverage policies for such services, including any limitations based on indication or population, continue to apply. In some cases, national coverage policies may currently limit Medicare coverage based on the indication or population, consistent with the USPSTF recommendations with a grade of A or B for the indication or population. In other cases where Medicare does not explicitly noncover preventive services for a specific population or indication, we would expect that, particularly in those cases where the USPSTF recommendation grade is a D (that is, the USPTF recommends against the service because there is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits), practitioners would only order those preventive services that are clinically appropriate for the beneficiary. If we have future concerns about the appropriateness of preventive services for an indication or population in light of the USPSTF's recommendations, we may consider using our authority under section 1834(n)(1) of the Act (as added by section 4105 of the Affordable Care Act) to modify Medicare coverage of any preventive service consistent with the recommendations of the USPSTF.

We note that section 4103(c)(3)(A) of the Affordable Care Act excludes the PPPS from payment under the OPPS and establishes payment for the PPPS when performed in a hospital outpatient department under the MPFS. In this OPPS/ASC proposed rule, we are proposing to add a new § 419.22(t) to the regulations to specify that the PPPS is excluded from payment under the OPPS. In the process of revising the regulations to reflect the exclusion of PPPS from the OPPS, we noticed the need for existing § 419.21(e) to be updated to reflect that an IPPE may be performed within 12 months after the date of the individual's initial enrollment in Part B effective January 1, 2009. We also noticed that existing § 419.22(m) of the regulations should be updated to reflect that a revised payment methodology for end-stage renal disease (ESRD) services will go into effect on January 1, 2011. Therefore, we also are proposing to revise §§ 419.21(e) and 419.22(m). We refer readers to the CY 2011 MPFS proposed rule for a discussion of the proposed changes to § 410.160(b) and § 410.152 of the regulations to implement the provisions related to the

definition of preventive services and the waiver of the coinsurance and deductible for preventive services as specified by sections 4103 and 4104 of the Affordable Care Act.

BILLING CODE 4120–01–P

TABLE 38.--PROPOSED CY 2011 DEDUCTIBLE AND COINSURANCE FOR OPPS PREVENTIVE SERVICES UNDER SECTION 1861(ddd)(3)(A) OF THE ACT* (INCLUDES THE INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE))

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
Initial Preventive Physical Examination (IPPE)	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	*Not Rated	Coinsurance applies and deductible is waived	Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived	Not Waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389	Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	B	Coinsurance applies and deductible is waived	Waived
Screening Pap Test	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	A	Coinsurance applies and deductible is waived	Waived
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	A	Coinsurance applies and deductible is waived	Waived
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	B	Not Waived	Waived

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)		Not Waived	Waived
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)		Not Waived	Waived
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)		Not Waived	Waived
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)		Not Waived	Waived
	77083	Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites		Not Waived	Waived
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		Not Waived	Waived
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	A	Coinsurance applies and deductible is waived	Waived
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		Coinsurance applies and deductible is waived	Waived
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk		Coinsurance applies and deductible is waived	Waived

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	*Not Rated	Coinsurance applies and deductible is waived	Coinsurance applies and deductible is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.		Coinsurance applies and deductible is waived	Coinsurance applies and deductible is waived
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	D	Not Waived	Not Waived
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	I	Not Waived	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived	Not Waived
Influenza Virus Vaccine	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use	B	Waived	Waived
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		Waived	Waived
	90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use		Waived	Waived

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
	90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use		Waived	Waived
	90660	Influenza virus vaccine, live, for intranasal use		Waived	Waived
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		Waived	Waived
	G0008	Administration of influenza virus vaccine		Waived	Waived
	G9141	Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)		Waived	Waived
	G9142	Influenza a (h1n1) vaccine, any route of administration		Waived	Waived
Pneumo-coccal Vaccine	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	B	Waived	Waived
	90670	Pneumococcal vacc, 13 val im		Waived	Waived
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		Waived	Waived

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
	G0009	Administration of pneumococcal vaccine		Waived	Waived
Hepatitis B Vaccine	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	A	Not Waived	Waived
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		Not Waived	Waived
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		Not Waived	Waived
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		Not Waived	Waived
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		Not Waived	Waived

*This table lists only the preventive services, as defined by the Affordable Care Act, that are paid under the OPPS or at reasonable cost, and excludes preventive services such as screening mammography and cardiovascular screening blood tests that are paid under another fee schedule such as the MPFS or the Clinical Laboratory Fee Schedule. A listing of all services defined by the Affordable Care Act as preventive services can be found in the CY 2011 MPFS proposed rule. We note that any preventive service must meet the Medicare coverage guidelines for the service including being appropriate to the beneficiary to whom it is being furnished.

[1] **U.S. Preventive Services Task Force Recommendations:**
A -- The USPSTF strongly recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)
B -- The USPSTF recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.)
C -- The USPSTF makes no recommendation for or against routine provision of [the service]. (The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.)
D -- The USPSTF recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)
I -- The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

<FNP>

3. Extension of Waiver of Deductible to Services Furnished in Connection With or in Relation to a Colorectal Cancer Screening Test That Becomes Diagnostic or Therapeutic

Section 4104(c) of the Affordable Care Act amended section 1833(b) of the Act to waive the Part B deductible for colorectal cancer screening tests that become diagnostic. Specifically, section 4104(c)(2) of the Affordable Care Act waives the deductible with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test.

We are proposing that all surgical services furnished on the same date as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema be viewed as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test. We believe that this interpretation is appropriate because we believe that it would be very rare for an unrelated surgery to occur on the same date as one of these scheduled screening tests. Moreover, we believe that the risk of improper expenditures would be very small under this policy because it is the deductible, and not the coinsurance, that is waived for the related procedures other than the screening tests. In the event of a legislative change to this policy (for example, a statutory change that would waive the coinsurance for these related services in addition to the deductible), we would reassess the appropriateness of this proposed definition of services that are furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test that becomes diagnostic. We also note that the annual deductible would likely be met when any surgical procedure (related or not) is performed on the same day as the scheduled screening test.

We are proposing to implement this provision by creating a HCPCS modifier that providers would append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service. The claims processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance or copayment would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

C. Payment for Pulmonary Rehabilitation, Cardiac Rehabilitation, and Intensive Cardiac Rehabilitation Services Furnished to Hospital Outpatients

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60566 through 60574), we addressed the provisions of section 144(a) of the Medicare Improvements for Patients and Providers Act (MIPPA, Pub. L. 110–275). Section 144(a) provided for Medicare Part B coverage and payment for pulmonary and cardiac rehabilitation services furnished to beneficiaries with chronic obstructive pulmonary disease and certain other conditions, effective January 1, 2010. Medicare Part B coverage is provided for items and services under a cardiac rehabilitation (CR) program, a pulmonary rehabilitation (PR) program, and an intensive cardiac rehabilitation (ICR) program furnished in a physician's office, a hospital on an outpatient basis, or in other settings as the Secretary determines appropriate. We have received questions as to whether a CAH outpatient department is a covered setting for services furnished under these programs because the amendments made to the Act by section 144(a) of the MMA do not specifically define CAHs as hospitals for this benefit.

In this proposed rule, we are clarifying that a CAH outpatient department is considered a covered setting for PR, CR and ICR programs, provided that the programs meet all of the regulatory requirements, including, but not limited to, direct supervision of all services by a physician, specified in 42 CFR 410.27(a)(1)(iv)(A) and 410.47(a)(2)(ii). We can establish that CAHs are a covered setting because the law and implementing regulations specify that PR, CR and ICR services are covered in the hospital outpatient setting, and we define a hospital outpatient in the regulations and program instructions as "a person * * * who * * * receives services * * * directly from the hospital or CAH" (42 CFR 410.2 and the Medicare Benefit Policy Manual, Chapter 6, Section 20.2, available at the CMS Web site at: *http://www.cms.gov/manuals/Downloads/bp102c06.pdf*). We also note that under section 1861(e) of the Act, the context of the term "hospital" as used in the coverage provisions for PR, CR and ICR reflects the inclusion of CAHs.

D. Expansion of Multiple Procedure Reduction Under the Medicare Physician Fee Schedule (MPFS) to Therapy Services

Hospitals are paid for outpatient physical therapy (which includes speech language pathology services) and outpatient occupational therapy under the Medicare Physician Fee Schedule (MPFS). Outpatient physical therapy (which includes speech language pathology services) and outpatient occupational therapy services, as described in section 1833(a)(8) of the Act, are excluded from the OPPS by section 1833(t)(1)(B)(iv) of the Act. Section 1833(a)(8) of the Act provides that outpatient physical and occupational therapy are to be paid as provided in section 1834(k)of the Act. Section 1834(k)(3) of the Act specifies that these services are paid under the fee schedule established under section 1848 of the Act and section 1848 of the Act establishes payment under the MPFS.

For CY 2011, we are proposing to revise the MPFS to apply a multiple procedure reduction to payment for all outpatient physical and occupational therapy services paid under the MPFS. This proposal is contained in the CY 2011 MPFS proposed rule (CMS–1503–P, Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011). To be considered in the development of the final policy for CY 2011, public comments on this issue should be submitted in response to the CY 2011 MPFS proposed rule.

XIII. Proposed OPPS Payment Status and Comment Indicators

A. Proposed OPPS Payment Status Indicator Definitions

Payment status indicators (SIs) that we assign to HCPCS codes and APCs play an important role in determining payment for services under the OPPS. They indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. Our proposed CY 2011 status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively, to this proposed rule.

For CY 2011, we are not proposing to make any changes to the status indicators that were listed in Addendum D1 of the CY 2010 OPPS/ASC final rule with comment period.

These status indicators are listed in the tables under sections XIII.A.1., 2., 3., and 4. of this proposed rule.

1. Proposed Payment Status Indicators To Designate Services That Are Paid Under the OPPS

BILLING CODE 4120–01–P

Indicator	Item/Code/Service	OPPS Payment Status
G	Pass-Through Drugs and Biologicals	Paid under OPPS; separate APC payment.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; not subject to copayment.
K	Nonpass-Through Drugs and Nonimplantable Biologicals, including Therapeutic Radiopharmaceuticals	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. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; per diem APC payment.
Q1	STVX-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "S," "T," "V," or "X." (2) In all other circumstances, payment is made through a separate APC payment.

Indicator	Item/Code/Service	OPPS Payment Status
Q2	T-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T." (2) In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service. (2) In all other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
R	Blood and Blood Products	Paid under OPPS; 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.
U	Brachytherapy Sources	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.

BILLING CODE 4120–01–C

Section 142 of Public Law 110–275 (MIPPA) required CMS to pay for therapeutic radiopharmaceuticals for the period of July 1, 2008, through December 31, 2009, at hospitals' charges adjusted to the costs. The status indicator "H" was assigned to therapeutic radiopharmaceuticals to indicate that an item was paid at charges adjusted to cost during CY 2009. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60593), we changed our policy to pay prospectively and separately for therapeutic radiopharmaceuticals with average per day costs greater than the CY 2010 drug packaging threshold of $65 under the OPPS. Therefore, we changed the status indicator for HCPCS codes used to report separately payable therapeutic radiopharmaceuticals from "H" to "K," which indicated that an item is separately paid under the OPPS at the APC payment rate established for the item. We refer readers to section V.B.5. of the CY 2010 OPPS/ASC final rule with comment period for discussion of the final CY 2010 changes to our payment policy for therapeutic radiopharmaceuticals (74 FR 60593). For CY 2011 OPPS, we are proposing to continue to pay for therapeutic radiopharmaceuticals under the OPPS at the APC payment rate established for the item. (We refer readers to our discussion of this proposal for payment of therapeutic radiopharmaceuticals in section V.B.3. of this proposed rule.)

For CY 2010, we established a policy to consider implantable biologicals that are not on pass-through status as a biological before January 1, 2010, as devices for pass-through evaluation and payment beginning in CY 2010. Therefore, pass-through implantable biologicals were assigned a status indicator of "H," while nonpass-through implantable biologicals were assigned a status indicator of "N" beginning in CY 2010. Those implantable biologicals that have been granted pass-through status under the drug and biological criteria prior to January 1, 2010, continued to be assigned a status indicator of "G" until they are proposed for expiration from pass-through status during our annual rulemaking cycle. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60593), we assigned status indicator "K" to nonimplantable biologicals and adjusted the definition of status indicator "K" accordingly. For CY 2011, we are not proposing any changes to current policy. We discuss our proposed treatment of drugs, biologicals, and radiopharmaceuticals with new or

continuing pass-through status in CY 2011 in section V.A.3. of this proposed rule, and we discuss our proposed treatment of drugs and biologicals with expiring pass-through status in CY 2010 including the specific implantable biologicals to which this policy is proposed to apply for CY 2011 OPPS in section V.A.2. of this proposed rule.

The proposed CY 2011 status indicators are displayed in both the table above and in Addendum D1 to this proposed rule.

2. Proposed Payment Status Indicators To Designate Services That Are Paid Under a Payment System Other Than the OPPS

We are not proposing any changes to the status indicators listed below for the CY 2011 OPPS.

Indicator	Item/Code/Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example:	Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS.
	• Ambulance Services	
	• Clinical Diagnostic Laboratory Services	Not subject to deductible or coinsurance.
	• Non-Implantable Prosthetic and Orthotic Devices	
	• EPO for ESRD Patients	
	• Physical, Occupational, and Speech Therapy	
	• Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital	
	• Diagnostic Mammography	
	• Screening Mammography	Not subject to deductible.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
F	Corneal Tissue Acquisition; Certain CRNA Services; and Hepatitis B Vaccines	Not paid under OPPS. Paid at reasonable cost.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary/MAC	Not paid under OPPS.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

The proposed CY 2011 status indicators displayed in the table above are also displayed in Addendum D1 to this proposed rule.

3. Proposed Payment Status Indicators To Designate Services That Are Not Recognized Under the OPPS But That May Be Recognized by Other Institutional Providers

We are not proposing any changes to the status indicators listed below for the CY 2011 OPPS.

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 fiscal intermediaries/MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS.
		• An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.

The proposed status indicators are also displayed in Addendum D1 to this proposed rule.

4. Proposed Payment Status Indicators To Designate Services That Are Not Payable by Medicare on Outpatient Claims

We are not proposing any changes to the payment status indicators listed below for the CY 2011 OPPS.

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:	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).
	• That are not covered by any Medicare outpatient benefit based on statutory exclusion	
	• That are not covered by any Medicare outpatient benefit for reasons other than statutory exclusion.	
	• That are not recognized by Medicare for outpatient claims; alternate code for the same item or service may be available	
	• For which separate payment is not provided on outpatient claims	

Addendum B, with a complete listing of HCPCS codes including proposed payment status indicators for each code and proposed APC assignments for CY 2011, is available electronically on the CMS Web site under supporting documentation for this proposed rule at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage.*

B. Proposed Comment Indicator Definitions

For the CY 2011 OPPS, we are proposing to use the same two comment indicators that are in effect for the CY 2010 OPPS.

• "CH"—Active HCPCS codes in current and next calendar year; status indicator and/or APC assignment have changed or active HCPCS code that will be discontinued at the end of the current calendar year.

• "NI"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year as compared to current calendar year, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.

We are using the "CH" indicator in this proposed rule to call attention to proposed changes in the payment status indicator and/or APC assignment for HCPCS codes for CY 2011 compared to their assignment as of June 30, 2010. We believe that using the "CH" indicator in this proposed rule will help facilitate the public's review of the changes that we are proposing for CY 2011. The use of the comment indicator "CH" in association with a composite APC indicates that we have proposed a

change to the configuration of the composite APC in this proposed rule.

We are proposing to use the "CH" comment indicator in the CY 2011 OPPS/ASC final rule with comment period to indicate HCPCS codes for which the status indicator or APC assignment, or both, would change in CY 2011 compared to their assignment as of December 31, 2010.

We are not proposing any changes to our policy regarding the use of comment indicator "NI." In our CY 2010 OPPS/ASC final rule with comment period, we expanded the definition of comment indicator "NI" to include an existing code with a substantial revision to its code descriptor in the next calendar year as compared to the current calendar year to indicate that the code's CY 2010 OPPS treatment was open to public comment on the CY 2010 OPPS/ASC final rule with comment period.

In the CY 2010 OPPS/ASC final rule with comment period, there are numerous instances in which the descriptor of a previously existing Category I CPT code was substantially revised for the next calendar year so that it described a new service or procedure that could have been assigned a new code number by the CPT Editorial Panel and that new code number would then had been assigned the "NI" comment indicator. We anticipate that, for CY 2011, not all new services or procedures will be assigned a new CPT code number, but instead will be described by an existing CPT code number with a substantially revised code descriptor. We are proposing to continue to assign the comment indicator "NI" to these codes in order to allow for comment on our proposed payment for these substantially revised codes. Like all codes labeled with comment indicator "NI," in a final rule, we will respond to public comments and finalize their OPPS treatment in the CY 2012 OPPS/ASC final rule with comment period. In accordance with our usual practice, CPT and Level II HCPCS code numbers that are new for CY 2011 will also be labeled with comment indicator "NI" in Addendum B to the CY 2011 OPPS/ASC final rule with comment period.

Only HCPCS codes with comment indicator "NI" in the CY 2011 OPPS/ASC final rule with comment period will be subject to comment. HCPCS codes that do not appear with comment indicator "NI" in the CY 2011 OPPS/ASC final rule with comment period will not be open to public comment, unless we specifically have requested additional comments elsewhere in the final rule with comment period. The CY 2011 treatment of HCPCS codes that appears in the CY 2011 OPPS/ASC final rule with comment period to which comment indicator "NI" is not appended will be open to public comment during the comment period for this proposed rule, and we will respond to those comments in the final rule with comment period.

We are not proposing any changes to the definitions of the OPPS comment indicators for CY 2011. Their proposed definitions are listed in Addendum D2 to this proposed rule.

XIV. OPPS Policy and Payment Recommendations

A. MedPAC Recommendations

MedPAC was established under section 1805 of the Act to advise the U.S. Congress on issues affecting the Medicare program. As required under the statute, MedPAC submits reports to Congress not later than March and June of each year that contain its Medicare payment policy recommendations. This section describes recent recommendations relevant to the OPPS that have been made by MedPAC.

The March 2010 MedPAC "Report to Congress: Medicare Payment Policy" included the following recommendation relating specifically to the Medicare hospital OPPS:

Recommendation 2A–1: The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2011 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program.

CMS Response: Subsequent to the issuance of the MedPAC report, Congress enacted the Affordable Care Act. Section 1833(t)(3)(F) as added by section 3401 of the Affordable Care Act and as amended by section 10319 of the Affordable Care Act and section 1105 of the HCERA provides that after determining the OPD fee schedule increase factor, the Secretary shall reduce such increase factor by 0.25 percentage point in 2011. As discussed in section II.B. of this proposed rule, we are proposing to increase the full CY 2011 conversion factor by the projected rate of increase in the hospital market basket less the mandated 0.25 percentage point reduction. Simultaneously, we are proposing for CY 2011 to reduce the annual update factor by 2.0 percentage points for hospitals that are defined under section 1886(d)(1)(B) of the Act and that do not meet the hospital outpatient quality data reporting required by section 1833(t)(17) of the Act. We would make this adjustment after the application of the 0.25 percentage point reduction. For the adjustment under section 1833(t)(17) of the Act, we are proposing to calculate two conversion factors: a full conversion factor based on the annual update factor, adjusted by the 0.25 percentage point reduction required by the Affordable Care Act for CY 2011; and a reduced conversion factor that reflects the 2.0 percentage points reduction to the annual update factor, as adjusted by the 0.25 percentage point reduction. CMS implemented the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) in CY 2008 and is proposing to continue this program in CY 2011 (as discussed in section XVI. of this proposed rule).

The full March 2010 MedPAC report can be downloaded from MedPAC's Web site at: *http://www.medpac.gov/documents/Mar10_EntireReport.pdf.*

B. APC Panel Recommendations

Recommendations made by the APC Panel at its February 2010 meeting are discussed in the sections of this proposed rule that correspond to topics addressed by the APC Panel. The report and recommendations from the APC Panel's February 17–18, 2010 meeting are available on the CMS Web site at: *http://www.cms.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp.*

C. OIG Recommendations

The mission of the Office of the Inspector General (OIG), as mandated by Public Law 95–452, as amended, is to protect the integrity of the U.S. Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections. As of the publication of the proposed rule, there were no OIG reports that resulted in OIG recommendations for OPPS policy changes for CY 2011.

XV. Proposed Updates to the Ambulatory Surgical Center (ASC) Payment System

A. Background

1. Legislative Authority for the ASC Payment System

Section 1832(a)(2)(F)(i) of the Act provides that benefits under Medicare Part B include payment for facility services furnished in connection with surgical procedures specified by the Secretary that are performed in an Ambulatory Surgical Center (ASC). To participate in the Medicare program as an ASC, a facility must meet the standards specified in section

1832(a)(2)(F)(i) of the Act, which are set forth in 42 CFR part 416, Subpart B and Subpart C of our regulations. The regulations at 42 CFR part 416, Subpart B describe the general conditions and requirements for ASCs, and the regulations at Subpart C explain the specific conditions for coverage for ASCs.

Section 141(b) of the Social Security Act Amendments of 1994, Public Law 103–432, required establishment of a process for reviewing the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act for intraocular lenses (IOLs) that belong to a class of new technology intraocular lenses (NTIOLs). That process was the subject of a final rule entitled "Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers," published on June 16, 1999, in the **Federal Register** (64 FR 32198).

Section 626(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, added subparagraph (D) to section 1833(i)(2) of the Act, which required the Secretary to implement a revised ASC payment system to be effective not later than January 1, 2008. Section 626(c) of the MMA amended section 1833(a)(1) of the Act by adding new subparagraph (G), which requires that, beginning with implementation of the revised ASC payment system, payment for surgical procedures furnished in ASCs shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under the revised payment system.

Section 5103 of the Deficit Reduction Act of 2005 (DRA), Public Law 109–171, amended section 1833(i)(2) of the Act by adding new subparagraph (E) to place a limitation on payment amounts for surgical procedures furnished in ASCs on or after January 1, 2007, but before the effective date of the revised ASC payment system (that is, January 1, 2008). Section 1833(i)(2)(E) of the Act provides that if the standard overhead amount under section 1833(i)(2)(A) of the Act for an ASC facility service for such surgical procedures, without application of any geographic adjustment, exceeds the Medicare payment amount under the hospital OPPS for the service for that year, without application of any geographic adjustment, the Secretary shall substitute the OPPS payment amount for the ASC standard overhead amount.

Section 109(b) of the Medicare Improvements and Extension Act of 2006 of the Tax Relief and Health Care Act of 2006 (MIEA–TRHCA), Public Law 109–432, amended section 1833(i)(2)(D) of the Act, in part, by redesignating clause (iv) as clause (v) and adding a new clause (iv) and by adding new section 1833(i)(7)(A). These amendments provide the Secretary the authority to require ASCs to submit data on quality measures and to reduce the annual update by 2 percentage points for an ASC that fails to submit data as required by the Secretary on selected quality measures. Section 109(b) of the MIEA–TRHCA also amended section 1833(i) of the Act by adding new section 1833(i)(7)(B), which requires that, to the extent the Secretary establishes such an ASC quality reporting program, certain quality of care reporting requirements mandated for hospitals paid under the OPPS, under sections 1833(t)(17)(B), (C), (D) and (E) of the Act, as added by section 109(a) of the MIEA–TRHCA, be applied in a similar manner to ASCs unless otherwise specified by the Secretary.

Sections 4104 and 10406 of the Affordable Care Act amend sections 1833(a)(1) and (b)(1) of the Act to waive the coinsurance and the Part B deductible for those preventive services described in section 1861(ww)(2) of the Act (excluding electrocardiograms) that are recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual. Section 4104(c) of the Affordable Care Act amends section 1833(b)(1) of the Act to waive the Part B deductible for colorectal cancer screening tests that become diagnostic. These provisions apply to these items and services furnished in an ASC on or after January 1, 2011.

Section 3401(k) of the Affordable Care Act amends section 1833(i)(2)(D) of the Act to require that, effective for CY 2011 and subsequent years, any annual update under the ASC payment system be reduced by a productivity adjustment, which is equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period). Application of this productivity adjustment to the ASC payment system may result in the update to the ASC payment system being less than zero for a year and may result in payment rates under the ASC payment system for a year being less than such payment rates for the preceding year.

For a detailed discussion of the legislative history related to ASCs, we refer readers to the June 12, 1998 proposed rule (63 FR 32291 through 32292).

2. Prior Rulemaking

On August 2, 2007, we published in the **Federal Register** (72 FR 42470) the final rule for the revised ASC payment system, effective January 1, 2008 (the "August 2, 2007 final rule"). In that final rule, we revised our criteria for identifying surgical procedures that are eligible for Medicare payment when furnished in ASCs and adopted the method we would use to set payment rates for ASC covered surgical procedures and covered ancillary services furnished in association with those covered surgical procedures beginning in CY 2008. We also established a policy for treating new and revised HCPCS and CPT codes under the ASC payment system. This policy is consistent with the OPPS to the extent possible (72 FR 42533). Additionally, we established a standard ASC ratesetting methodology that bases payment for most services on the list of ASC covered surgical procedures on the OPPS relative payment weight multiplied by an ASC conversion factor. We also established modifications to this methodology for subsets of services, such as device-intensive services (where the estimated device portion of the ASC payment is the same as that paid under the OPPS) and services that are predominantly performed in the office setting and covered ancillary radiology services (where ASC payment may be based on the MPFS non-facility practice expense (PE) Relative Value Units (RVUs)). Additionally, we established a policy for updating the conversion factor, the relative payment weights, and the ASC payment rates on an annual basis. We also annually update the list of procedures for which Medicare would not make an ASC payment.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66827), we updated and finalized the CY 2008 ASC rates and lists of covered surgical procedures and covered ancillary services. We also made regulatory changes to 42 CFR Parts 411, 414, and 416 related to our final policies to provide payments to physicians who perform noncovered ASC procedures in ASCs based on the facility PE RVUs, to exclude covered ancillary radiology services and covered ancillary drugs and biologicals from the categories of designated health services (DHS) that are subject to the physician self-referral prohibition, and to reduce ASC

payments for surgical procedures when the ASC receives full or partial credit toward the cost of the implantable device. In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68722), we updated and finalized the CY 2009 ASC rates and lists of covered surgical procedures and covered ancillary services.

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60596), we updated and finalized the CY 2010 ASC rates and lists of covered surgical procedures and covered ancillary services. We also corrected some of those ASC rates in a correction notice published in the **Federal Register** on December 31, 2009 (74 FR 69502). In that correction notice, we revised the ASC rates to reflect changes in the MPFS conversion factor and PE RVUs listed for some CPT codes in Addendum B to the CY 2010 MPFS final rule with comment period (74 FR 62017), which were incorrect due to methodological errors and, consequently, were corrected in a correction notice to that final rule with comment period (74 FR 65449). We also are publishing a second correction notice in the **Federal Register** around the time of this proposed rule to address changes to the ASC rates resulting from corrections to the PE RVUs identified subsequent to publication of the December 31, 2009 correction notice. Finally, we are publishing a notice around the time of this proposed rule in the **Federal Register** to reflect changes to CY 2010 ASC payment rates for certain ASC services due to changes to the OPPS and MPFS under ACA. It also reflects technical changes to the ASC payment rates announced in prior correction notices.

3. Policies Governing Changes to the Lists of Codes and Payment Rates for ASC Covered Surgical Procedures and Covered Ancillary Services

The August 2, 2007 final rule established our policies for determining which procedures are ASC covered surgical procedures and covered ancillary services. Under §§ 416.2 and 416.166 of the regulations, subject to certain exclusions, covered surgical procedures are surgical procedures that are separately paid under the OPPS, that would not be expected to pose a significant risk to beneficiary safety when performed in an ASC, and that would not be expected to require active medical monitoring and care at midnight following the procedure ("overnight stay"). We adopted this standard for defining which surgical procedures are covered surgical procedures under the ASC payment system as an indicator of the complexity of the procedure and its appropriateness for Medicare payment in ASCs. We use this standard only for purposes of evaluating procedures to determine whether or not they are appropriate for Medicare beneficiaries in ASCs. We define surgical procedures as those described by Category I CPT codes in the surgical range from 10000 through 69999, as well as those Category III CPT codes and Level II HCPCS codes that crosswalk or are clinically similar to ASC covered surgical procedures (72 FR 42478). We note that we added over 800 surgical procedures to the list of covered surgical procedures for ASC payment in CY 2008, the first year of the revised ASC payment system, based on the criteria for payment that we adopted in the August 2, 2007 final rule as described above in this section. Patient safety and health outcomes continue to be important to us as more health care moves to the ambulatory care setting. Therefore, as we gain additional experience with the ASC payment system, we are interested in any information the public may have regarding the comparative patient outcomes of surgical care provided in ambulatory settings, including HOPDs, ASCs, and physicians' offices, particularly with regard to the Medicare population.

In the August 2, 2007 final rule, we also established our policy to make separate ASC payments for the following ancillary items and services when they are provided integral to ASC covered surgical procedures: brachytherapy sources; certain implantable items that have pass-through status under the OPPS; certain items and services that we designate as contractor-priced, including, but not limited to, procurement of corneal tissue; certain drugs and biologicals for which separate payment is allowed under the OPPS; and certain radiology services for which separate payment is allowed under the OPPS. These covered ancillary services are specified in § 416.164(b) and, as stated previously, are eligible for separate ASC payment (72 FR 42495). Payment for ancillary items and services that are not paid separately under the ASC payment system is packaged into the ASC payment for the covered surgical procedure.

We update the lists of, and payment rates for, covered surgical procedures and covered ancillary services, in conjunction with the annual proposed and final rulemaking process to update the OPPS and the ASC payment system (§ 416.173; 72 FR 42535). In addition, as discussed in detail below in section XV.B., because we base ASC payment policies for covered surgical procedures, drugs, biologicals, and certain other covered ancillary services on the OPPS payment policies, we also provide quarterly updates for ASC services throughout the year (January, April, July, and October), just as we do for the OPPS. The updates are to implement newly created Level II HCPCS and Category III CPT codes for ASC payment and to update the payment rates for separately paid drugs and biologicals based on the most recently submitted ASP data. New Category I CPT codes, except vaccine codes, are released only once a year and, therefore, are implemented through the January quarterly update. New Category I CPT vaccine codes are released twice a year and thus are implemented through the January and July quarterly updates.

In our annual updates to the ASC list of, and payment rates for, covered surgical procedures and covered ancillary services, we undertake a review of excluded surgical procedures (including all procedures newly proposed for removal from the OPPS inpatient list), new procedures, and procedures for which there is revised coding, to identify any that we believe meet the criteria for designation as ASC covered surgical procedures or covered ancillary services. Updating the lists of covered surgical procedures and covered ancillary services, as well as their payment rates, in association with the annual OPPS rulemaking cycle is particularly important because the OPPS relative payment weights and, in some cases, payment rates, are used as the basis for the payment of covered surgical procedures and covered ancillary services under the revised ASC payment system. This joint update process ensures that the ASC updates occur in a regular, predictable, and timely manner.

B. Proposed Treatment of New Codes

1. Proposed Process for Recognizing New Category I and Category III CPT Codes and Level II HCPCS Codes

CPT and Level II HCPCS codes are used to report procedures, services, items, and supplies under the ASC payment system. Specifically, we recognize the following codes on ASC claims: (1) Category I CPT codes, which describe medical services and procedures; (2) Category III CPT codes, which describe new and emerging technologies, services, and procedures; and (3) Level II HCPCS codes, which are used primarily to identify products, supplies, temporary procedures, and services not described by CPT codes. CPT codes are established by the

American Medical Association (AMA) and the Level II HCPCS codes are established by the CMS HCPCS Workgroup. These codes are updated and changed throughout the year. CPT and HCPCS code changes that affect ASCs are addressed both through the ASC quarterly update Change Requests (CRs) and through the annual rulemaking cycle. CMS releases new Level II HCPCS codes to the public or recognizes the release of new CPT codes by the AMA and makes these codes effective (that is, the codes are recognized on Medicare claims) outside of the formal rulemaking process via ASC quarterly update CRs. This quarterly process offers ASCs access to codes that may more accurately describe items or services furnished and/or provides payment or more accurate payment for these items or services in a more timely manner than if we waited for the annual rulemaking process. We solicit comments on the new codes recognized for ASC payment and finalize our proposals related to these codes through our annual rulemaking process.

We finalized a policy in the August 2, 2007 final rule to evaluate each year all new Category I and Category III CPT codes and Level II HCPCS codes that describe surgical procedures, and to make preliminary determinations in the annual OPPS/ASC final rule with comment period regarding whether or not they meet the criteria for payment in the ASC setting and, if so, whether they are office-based procedures (72 FR 42533 through 42535). In addition, we identify new codes as ASC covered ancillary services based upon the final payment policies of the revised ASC payment system.

In Table 39 below, we summarize our proposed process for updating the HCPCS codes recognized under the ASC payment system.

TABLE 39.—PROPOSED COMMENT TIMEFRAME FOR NEW HCPCS CODES

OPPS/ASC Quarterly Update CR	Type of Code	Effective Date	Comments Sought	When Finalized
April l, 2010	Level II HCPCS Codes	April 1, 2010	CY 2011 OPPS/ASC proposed rule	CY 2011 OPPS/ASC final rule with comment period
July 1, 2010	Level II HCPCS Codes	July 1, 2010	CY 2011 OPPS/ASC proposed rule	CY 2011 OPPS/ASC final rule with comment period
	Category I (certain vaccine codes) and III CPT codes	July 1, 2010	CY 2011 OPPS/ASC proposed rule	CY 2011 OPPS/ASC final rule with comment period
October 1, 2010	Level II HCPCS Codes	October 1, 2010	CY 2011 OPPS/ASC final rule with comment period	CY 2012 OPPS/ASC final rule with comment period
January 1, 2011	Level II HCPCS Codes	January 1, 2011	CY 2011 OPPS/ASC final rule with comment period	CY 20112 OPPS/ASC final rule with comment period
	Category I and III CPT Codes	January 1, 2011	CY 2011 OPPS/ASC final rule with comment period	CY 2012 OPPS/ASC final rule with comment period

This process is discussed in detail below and we have separated our discussion based on whether we are proposing to solicit public comments in this CY 2011 proposed rule on a specific group of the CPT and Level II HCPCS codes (and respond to those comments in the CY 2011 OPPS/ASC final rule with comment period) or whether we are proposing to solicit public comments on another specific group of the codes in the CY 2011 final rule with comment period (and respond to those comments in the CY 2012 OPPS/ASC final rule with comment period). We sought public comments in the CY 2010 OPPS/ASC final rule with comment period on the new CPT and HCPCS codes that were effective January 1, 2010. These new codes were flagged with comment indicator "N1" in Addendum AA and BB to the CY 2010 OPPS/ASC final rule with comment period to indicate that we were assigning them an interim payment status and payment rate, if applicable, which were subject to public comment following publication of the CY 2010 OPPS/ASC final rule with comment period. We will respond to public

comments and finalize our proposed ASC treatment of these codes in the CY 2011 OPPS/ASC final rule with comment period.

2. Proposed Treatment of New Level II HCPCS Codes and Category III CPT Codes Implemented in April and July 2010 for Which We Are Soliciting Public Comments in This Proposed Rule

In the April and July CRs, we made effective for April 1 or July 1, 2010, a total of 14 new Level II HCPCS codes and 7 new Category III CPT codes that were not addressed in the CY 2010 OPPS/ASC final rule with comment period. (We note that one Level II HCPCS code, C9262, that was added in the April 2010 CR, was deleted June 30, 2010 and replaced with Q2025 effective July 1, 2010). The 13 new Level II HCPCS codes describe covered ancillary services.

Through the April 2010 ASC quarterly update (Transmittal 1943, CR 6866, dated April 6, 2010), we added six new drug and biological Level II HCPCS codes to the list of covered ancillary services. Specifically, as displayed in Table 40, these included HCPCS codes C9258 (Injection, telavancin, 10 mg), C9259 (Injection, pralatrexate, 1 mg), C9260 (Injection, ofatumumab, 10 mg), C9261 (Injection, ustekinumab, 1 mg), C9262 (Fludarabine phosphate, oral, 1 mg), and C9263 (Injection, ecallantide, 1 mg).

Through the July 2010 quarterly update (Transmittal 1984, Change Request 7008, dated June 11, 2010), we are adding seven new drug and biological Level II HCPCS codes to the list of covered ancillary services. Specifically, as displayed in Table 41, we provide separate payment for HCPCS codes C9264 (Injection, tocilizumab, 1 mg), C9265 (Injection, romidepsin, 1 mg), C9266 (Injection, collagenase clostridium histolyticum, 0.1 mg), C9267 (Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO), C9268 (Capsaicin, patch, 10cm2), C9367 (Skin substitute, Endoform Dermal Template, per square centimeter), and Q2025 (Fludarabine phosphate oral, 10mg). As noted above, HCPCS code C9262 was made effective April 1, 2010, and deleted June 30, 2010, when it was replaced with HCPCS code Q2025.

We assigned payment indicator "K2" (Drugs and biologicals paid separately when provided integral to a surgical procedure on the ASC list; payment based on OPPS rate) to these 13 new Level II to indicate that they are separately paid when provided in ASCs. In this CY 2011 OPPS/ASC proposed rule, we are soliciting public comment on the proposed CY 2010 ASC payment indicators and payment rates for the drugs and biologicals, as listed in Tables 40 and 41 below. Those HCPCS codes became payable in ASCs, beginning in April or July 2010, respectively, and are paid at the ASC rates posted for the appropriate calendar quarter on the CMS Web site at *http://www.cms.gov/ASCPayment/.*

The codes listed in Table 40 are included in Addendum BB to this proposed rule. (We note that Level II HCPCS code C9262 was deleted June 30, 2010, and replaced with Q2025 effective July 1, 2010, and therefore is not included in Addendum BB and is not open to public comment. Instead, Level II HCPCS code Q2025 is open for public comment.)

However, because HCPCS codes that become effective for July (listed in Table 41) are not available to us in time for incorporation into the Addenda to the OPPS/ASC proposed rule, our policy is to include these HCPCS codes and their proposed payment indicators and payment rates in the preamble to the proposed rule but not in the Addenda to the proposed rule. These codes and their final payment indicators and rates will be included in the appropriate Addendum to the CY 2011 OPPS/ASC final rule with comment period. Thus, the codes implemented by the July 2010 ASC quarterly update CR and their proposed CY 2011 payment rates (based on July 2010 ASP data) that are displayed in Table 41 are not included in Addendum BB to this proposed rule. We are proposing to include these services reported using the new Level II HCPCS codes displayed in Tables 40 and 41 as covered ancillary services for payment to ASCs for CY 2011. The final list of covered ancillary services and the associated payment weights and payment indicators will be included in Addendum BB to the CY 2011 OPPS/ASC final rule with comment period, consistent with our annual update policy.

BILLING CODE 4120–01–P

TABLE 40.—NEW LEVEL II HCPCS CODES FOR COVERED ANCILLARY SERVICES IMPLEMENTED IN APRIL 2010

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 Payment Indicator
C9258	Injection, telavancin, 10 mg	K2
C9259	Injection, pralatrexate, 1 mg	K2
C9260	Injection, ofatumumab, 10 mg	K2
C9261	Injection, ustekinumab, 1 mg	K2
C9262*	Fludarabine phosphate, oral, 1 mg	D5
C9263	Injection, ecallantide, 1 mg	K2

*Level II HCPCS code C9262 was deleted June 30, 2010, and replaced with Q2025 effective July 1, 2010. Because Addendum BB to this proposed rule is based on the codes effective in April, C9262 appears as having a proposed payment indicator of "K2."

TABLE 41.—NEW LEVEL II HCPCS CODES FOR COVERED ANCILLARY SERVICES IMPLEMENTED IN JULY 2010

CY 2010 HCPCS Code	CY 2010 Descriptor	Proposed CY 2011 Payment Indicator	Proposed CY 2011 ASC Payment Rate*
C9264	Injection, tocilizumab, 1 mg	K2	$3.52
C9265	Injection, romidepsin, 1 mg	K2	$223.78
C9266	Injection, collagenase clostridium histolyticum, 0.1 mg	K2	$382.78
C9267	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	K2	$122.07
C9268	Capsaicin, patch, 10cm2	K2	$11.18
C9367	Skin substitute, Endoform Dermal Template, per square centimeter	K2	$4.35
Q2025**	Fludarabine phosphate oral, 10mg	K2	$8.18

* Based on July 2010 ASP information.
**Level II HCPCS code Q2025 replaced C9262.

Through the July 2010 quarterly update CR, we also implemented ASC payment for seven new Category III CPT codes and one new Level II HCPCS code as ASC covered surgical procedures, effective July 1, 2010. These codes are listed in Table 42 below, along with their proposed payment indicators and proposed payment rates for CY 2011. Because new Category III CPT and Level II HCPCS codes that become effective for July are not available to us in time for incorporation into the Addenda to the OPPS/ASC proposed rule, our policy is to include the codes, their proposed payment indicators, and proposed payment rates in the preamble to the proposed rule but not in the Addenda to the proposed rule. These codes and their final payment indicators and rates will be included in the Addenda to the OPPS/ASC final rule with comment period. The new mid-year codes for the covered surgical procedures implemented in July 2010 are displayed in Table 42 below, along with their proposed payment indicators and proposed payment rates. These codes and their final payment indicators and rates will be included in Addendum AA to the CY 2011 OPPS/ASC final rule with comment period.

TABLE 42.—NEW CATEGORY III CPT CODES AND LEVEL II HCPCS CODE IMPLEMENTED IN JULY 2010 AS ASC COVERED SURGICAL PROCEDURES

CY 2010 CPT Code	CY 2010 Long Descriptor	Proposed CY 2011 Payment Indicator**	Proposed CY 2011 ASC Payment Rate
0226T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	R2*	$26.78
0227T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	R2*	$231.07
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level	G2	$288.11
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)	G2	$148.93
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level	G2	$288.11
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)	G2	$148.93
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	R2*	$26.78
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	R2*	$177.60

* If designation is temporary.

**Proposed payment indicators are based on a comparison of the proposed rates according to the ASC standard ratesetting methodology and the MPFS proposed rates. At the time this proposed rule is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this proposed rule reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the CY 2011 OPPS/ASC final rule with comment period.

BILLING CODE 4120–01–C

For CY 2011, we are soliciting public comments on the proposed payment indicators and the payment rates, if applicable, for the new Level II HCPCS codes and Category III CPT codes that were newly recognized in April or July 2010 through the respective quarterly update CRs. These codes are listed in Tables 40, 41, and 42 of this proposed rule. We are proposing to finalize their payment indicators and their payment rates, if applicable, in the CY 2011 OPPS/ASC final rule with comment period.

3. Proposed Process for New Level II HCPCS Codes and Category I and III CPT Codes for Which We Will Be Soliciting Public Comments in the CY 2011 OPPS/ASC Final Rule With Comment Period

As has been our practice in the past, we incorporate those new Category I and Category III CPT codes and new Level II HCPCS codes that are effective January 1 in the final rule with comment period updating the ASC payment system for the following calendar year. These codes are released to the public via the CMS HCPCS (for Level II HCPCS codes) and AMA Web sites (for CPT codes), and also through the January ASC quarterly update CRs. In the past, we also have released new Level II HCPCS codes that are effective October 1 through the October ASC quarterly update CRs and incorporated these new codes in the final rule with comment period updating the ASC payment system for the following calendar year. All of these codes are flagged with comment indicator "NI" in Addenda AA and BB to the OPPS/ASC final rule with comment period to indicate that we are assigning them an interim payment status which is subject to public comment. Specifically, the payment indicator and payment rate, if applicable, for all such codes flagged with comment indicator "NI" are open to public comment in the OPPS/ASC final rule with comment period, and we respond to these comments in the final rule with comment period for the next calendar year's OPPS/ASC update. We are proposing to continue this process for CY 2011.

For CY 2011, we are proposing to include in Addenda AA and BB to the CY 2011 OPPS/ASC final rule with comment period the new Category I and III CPT codes effective January 1, 2011 (including those Category III CPT codes that were released by the AMA in July 2010) that would be incorporated in the January 2011 ASC quarterly update CR and the new Level II HCPCS codes, effective October 1, 2010 or January 1, 2011, that would be released by CMS in its October 2010 and January 2011 ASC quarterly update CRs. These codes would be flagged with comment indicator "NI" in Addenda AA and BB to the CY 2011 OPPS/ASC final rule with comment period to indicate that we have assigned them an interim payment status. Their payment indicators and payment rates, if applicable, would be open to public comment in the CY 2011 OPPS/ASC final rule with comment period and would be finalized in the CY 2012 OPPS/ASC final rule with comment period.

C. Proposed Update to the Lists of ASC Covered Surgical Procedures and Covered Ancillary Services

1. Covered Surgical Procedures

a. Proposed Additions to the List of ASC Covered Surgical Procedures

We are proposing to update the list of ASC covered surgical procedures by adding five procedures to the list. These five procedures were among those excluded from the ASC list for CY 2010 because we believed they did not meet the definition of a covered surgical procedure based on our expectation that they would pose a significant safety risk to Medicare beneficiaries or would require an overnight stay if performed in ASCs. We conducted a review of all HCPCS codes that currently are paid under the OPPS, but not included on the ASC list of covered surgical procedures, to determine if changes in technology and/or medical practice changed the clinical appropriateness of these procedures for the ASC setting. We determined that these five procedures could be safely performed in the ASC setting and are therefore proposing to include them on the list of ASC covered surgical procedures for CY 2011.

The five procedures that we are proposing to add to the ASC list of covered surgical procedures, including their HCPCS code long descriptors and proposed CY 2010 payment indicators, are displayed in Table 43 below.

TABLE 43.—PROPOSED NEW ASC COVERED SURGICAL PROCEDURES FOR CY 2011

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 ASC Payment Indicator*
37204	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	G2
37205	Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel	P3
37206	Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel (list separately in addition to code for primary procedure)	P3
37210	Laser enucleation of the prostate with morcellation, 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 (Do not report 52649 with 52000, 52276, 52281, 52601, 52647, 52648, 53020, 55250)	P3
50593	Uterine fibroid embolization (ufe, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the procedure	P2

*Proposed payment indicators are based on a comparison of the proposed rates according to the ASC standard ratesetting methodology and the MPFS proposed rates. At the time this proposed rule is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this proposed rule reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the CY 2011 OPPS/ASC final rule with comment period.

b. Proposed Covered Surgical Procedures Designated as Office-Based

(1) Background

In the August 2, 2007 ASC final rule, we finalized our policy to designate as "office-based" those procedures that are added to the ASC list of covered surgical procedures in CY 2008 or later years that we determine are performed predominantly (more than 50 percent of the time) in physicians' offices based on consideration of the most recent available volume and utilization data for each individual procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. In that rule, we also finalized our policy to exempt all procedures on the CY 2007 ASC list from application of the office-based classification (72 FR 42512). The procedures that were added to the ASC list of covered surgical procedures beginning in CY 2008 that we determined were office-based were identified in Addendum AA to that rule by payment indicator "P2" (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on OPPS relative payment weight); "P3" (Office-based surgical procedures added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on MPFS non-facility PE RVUs); or "R2" (Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS non-facility PE RVUs; payment based on OPPS relative payment weight), depending on whether we estimated it would be paid according to the standard ASC payment methodology based on its OPPS relative payment weight or at the MPFS non-facility PE RVU amount.

Consistent with our final policy to annually review and update the list of surgical procedures eligible for payment in ASCs, each year we identify surgical procedures as either temporarily or permanently office-based after taking into account updated volume and utilization data.

(2) Proposed Changes to Covered Surgical Procedures Designated as Office-Based for CY 2011

In developing this proposed rule, we followed our policy to annually review and update the surgical procedures for which ASC payment is made and to identify new procedures that may be

appropriate for ASC payment, including their potential designation as office-based. We reviewed CY 2009 volume and utilization data and the clinical characteristics for all surgical procedures that are assigned payment indicator "G2" in CY 2010, as well as for those procedures assigned one of the temporary office-based payment indicators, specifically "P2*," "P3*," or "R2*" in the CY 2010 ASC final rule with comment period (74 FR 60605 through 60608). We also examined the data for the five procedures that we are proposing to add to the ASC list of covered surgical procedures for CY 2011 (listed in Table 43 above) to determine if these procedures should be designated as office-based.

Our review of the CY 2009 volume and utilization data resulted in our identification of six surgical procedures that we believe meet the criteria for designation as office-based. The data indicate that the procedures are performed more than 50 percent of the time in physicians' offices. Our medical advisors believe the services are of a level of complexity consistent with other procedures performed routinely in physicians' offices. The six procedures we are proposing to permanently designate as office-based are listed in Table 44 below. We note that four of these procedures are procedures that we also are proposing to add to the ASC list of covered surgical procedures for CY 2011: CPT code 37205; CPT code 37206; CPT code 37210; and CPT code 50593. The other two procedures are already on the ASC list of covered surgical procedures.

BILLING CODE 4120–01–P

TABLE 44.—ASC COVERED SURGICAL PROCEDURES PROPOSED FOR OFFICE-BASED DESIGNATION FOR CY 2011

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 ASC Payment Indicator	Proposed CY 2011 ASC Payment Indicator*
20697	Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement of strut, each	G2	P2
27767	Closed treatment of posterior malleolus fracture; without manipulation	G2	P2
37205	Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel	X5	P3
37206	Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel (list separately in addition to code for primary procedure)	X5	P3
37210	Laser enucleation of the prostate with morcellation, 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 (Do not report 52649 with 52000, 52276, 52281, 52601, 52647, 52648, 53020, 55250)	X5	P3
50593	Uterine fibroid embolization (ufe, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous	X5	P2

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 ASC Payment Indicator	Proposed CY 2011 ASC Payment Indicator*
	approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the procedure		

*Proposed payment indicators are based on a comparison of the proposed rates according to the ASC standard ratesetting methodology and the MPFS proposed rates. At the time this proposed rule is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this proposed rule reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the CY 2011 OPPS/ASC final rule with comment period.

We also reviewed CY 2009 volume and utilization data and other information for the six procedures proposed for temporary office-based status in the CY 2010 OPPS/ASC proposed rule (74 FR 35382) and finalized for temporary office-based status in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60607). Among these six procedures, there were almost no claims data for three procedures: CPT code 0099T (Implantation of intrastromal corneal ring segments); CPT code 0124T (Conjunctival drug placement); and CPT code 67229 (Treatment of extensive or progressive retinopathy, one or more sessions; preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (e.g., retinopathy of prematurity), photocoagulation or cryotherapy). Consequently, we are proposing to maintain their temporary office-based designations for CY 2011. We also are proposing to maintain in CY 2011 the temporary office-based designation for the four codes that became effective in the July 2010 ASC quarterly update: CPT code 0226T (Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed); CPT code 0227T (Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)); CPT code 0232T (Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed); and HCPCS code C9800 (Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies), because no data are available for these codes at this time.

As a result of our review of the remaining three procedures that have temporary office-based designations for CY 2010 for which we do have claims data, we are proposing to make permanent the office based designations for all of them for CY 2011. The three surgical procedure codes are: CPT code 46930 (Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency)); CPT code 64455 (Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)); and CPT code 64632 (Destruction by neurolytic agent; plantar common digital nerve). The volume and utilization data for these CPT codes are sufficient to support our determination that these procedures are performed predominantly in physicians' offices. Therefore, we are proposing to make permanent the office-based designations for the 3 procedures for CY 2011.

The procedures that we are proposing to permanently designate as office-based for CY 2011 that were temporarily designated as office-based procedures in CY 2010 are displayed in Table 45 below. The procedures that we are proposing to temporarily designate as office-based for CY 2011 are displayed in Table 46 below. The procedures for which the proposed office-based designation for CY 2011 is temporary also are indicated by an asterisk in Addendum AA to this proposed rule.

BILLING CODE 4120–01–P

TABLE 45.—CY 2010 TEMPORARILY DESIGNATED OFFICE-BASED ASC COVERED SURGICAL PROCEDURES PROPOSED FOR PERMANENT OFFICE-BASED FOR CY 2011

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 ASC Payment Indicator	Proposed CY 2011 ASC Payment Indicator**
46930	Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency)	P3*	P3
64455	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton's neuroma)	P3*	P3
64632	Destruction by neurolytic agent; plantar common digital nerve	P3*	P3

* If designation is temporary.

**Proposed payment indicators are based on a comparison of the proposed rates according to the ASC standard ratesetting methodology and the MPFS proposed rates. At the time this proposed rule is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this proposed rule reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the CY 2011 OPPS/ASC final rule with comment period.

TABLE 46.—CY 2010 TEMPORARILY DESIGNATED OFFICE-BASED ASC COVERED SURGICAL PROCEDURES PROPOSED FOR TEMPORARY OFFICE-BASED DESIGNATION IN CY 2011

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 ASC Payment Indicator	Proposed CY 2011 ASC Payment Indicator**
0099T	Implantation of intrastromal corneal ring segments	R2*	R2*
0124T	Conjunctival incision with posterior extrascleral placement of pharmacological agent (does not include supply of medication)	R2*	R2*
0226T	Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	P2*	R2*
0227T	Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	P2*	R2*
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	P2*	R2*
67229	Treatment of extensive or progressive retinopathy, one or more sessions; preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy	R2*	R2*
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	R2*	R2*

* If designation is temporary.

**Proposed payment indicators are based on a comparison of the proposed rates according to the ASC standard ratesetting methodology and the MPFS proposed rates. At the time this proposed rule is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this proposed rule reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the CY 2011 OPPS/ASC final rule with comment period.

BILLING CODE 4120–01–C

Displayed in Table 47 below are new (or substantially revised) CY 2010 HCPCS codes to which we assigned temporary office-based payment indicators in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60608). As explained in section XV.B.1. of that final rule with comment period (74 FR 60599 and 60607), we reviewed all of the newly created HCPCS codes that became available after the issuance of the CY 2009 OPPS/ASC proposed rule that are used to report surgical procedures in CY 2010 to evaluate their appropriateness for the ASC list of covered surgical procedures. Of the procedures reported by new or substantially revised CY 2010 HCPCS codes that we determined should not be excluded from the ASC list based on our clinical review, including assessment of available utilization and volume data for any closely related procedures and consideration of other available information, we determined that 16 of the procedures would predominantly be performed in physicians' offices. However, because we had no utilization data for the procedures specifically described by these new HCPCS codes, we made the office-based designations temporary rather than permanent and

stated that we would reevaluate the procedures when data become available (74 FR 60607 through 60608). The temporary payment indicators for the 16 office-based procedures displayed in Table 47 were interim designations and were open to public comment during the 60-day comment period following the release of the CY 2010 OPPS/ASC final rule with comment period. We will respond to public comments received during that 60-day comment period as well as the comment period following this proposed rule in the CY 2011 OPPS/ASC final rule with comment period.

BILLING CODE 4120–01–P

TABLE 47.—PROPOSED CY 2011 PAYMENT INDICATORS FOR NEW CY 2010 HCPCS CODES FOR ASC COVERED SURGICAL PROCEDURES DESIGNATED AS TEMPORARILY OFFICE-BASED ON AN INTERIM BASIS IN THE CY 2010 OPPS/ASC FINAL RULE WITH COMMENT PERIOD

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 ASC Payment Indicator	Proposed CY 2011 ASC Payment Indicator**
21015	Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm	R2 *	R2**
21555	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm	P3*	P3**
21930	Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm	P3*	P3**
23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm	P3*	P3**
24075	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm	P3*	P3**
25075	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm	P3*	P3**
26115	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm	P3*	P3**
27047	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm	P3*	P3**
27327	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm	P3*	P3**
27618	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm	P3*	P3**
28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater	P3*	P3**
28041	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater	R2*	R2**
28043	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm	P3*	P3**
28045	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	P3*	P3**
28046	Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; less than 3 cm	R2*	R2**
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	R2*	R2**

* If designation is temporary.

**Proposed payment indicators are based on a comparison of the proposed rates according to the ASC standard rate setting methodology and the MPFS proposed rates. At the time this proposed rule is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this proposed rule reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the CY 2011 OPPS/ASC final rule with comment period.

BILLING CODE 4120–01–C

c. ASC Covered Surgical Procedures Designated as Device-Intensive

(1) Background

As discussed in the August 2, 2007 final rule (72 FR 42503 through 42508), we adopted a modified payment methodology for calculating the ASC payment rates for covered surgical procedures that are assigned to the subset of OPPS device-dependent APCs with a device offset percentage greater than 50 percent of the APC cost under the OPPS, in order to ensure that payment for the procedure is adequate to provide packaged payment for the high-cost implantable devices used in those procedures. We assigned payment indicators "H8" (Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate) and "J8" (Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate) to identify the procedures that were eligible for ASC payment calculated according to the modified methodology, depending on whether the procedure was included on the ASC list of covered surgical procedures prior to CY 2008 and, therefore, subject to transitional payment as discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68739 through 68742). The device-intensive procedures for which the modified rate calculation methodology applies in CY 2010 were displayed in Table 68 and in Addendum AA to the CY 2010 OPPS/ASC final rule with comment period (74 FR 60610 through 60611 and 60692 through 60752).

(2) Proposed Changes to List of Covered Surgical Procedures Designated as Device Intensive for CY 2011

We are proposing to update the ASC list of covered surgical procedures that are eligible for payment according to the device-intensive procedure payment methodology for CY 2011, consistent with the proposed OPPS device-dependent APC update, reflecting the proposed APC assignments of procedures, designation of APCs as device dependent, and APC device offset percentages based on the CY 2009 OPPS claims and cost report data available for the proposed rule. The OPPS device-dependent APCs are discussed further in section II.A.2.d.(1) of this proposed rule. The ASC covered surgical procedures that we are proposing to designate as device-intensive and that would be subject to the device-intensive procedure payment methodology for CY 2011 are listed in Table 48 below. The CPT code, the CPT code short descriptor, the proposed CY 2011 ASC payment indicator, the proposed CY 2011 OPPS APC assignment and title, and the proposed CY 2011 OPPS APC device offset percentage are also listed in Table 48 below. Each proposed device-intensive procedure is assigned payment indicator "H8" or "J8" depending on whether it was subject to transitional payment prior to CY 2011, and all of these procedures are included in Addendum AA to this proposed rule.

BILLING CODE 4120–01–P

TABLE 48.--ASC COVERED SURGICAL PROCEDURES PROPOSED FOR DEVICE-INTENSIVE DESIGNATION FOR CY 2011

CY 2010 CPT Code	CY 2010 Short Descriptor	Proposed CY 2011 ASC Payment Indicator	Proposed CY 2011 OPPS APC	OPPS APC Title	Proposed CY 2011 Device-Dependent APC Offset Percentage
24361	Reconstruct elbow joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
24363	Replace elbow joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
24366	Reconstruct head of radius	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
25441	Reconstruct wrist joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
25442	Reconstruct wrist joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
25446	Wrist replacement	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
27446	Revision of knee joint	J8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
33206	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	70%
33207	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	70%
33208	Insertion of heart pacemaker	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	73%
33212	Insertion of pulse generator	H8	0090	Insertion/Replacement of Pacemaker Pulse Generator	72%
33213	Insertion of pulse generator	H8	0654	Insertion/Replacement of a permanent dual chamber pacemaker	73%
33214	Upgrade of pacemaker system	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	73%
33224	Insert pacing lead & connect	J8	0418	Insertion of Left Ventricular Pacing Elect.	72%
33225	Lventric pacing lead add-on	J8	0418	Insertion of Left Ventricular Pacing Elect.	72%
33240	Insert pulse generator	J8	0107	Insertion of Cardioverter-Defibrillator	88%
33249	Eltrd/insert pace-defib	J8	0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	87%

CY 2010 CPT Code	CY 2010 Short Descriptor	Proposed CY 2011 ASC Payment Indicator	Proposed CY 2011 OPPS APC	OPPS APC Title	Proposed CY 2011 Device-Dependent APC Offset Percentage
33282	Implant pat-active ht record	J8	0680	Insertion of Patient Activated Event Recorders	71%
53440	Male sling procedure	H8	0385	Level I Prosthetic Urological Procedures	61%
53444	Insert tandem cuff	H8	0385	Level I Prosthetic Urological Procedures	61%
53445	Insert uro/ves nck sphincter	H8	0386	Level II Prosthetic Urological Procedures	71%
53447	Remove/replace ur sphincter	H8	0386	Level II Prosthetic Urological Procedures	71%
54400	Insert semi-rigid prosthesis	H8	0385	Level I Prosthetic Urological Procedures	61%
54401	Insert self-contd prosthesis	H8	0386	Level II Prosthetic Urological Procedures	71%
54405	Insert multi-comp penis pros	H8	0386	Level II Prosthetic Urological Procedures	71%
54410	Remove/replace penis prosth	H8	0386	Level II Prosthetic Urological Procedures	71%
54416	Remv/repl penis contain pros	H8	0386	Level II Prosthetic Urological Procedures	71%
55873	Cryoablate prostate	H8	0674	Prostate Cryoablation	58%
61885	Insrt/redo neurostim 1 array	H8	0039	Level I Implantation of Neurostimulator Generator	85%
61886	Implant neurostim arrays	H8	0315	Level II Implantation of Neurostimulator Generator	88%
62361	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device	81%
62362	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device	81%
63650	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%
63655	Implant neuroelectrodes	J8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%
63685	Insrt/redo spine n generator	H8	0039	Level I Implantation of Neurostimulator Generator	85%
64553	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%
64555	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%

CY 2010 CPT Code	CY 2010 Short Descriptor	Proposed CY 2011 ASC Payment Indicator	Proposed CY 2011 OPPS APC	OPPS APC Title	Proposed CY 2011 Device-Dependent APC Offset Percentage
64560	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%
64561	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%
64565	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%
64573	Implant neuroelectrodes	H8	0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	78%
64575	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%
64577	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%
64580	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%
64581	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%
64590	Insrt/redo pn/gastr stimul	H8	0039	Level I Implantation of Neurostimulator Generator	85%
65770	Revise cornea with implant	H8	0293	Level VI Anterior Segment Eye Procedures	59%
69714	Implant temple bone w/stimul	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
69715	Temple bne implnt w/stimulat	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
69717	Temple bone implant revision	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
69718	Revise temple bone implant	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
69930	Implant cochlear device	H8	0259	Level VII ENT Procedures	86%

BILLING CODE 4120–01–C

d. ASC Treatment of Surgical Procedures Proposed for Removal From the OPPS Inpatient List for CY 2011

As we discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68724), we adopted a policy to include in our annual evaluation procedures proposed for removal from the OPPS inpatient list for possible inclusion on the ASC list of covered surgical procedures. We evaluated each of the three procedures we are proposing to remove from the OPPS inpatient list for CY 2011 according to the criteria for exclusion from the list of covered ASC surgical procedures. We believe that all of these procedures should continue to be excluded from the ASC list of covered surgical procedures for CY 2011 because they would be expected to pose a significant risk to beneficiary safety or to require an overnight stay in ASCs. A full discussion about the APC Panel's recommendations regarding the procedures we are proposing to remove from the OPPS inpatient list for CY 2011 and the procedures we are proposing to remove from the OPPS inpatient list for CY 2011 may be found in section XI.B. of this proposed rule. The HCPCS codes for these three procedures and their long descriptors are listed in Table 49 below.

TABLE 49.—PROCEDURES PROPOSED FOR EXCLUSION FROM THE ASC LIST OF COVERED PROCEDURES FOR CY 2011 THAT ARE PROPOSED FOR REMOVAL FROM THE CY 2011 OPPS INPATIENT LIST

CY 2010 HCPCS Code	CY 2010 Long Descriptor
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)
25909	Amputation, forearm, through radius and ulna; re-amputation

2. Covered Ancillary Services

Consistent with the established ASC payment system policy, we are proposing to update the ASC list of covered ancillary services to reflect the proposed payment status for the services under the CY 2011 OPPS. Maintaining consistency with the OPPS may result in proposed changes to ASC payment indicators for some covered ancillary items and services because of changes that are being proposed under the OPPS for CY 2011. For example, a covered ancillary service that was separately paid under the revised ASC payment system in CY 2010 may be proposed for packaged status under the CY 2011 OPPS and, therefore, also under the ASC payment system for CY 2011. Comment indicator "CH," discussed in section XV.F. of this proposed rule, is used in Addendum BB to this proposed rule to indicate covered ancillary services for which we are proposing a change in the ASC payment indicator to reflect a proposed change in the OPPS treatment of the service for CY 2011.

Except for the Level II HCPCS codes listed in Table 41 of this proposed rule, all ASC covered ancillary services and their proposed payment indicators for CY 2011 are included in Addendum BB to this proposed rule.

D. Proposed ASC Payment for Covered Surgical Procedures and Covered Ancillary Services

1. Proposed Payment for Covered Surgical Procedures

a. Background

Our ASC payment policies for covered surgical procedures under the revised ASC payment system are fully described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66828 through 66831). Under our established policy for the revised ASC payment system, the ASC standard ratesetting methodology of multiplying the ASC relative payment weight for the procedure by the ASC conversion factor for that same year is used to calculate the national unadjusted payment rates for procedures with payment indicator "G2." For procedures assigned payment indicator "A2," our final policy established blended rates to be used during the transitional period and, beginning in CY 2011, ASC rates calculated according to the ASC standard ratesetting methodology. The rate calculation established for device intensive procedures (payment indicators "H8" and "J8") is structured so that the packaged device payment amount is the same as under the OPPS, and only the service portion of the rate is subject to the ASC standard ratesetting methodology. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60596 through 60629), we updated the CY 2009 ASC payment rates for ASC covered surgical procedures with payment indicators of "A2," "G2," "H8," and "J8" using CY 2008 data, consistent with the CY 2010 OPPS update. Payment rates for device-intensive procedures also were updated to incorporate the CY 2010 OPPS device offset percentages.

Payment rates for office-based procedures (payment indicators "P2," "P3," and "R2") are the lower of the MPFS non-facility PE RVU amount (we refer readers to the CY 2011 MPFS proposed rule) or the amount calculated using the ASC standard ratesetting methodology for the procedure. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60596 through 60629), we updated the payment amounts for office-based procedures (payment indicators "P2," "P3," and "R2") using the most recent available MPFS and OPPS data. We compared the estimated CY 2010 rate for each of the office-based procedures, calculated according to the ASC standard ratesetting methodology, to the MPFS nonfacility PE RVU amount (multiplied by the conversion factor) to determine which was lower and, therefore, would be the CY 2010 payment rate for the procedure according to the final policy of the revised ASC payment system (§ 416.171(d)).

b. Proposed Update to ASC-Covered Surgical Procedure Payment Rates for CY 2011

We are proposing to update ASC payment rates for CY 2011 using the established rate calculation methodologies under § 416.171. Under § 416.171(c)(4), the transitional payment rates are no longer used for CY 2011 and subsequent calendar years for a covered surgical procedure designated in accordance with § 416.166. Thus, we are proposing to calculate CY 2011 payments for procedures formerly subject to the transitional payment methodology (payment indicators "A2" and "H8") using the proposed CY 2011 ASC rate calculated according to the ASC standard ratesetting methodology, incorporating the device-intensive procedure methodology, as appropriate, for procedures assigned ASC payment indicator "H8." We are not proposing to modify the payment indicators for procedures that were subject to transitional payment prior to CY 2011 but will consider doing so in future rulemaking. We are proposing to continue to use the amount calculated under the ASC standard ratesetting methodology for procedures assigned payment indicator "G2."

We are proposing that payment rates for office-based procedures (payment indicators "P2," "P3," and "R2") and device-intensive procedures that were not subject to transitional payment (payment indicator "J8") be calculated according to our established policies, incorporating the device-intensive procedure methodology as appropriate. Thus, we are proposing to update the payment amounts for device-intensive procedures based on the CY 2011 OPPS proposal that reflects updated OPPS device offset percentages, and to make payment for office-based procedures at

the lesser of the CY 2011 proposed MPFS non-facility PE RVU amount or the proposed CY 2011 ASC payment amount calculated according to the standard ratesetting methodology.

c. Proposed Adjustment to ASC Payments for No Cost/Full Credit and Partial Credit Devices

Our ASC policy with regard to payment for costly devices implanted in ASCs at no cost or with full or partial credit as set forth in § 416.179 is consistent with the OPPS policy. The proposed CY 2011 OPPS APCs and devices subject to the adjustment policy are discussed in section IV.B.2. of this proposed rule. The established ASC policy includes adoption of the OPPS policy for reduced payment to providers when a specified device is furnished without cost or with full or partial credit for the cost of the device for those ASC covered surgical procedures that are assigned to APCs under the OPPS to which this policy applies. We refer readers to the CY 2009 OPPS/ASC final rule with comment period for a full discussion of the ASC payment adjustment policy for no cost/full credit and partial credit devices (73 FR 68742 through 68745).

Consistent with the OPPS, we are proposing to update the list of ASC covered device intensive procedures and devices that would be subject to the no cost/full credit and partial credit device adjustment policy for CY 2011. Table 50 below displays the ASC covered device-intensive procedures that we are proposing would be subject to the no cost/full credit and partial credit device adjustment policy for CY 2011. Specifically, when a procedure that is listed in Table 50 is performed to implant a device that is listed in Table 51 below, where that device is furnished at no cost or with full credit from the manufacturer, the ASC would append the HCPCS "FB" modifier on the line with the procedure to implant the device. The contractor would reduce payment to the ASC by the device offset amount that we estimate represents the cost of the device when the necessary device is furnished without cost to the ASC or with full credit. We would provide the same amount of payment reduction based on the device offset amount in ASCs that would apply under the OPPS under the same circumstances. We continue to believe that the reduction of ASC payment in these circumstances is necessary to pay appropriately for the covered surgical procedure being furnished by the ASC.

We also are proposing to reduce the payment for implantation procedures listed in Table 50 by one-half of the device offset amount that would be applied if a device was provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the cost of the new device. The ASC would append the HCPCS "FC" modifier to the HCPCS code for a surgical procedure listed in Table 50 when the facility receives a partial credit of 50 percent or more of the cost of a device listed in Table 51 below. In order to report that they received a partial credit of 50 percent or more of the cost of a new device, ASCs would have the option of either: (1) Submitting the claim for the device replacement procedure to their Medicare contractor after the procedure's performance but prior to manufacturer acknowledgment of credit for the device, and subsequently contacting the contractor regarding a claim adjustment once the credit determination is made; or (2) holding the claim for the device implantation procedure until a determination is made by the manufacturer on the partial credit and submitting the claim with the "FC" modifier appended to the implantation procedure HCPCS code if the partial credit is 50 percent or more of the cost of the replacement device. Beneficiary coinsurance would continue to be based on the reduced payment amount.

BILLING CODE 4120–01–P

TABLE 50.—PROPOSED CY 2011 PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY WOULD APPLY

CY 2010 CPT Code	CY 2010 Short Descriptor	Proposed CY 2011 ASC Payment Indicator	Proposed CY 2011 OPPS APC	OPPS APC Title	Proposed CY 2011 OPPS Full APC Offset Percentage	Proposed CY 2011 OPPS Partial APC Offset Percentage
24361	Reconstruct elbow joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
24363	Replace elbow joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
24366	Reconstruct head of radius	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
25441	Reconstruct wrist joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
25442	Reconstruct wrist joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
25446	Wrist replacement	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
27446	Revision of knee joint	J8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
33206	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	70%	35%
33207	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	70%	35%
33208	Insertion of heart pacemaker	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	73%	37%
33212	Insertion of pulse generator	H8	0090	Insertion/Replacement of Pacemaker Pulse Generator	72%	36%
33213	Insertion of pulse generator	H8	0654	Insertion/Replacement of a permanent dual chamber pacemaker	73%	37%
33214	Upgrade of pacemaker system	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	73%	37%
33224	Insert pacing lead & connect	J8	0418	Insertion of Left Ventricular Pacing Elect.	72%	36%
33225	Lventric pacing lead add-on	J8	0418	Insertion of Left Ventricular Pacing Elect.	72%	36%
33240	Insert pulse generator	J8	0107	Insertion of Cardioverter-Defibrillator	88%	44%
33249	Eltrd/insert pace-defib	J8	0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	87%	44%

CY 2010 CPT Code	CY 2010 Short Descriptor	Proposed CY 2011 ASC Payment Indicator	Proposed CY 2011 OPPS APC	OPPS APC Title	Proposed CY 2011 OPPS Full APC Offset Percentage	Proposed CY 2011 OPPS Partial APC Offset Percentage
33282	Implant pat-active ht record	J8	0680	Insertion of Patient Activated Event Recorders	71%	35%
53440	Male sling procedure	H8	0385	Level I Prosthetic Urological Procedures	61%	30%
53444	Insert tandem cuff	H8	0385	Level I Prosthetic Urological Procedures	61%	30%
53445	Insert uro/ves nck sphincter	H8	0386	Level II Prosthetic Urological Procedures	71%	36%
53447	Remove/replace ur sphincter	H8	0386	Level II Prosthetic Urological Procedures	71%	36%
54400	Insert semi-rigid prosthesis	H8	0385	Level I Prosthetic Urological Procedures	61%	30%
54401	Insert self-contd prosthesis	H8	0386	Level II Prosthetic Urological Procedures	71%	36%
54405	Insert multi-comp penis pros	H8	0386	Level II Prosthetic Urological Procedures	71%	36%
54410	Remove/replace penis prosth	H8	0386	Level II Prosthetic Urological Procedures	71%	36%
54416	Remv/repl penis contain pros	H8	0386	Level II Prosthetic Urological Procedures	71%	36%
61885	Insrt/redo neurostim 1 array	H8	0039	Level I Implantation of Neurostimulator Generator	85%	43%
61886	Implant neurostim arrays	H8	0315	Level II Implantation of Neurostimulator Generator	88%	44%
62361	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device	81%	41%
62362	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device	81%	41%
63650	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%
63655	Implant neuroelectrodes	J8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%	31%
63685	Insrt/redo spine n generator	H8	0039	Level I Implantation of Neurostimulator Generator	85%	43%
64553	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%
64555	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%

CY 2010 CPT Code	CY 2010 Short Descriptor	Proposed CY 2011 ASC Payment Indicator	Proposed CY 2011 OPPS APC	OPPS APC Title	Proposed CY 2011 OPPS Full APC Offset Percentage	Proposed CY 2011 OPPS Partial APC Offset Percentage
64560	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%
64561	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%
64565	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%
64573	Implant neuroelectrodes	H8	0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	78%	39%
64575	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%	31%
64577	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%	31%
64580	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%	31%
64581	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%	31%
64590	Insrt/redo pn/gastr stimul	H8	0039	Level I Implantation of Neurostimulator Generator	85%	43%
69714	Implant temple bone w/stimul	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
69715	Temple bne implnt w/stimulat	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
69717	Temple bone implant revision	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
69718	Revise temple bone implant	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
69930	Implant cochlear device	H8	0259	Level VII ENT Procedures	86%	43%

TABLE 51.— PROPOSED DEVICES FOR WHICH THE "FB" OR "FC" MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE IN CY 2011 WHEN FURNISHED AT NO COST OR WITH FULL OR PARTIAL CREDIT

CY 2010 Device HCPCS Code	CY 2010 Short Descriptor
C1721	AICD, dual chamber
C1722	AICD, single chamber
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep dev, urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1778	Lead, neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual, rate-resp
C1786	Pmkr, single, rate-resp
C1813	Prosthesis, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro rechg bat sys
C1881	Dialysis access system
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
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
L8680	Implt neurostim elctr each
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8690	Aud osseo dev, int/ext comp

d. Proposed Waiver of Coinsurance and Deductible for Certain Preventive Services

As discussed in detail in section XII.B. of this proposed rule and in the CY 2011 MPFS proposed rule, sections 4104(b) and 10406 of the Affordable Care Act amended section 1833(a)(1) of the Act, in pertinent part, to waive the coinsurance for those preventive services described in section 1861(ww)(2) of the Act (excluding electrocardiograms) that are recommended by the USPSTF with a grade of A or B for any indication or population and that are appropriate for the individual. Section 4104(c) of the Affordable Care Act amended section 1833(b)(1) of the Act to waive the Part B deductible for these preventive services. These provisions apply to these items and services furnished in ASCs on or after January 1, 2011. In section XII.B. of this proposed rule and in the CY 2011 MPFS proposed rule, we are proposing to define the preventive services to which this provision applies and to apply the criteria specified in section 4104 of the Affordable Care Act for the waiver of coinsurance and deductible.

Table 52 identifies the ASC covered surgical and ancillary services that are included in the proposed definition of preventive services in section XII.B. of this proposed rule and in the CY 2011 MPFS proposed rule. All of the ASC covered surgical and ancillary services that are included in the chart below are preventive services that are recommended by the USPSTF with a grade of A or B. Therefore, we are

proposing to update § 416.160(a)(4) and add new § 416.160(a)(5) on the scope and basis of the ASC regulations and to update § 410.152(l) in this proposed rule to reflect the waiver of coinsurance and deductible for these services. We refer readers to the CY 2011 MPFS proposed rule for a discussion of the proposed changes to § 410.160(b) and proposed additional changes to § 410.152 of our regulations to implement the provisions related to the definition of preventive services and the waiver of the coinsurance and deductible for preventive services as specified by sections 4103, 4104, and 10406 of the Affordable Care Act.

TABLE 52.--PROPOSED CY 2011 ASC PREVENTIVE SERVICES FOR WHICH COINSURANCE AND DEDUCTIBLE WOULD BE WAIVED IN CY 2011

Service	CY 2010 CPT/ HCPCS Code	CY 2010 Long Descriptor	CY 2011 Coins. / Deductible	Proposed CY 2011 ASC Payment Indicator
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	Waived	Z3
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	Waived	Z2
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	Waived	Z3
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	Waived	Z2
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	Waived	Z3
	77083	Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites	Waived	Z3
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method	Waived	Z3

Service	CY 2010 CPT/ HCPCS Code	CY 2010 Long Descriptor	CY 2011 Coins. / Deductible	Proposed CY 2011 ASC Payment Indicator
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	Waived	P3
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk	Waived	A2
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	Waived	A2
Influenza Virus Vaccine	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use	Waived	L1
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use	Waived	L1
	90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use	Waived	L1
	90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use	Waived	L1
	90660	Influenza virus vaccine, live, for intranasal use	Waived	L1
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	Waived	L1
	G9141	Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)	Waived	L1

Service	CY 2010 CPT/ HCPCS Code	CY 2010 Long Descriptor	CY 2011 Coins. / Deductible	Proposed CY 2011 ASC Payment Indicator
	G9142	Influenza a (h1n1) vaccine, any route of administration	Waived	L1
Pneumococcal Vaccine	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	Waived	L1
	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	Waived	L1
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use	Waived	L1
Hepatitis B Vaccine	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	Waived	F4
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use	Waived	F4
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use	Waived	F4
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use	Waived	F4
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use	Waived	F4

BILLING CODE 4120–01–C

Section 4104(c) of the Affordable Care Act amended section 1833(b) of the Act to waive the Part B deductible for colorectal cancer screening tests that become diagnostic. Specifically, section 4104(c)(2) of the Affordable Care Act waives the deductible with respect to a colorectal cancer screening test "regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test." As discussed in section XII.B. of this proposed rule and in the CY 2011 MPFS proposed rule, we are proposing that all surgical services furnished on the same date as a planned screening colonoscopy or planned flexible sigmoidoscopy would be considered as being "furnished in connection with, as a result of, and in the same clinical encounter as the screening test." We believe that this interpretation is appropriate because we believe that it would be very rare for an unrelated surgery to occur on the same date as one of these scheduled screening tests. Moreover, we believe that the risk of improper expenditures would be very small under this policy because it is the deductible, and not the coinsurance, that is waived for the related procedures other than the screening tests. In the event of a legislative change to this policy (for example, a statutory change that would waive the coinsurance for these related services in addition to the deductible), we would reassess the appropriateness of this proposed definition of services that are furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test that becomes diagnostic. We also note that the annual deductible would likely be met when any surgical procedure (related or not) is performed on the same day as the scheduled screening test.

We are proposing to implement this provision by creating a HCPCS modifier that ASCs would append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code. The claims

processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance or copayment would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

2. Proposed Payment for Covered Ancillary Services

a. Background

Our final payment policies under the revised ASC payment system for covered ancillary services vary according to the particular type of service and its payment policy under the OPPS. Our overall policy provides separate ASC payment for certain ancillary items and services integrally related to the provision of ASC covered surgical procedures that are paid separately under the OPPS and provides packaged ASC payment for other ancillary items and services that are packaged under the OPPS. Thus, we established a final policy to align ASC payment bundles with those under the OPPS (72 FR 42495).

Our ASC payment policies provide separate payment for drugs and biologicals that are separately paid under the OPPS at the OPPS rates, while we pay for separately payable radiology services at the lower of the MPFS non-facility PE RVU (or technical component) amount or the rate calculated according to the ASC standard ratesetting methodology (72 FR 42497). In all cases, ancillary items and services must be provided integral to the performance of ASC covered surgical procedures for which the ASC bills Medicare, in order for those ancillary services also to be paid.

ASC payment policy for brachytherapy sources generally mirrors the payment policy under the OPPS. We finalized our policy in the CY 2008 OPPS/ASC final rule with comment period (72 FR 42499) to pay for brachytherapy sources applied in ASCs at the same prospective rates that were adopted under the OPPS or, if OPPS rates were unavailable, at contractor-priced rates. Subsequent to publication of that rule, section 106 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173) mandated that, for the period January 1, 2008 through June 30, 2008, brachytherapy sources be paid under the OPPS at charges adjusted to cost. Therefore, consistent with our final overall ASC payment policy, we paid ASCs at contractor-priced rates for brachytherapy sources provided in ASCs during that period of time. Beginning July 1, 2008, brachytherapy sources applied in ASCs were to be paid at the same prospectively set rates that were finalized in the CY 2008 OPPS/ASC final rule with comment period (72 FR 67165 through 67188). Immediately prior to the publication of the CY 2009 OPPS/ASC proposed rule, section 142 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) amended section 1833(t)(16)(C) of the Act (as amended by section 106 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. 110–173) to extend the requirement that brachytherapy sources be paid under the OPPS at charges adjusted to cost through December 31, 2009. Therefore, consistent with final ASC payment policy, ASCs continued to be paid at contractor-priced rates for brachytherapy sources provided integral to ASC covered surgical procedures during that period of time.

Other separately paid covered ancillary services in ASCs, specifically corneal tissue acquisition and device categories with OPPS pass-through status, do not have prospectively established ASC payment rates according to the final policies of the revised ASC payment system (72 FR 42502 and 42509; § 416.164(b)). Under the revised ASC payment system, corneal tissue acquisition is paid based on the invoiced costs for acquiring the corneal tissue for transplantation. As discussed in section IV.A.1. of this proposed rule, new pass-through device categories may be established on a quarterly basis, but currently there are no OPPS device pass-through categories that would continue for OPPS pass-through payment (and, correspondingly, separate ASC payment) in CY 2011.

b. Proposed Payment for Covered Ancillary Services for CY 2011

For CY 2011, we are proposing to update the ASC payment rates and make changes to ASC payment indicators as necessary to maintain consistency between the OPPS and ASC payment system regarding the packaged or separately payable status of services and the proposed CY 2011 OPPS and ASC payment rates. The proposed CY 2011 OPPS payment methodologies for separately payable drugs and biologicals and brachytherapy sources are discussed in sections V. and VII. of this proposed rule, respectively, and we are proposing to set the CY 2011 ASC payment rates for those services equal to the proposed CY 2011 OPPS rates.

Consistent with established ASC payment policy (72 FR 42497), the proposed CY 2011 payment for separately payable covered radiology services is based on a comparison of the CY 2011 proposed MPFS non-facility PE RVU amounts (we refer readers to the CY 2011 MPFS proposed rule) and the proposed CY 2011 ASC payment rates calculated according to the ASC standard ratesetting methodology and then set at the lower of the two amounts. Alternatively, payment for a radiology service may be packaged into the payment for the ASC covered surgical procedure if the radiology service is packaged under the OPPS. The payment indicators in Addendum BB indicate whether the proposed payment rates for radiology services are based on the MPFS nonfacility PE RVU amount or the ASC standard rate setting methodology, or whether payment for a radiology service is packaged into the payment for the covered surgical procedure (payment indicator "N1"). Radiology services that we are proposing to pay based on the ASC standard ratesetting methodology are assigned payment indicator "Z2" (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight) and those for which the proposed payment is based on the MPFS non-facility PE RVU amount are assigned payment indicator "Z3" (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS non-facility PE RVUs).

All covered ancillary services and their proposed payment indicators are listed in Addendum BB to this proposed rule.

E. New Technology Intraocular Lenses (NTIOLs)

1. Background

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68176), we finalized our current process for reviewing applications to establish new active classes of new technology intraocular lenses (NTIOLs) and for recognizing new candidate intraocular lenses (IOLs) inserted during or subsequent to cataract extraction as belonging to a NTIOL class that is qualified for a payment adjustment. Specifically, we established the following process:

- We announce annually in the **Federal Register** a 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. In accordance with section 141(b)(3) of Public Law 103–432 and our regulations at § 416.185(b), the deadline for receipt of public comments is 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—

° Provide a list of determinations made as a result of our review of all new class requests and public comments; and

° Announce the deadline for submitting requests for review of an application for a new NTIOL class for the following calendar year.

In determining whether a lens belongs to a new class of NTIOLs and whether the ASC payment amount for insertion of that lens in conjunction with cataract surgery is appropriate, we expect that the insertion of the candidate IOL would result in significantly improved clinical outcomes compared to currently available IOLs. In addition, to establish a new NTIOL class, the candidate lens must be distinguishable from lenses already approved as members of active or expired classes of NTIOLs that share a predominant characteristic associated with improved clinical outcomes that was identified for each class. Furthermore, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68227), we finalized our proposal to base our determinations on consideration of the following factors set out at § 416.195:

• 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; and

• 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 we consider 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; and/or

○ 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, other quantifiable symptom or vision deficiency.

For a request to be considered complete, we require submission of the information that is found in the guidance document entitled "Application Process and Information Requirements for Requests for a New Class of New Technology Intraocular Lens (NTIOL)" posted on the CMS Web site at: *http://www.cms.gov/ASCPayment/08_NTIOLs.asp#TopOfPage.*

As we stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68180), there are three possible outcomes from our review of a request for establishment of a new NTIOL class. As appropriate, for each completed request for consideration of a candidate IOL into a new class that is received by the established deadline, one of the following determinations is 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 candidate IOL for 5 full years as a member of a new NTIOL class described by a new HCPCS code;

• The request for a payment adjustment is approved for the candidate IOL for the balance of time remaining as a member of an active NTIOL class; or

• The request for a payment adjustment is not approved.

We also discussed our plan to summarize briefly in the final rule with comment period the evidence that we reviewed, the public comments, and the basis for our determinations in consideration of applications for establishment of a new NTIOL class. We established that when a new NTIOL class is created, we 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 that 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.

2. NTIOL Application Process for Payment Adjustment

In CY 2007, we posted an updated guidance document to the CMS Web site to provide process and information requirements for applications requesting a review of the appropriateness of the payment amount for insertion of an IOL to ensure that the ASC payment for covered surgical procedures includes payment that is reasonable and related to the cost of acquiring a lens that is approved as belonging to a new class of NTIOLs. This guidance document can be accessed on the CMS Web site at: *http://www.cms.gov/ASCPayment/downloads/NTIOLprocess.pdf.*

We note that we have also issued a guidance document entitled "Revised Process for Recognizing Intraocular Lenses Furnished by Ambulatory Surgery Centers (ASCs) as Belonging to an Active Subset of New Technology Intraocular Lenses (NTIOLs)." This guidance document can be accessed on the CMS Web site at: *http://www.cms.gov/ASCPayment/Downloads/Request_for_inclusion_in_current_NTIOL_subset.pdf.*

This second guidance document provides specific details regarding requests for recognition of IOLs as belonging to an existing, active NTIOL class, the review process, and information required for a request to review. Currently, there is one active NTIOL class whose defining characteristic is the reduction of spherical aberration. We accept requests throughout the year to review the appropriateness of recognizing an IOL as a member of an active class of NTIOLs. That is, review of candidate lenses for membership in an existing, active NTIOL class is ongoing and not limited to the annual review process that applies to the establishment of new NTIOL classes. We ordinarily complete the review of such a request within 90 days of receipt of all information that we consider pertinent to our review, and upon completion of our review, we notify the requestor of our determination and post on the CMS Web site notification of a lens newly approved for a payment adjustment as an NTIOL belonging to an active NTIOL class when furnished in an ASC.

3. Classes of NTIOLs Approved and New Requests for Payment Adjustment

a. Background

Since implementation of the process for adjustment of payment amounts for NTIOLs that was established in the June 16, 1999 **Federal Register**, we have approved three classes of NTIOLs, as shown in the following table, with the associated qualifying IOLs to date:

NTIOL Class	HCPCS Code	$50 Approved for Services Furnished On or After	NTIOL Characteristic	IOLs Eligible for Adjustment
1	Q1001	May 18, 2000, through May 18, 2005	Multifocal	Allergan AMO Array Multifocal lens, model SA40N
2	Q1002	May 18, 2000, through May 18, 2005	Reduction in Preexisting Astigmatism	STAAR Surgical Elastic Ultraviolet-Absorbing Silicone Posterior Chamber IOL with Toric Optic, models AA4203T, AA4203TF, and AA4203TL
3	Q1003	February 27, 2006, through February 26, 2011	Reduced Spherical Aberration	Advanced Medical Optics (AMO) Tecnis® IOL models Z9000, Z9001, Z9002, ZA9003, and AR40xEM and Tecnis® 1-Piece model ZCB00; Alcon Acrysof® IQ Model SN60WF, Acrysert Delivery System model SN60WS and Acrysof ® IQ Toric model SN6ATT; Bausch & Lomb Sofport AO models LI61AO and LI61AOV and Akreos AO models AO60 and MI60, Crystalens® AT-50AO and AT-52AO; STAAR Affinity Collamer model CQ2015A and CC4204A and Elastimide model AQ2015A; Hoya model FY-60AD, FC-60AD, PY-60AD, and PC-60AD

b. Request to Establish New NTIOL Class for CY 2010 and Deadline for Public Comment

As explained in the guidance document on the CMS Web site, the deadline for each year's requests for review of the appropriateness of the ASC payment amount for insertion of a candidate IOL as a member of a new class of NTIOLs is announced in the final rule updating the ASC and OPPS payment rates for that calendar year. Therefore, a request for review for a new class of NTIOLs for CY 2011 must have been submitted to CMS by March 8, 2010, the due date published in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60621). We received one request for review to establish a new NTIOL class for CY 2011 by the March 8, 2010 due date. A summary of this request follows.

Requestor/Manufacturer: Alcon Laboratories, Inc.

Lens Model Number: Acrysof® Natural IOLs, Models: SN60WF, SN60AT, MN60MA, and MN60AC.

Summary of the Request: Alcon Laboratories, Inc. (Alcon) submitted a request for CMS to determine that its Acrysof® Natural intraocular lenses meet the criteria for recognition as NTIOL and to concurrently establish a new class of NTIOLs for blue light filtering to improve driving safety under glare conditions, with these lenses as members. As part of its request, Alcon submitted descriptive information about the candidate IOLs as outlined in the guidance document that we make available on the CMS Web site for the establishment of a new class of NTIOLs, as well as information regarding approval of the candidate IOL by the

U.S Food and Drug Administration (FDA). This information included the approved labeling for the candidate lenses, a summary of the IOLs' safety and effectiveness, a copy of the FDA's approval notification, and instructions for their use. In addition, Alcon also submitted a number of studies in support of its claim that the blue light filtering design features of the candidate lenses would improve driving safety under glare conditions. We note that we have previously considered another candidate IOL for which ASC payment review was requested on the basis of blue light filtering properties. We discussed these lenses in the July 23, 2004 and March 25, 2005 NTIOL proposed and final rules published in the **Federal Register** (69 FR 44029 and 70 FR 15337, respectively).

In its CY 2011 request, Alcon asserts that its request is based on new research and measurement technologies that demonstrate that the Acrysof® Natural IOLs with a blue light filtering chromophore filter light in a manner that approximates the human crystalline lens in the 400–475 nm blue light wavelength range to reduce glare that impairs the ability of the eye to differentiate objects from the background. Alcon further states that glare reduction can help beneficiaries avoid hazards that can be caused by glare. Alcon also states that at present, there are no active or expired NTIOL classes that describe IOLs similar to its IOL.

We established in the CY 2007 OPPS/ASC final rule with comment period that when reviewing a request for recognition of an IOL as an NTIOL and a concurrent request to establish a new class of NTIOLs, we would base our determination on consideration of the three major criteria that are outlined in the discussion above. We have begun our review of Alcon's request to recognize its Acrysof® Natural IOLs as NTIOLs and concurrently establish a new class of NTIOLs. We are soliciting public comment on these candidate IOLs with respect to the established NTIOL criteria as discussed above.

First, for an IOL to be recognized as an NTIOL we require that 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. We note that FDA approval for the candidate lens was granted in May 2007 and that Alcon provided FDA approval documentation, including a copy of the FDA's approval notification, the FDA's summary of the IOL's safety and effectiveness, and the labeling approved by the FDA in its request for a new class of NTIOLs. The approved labels for the Alcon IOLs all state, "Alcon's proprietary blue light filtering chromophore filters light in a manner that approximates the human crystalline lens in the 400–475 nm blue light wavelength range." The FDA label does not otherwise reference specific clinical benefits or lens characteristics of blue light filtering on glare. We are interested in public comments on the specific clinical benefits or lens characteristics with established clinical relevance for the blue light filter effects on glare. Specifically, we are interested in public comments regarding the assertion that the specific blue light filter properties associated with the candidate IOLs improve driving safety via the reduction of glare.

Second, we also require that the candidate IOL not be 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. As noted in the table above regarding active and expired NTIOL classes, since implementation of the NTIOL review process that was established in the June 16, 1999 **Federal Register**, we have approved three classes of NTIOLs: Multifocal and Reduction in Preexisting Astigmatism classes, both of which were created in 2000 and expired in 2005, and the currently active Reduced Spherical Aberration class, which was created in 2006 and will expire in 2011. The class-defining characteristic specific to IOLs that are members of these classes is evident in the name assigned to the class. For example, IOLs recognized as members of the reduced spherical aberration class are characterized by their aspheric design that results in reduced spherical aberration. We refer readers to the table above for information about the NTIOL classes that have been created since the implementation of the review process. Based on this information, the candidate lens may not be described by an active or expired NTIOL class. Its proposed class-defining characteristic and associated clinical benefits that were described in the submitted request, specifically the blue light filtering properties, may not be similar to the class-defining characteristics and associated benefits of the two expired NTIOL classes, the Multifocal and Reduction in Preexisting Astigmatism classes, or to the class-defining characteristic and associated benefits of the currently active Reduced Spherical Aberration class. We welcome public comments that address whether the proposed class-defining characteristic and associated clinical benefits of the candidate Alcon IOLs are described by the expired or currently active NTIOL classes.

Third, our NTIOL evaluation criteria also require that an applicant submit evidence demonstrating that use of the IOL results in measurable, clinically meaningful, improved outcomes in comparison to use of currently available IOLs. We note that in the CY 2007 OPPS/ASC final rule with comment period, we sought comments as to what constitutes currently available IOLs for purposes of such comparisons, and we received several comments in response to our solicitation (71 FR 68178). We agreed with commenters that we should remain flexible with respect to our view of "currently available lenses" for purposes of reviewing NTIOL requests, in order to allow for consideration of technological advances in lenses over time. For purposes of reviewing this request to establish a new NTIOL class for CY 2011, we believe that foldable, spherical, monofocal IOLs made of acrylic, silicone, or polymethylmethacrylate materials represent the currently available lenses against which the candidate NTIOL to establish a new class should be compared. The Alcon request asserts that the proprietary blue light filtering chromophore incorporated into the design of the candidate lenses and asserted associated benefits makes them different from IOLs that are currently available in the U.S. market. We are again seeking public comment on our view of "currently available lenses" for the purposes of this CY 2011 review.

We reviewed the evidence submitted as part of the request, including two peer-reviewed articles and two related clinical studies. The first of the submitted articles discussed the effect of the candidate lenses on glare disability, while the second article discussed the effects of glare on driving in simulated driving conditions. The requestor also submitted data from two clinical studies directly related to the submitted articles discussed above. One cross sectional study with a planned sample size of 70 subjects evaluated glare disability by comparing the candidate lenses against control lenses which did not include the blue light filtering chromophore. Results from this study suggest that subjects implanted with the applicant IOLs had significantly faster photostress recovery times than subjects who had control IOLs implanted without the blue light filtering chromophore. We note that this

cross sectional study is ongoing; consequently the preliminary results submitted with the request only reflect 40 subjects from the planned total sample size. The requestor also submitted data from a second clinical study with a total sample size of 34 that evaluated the benefit of the blue light filtering chromophore on driving performance in patients implanted with the candidate IOLs compared to patients implanted with non blue light filtering IOLs. The results from this study suggested that incorporation of the yellow chromophore into the design of the candidate lenses reduce glare disability and thereby improve the ability of older drivers implanted with the candidate lenses to drive safely. Overall, the evidence submitted provides us with important information that is critical to our review of this request. However, in making our decision as to whether to establish a new class of NTIOL based on the primary characteristic of the candidate lenses, we are also interested in what other information the public can contribute related to the asserted benefits of the blue light filtering optic. Specifically, we are seeking public comment and relevant data on the following:

- Are there other peer-reviewed data that would support or disprove the claims of clinical benefit made by the applicant?
- The presented studies compare the blue filtering optic to clear IOLs, are there other IOLs or other clinical alternatives for reducing glare?
- Is the sample size used in both studies sufficient considering all confounding variables including, but not limited to age, sex, race, time from surgery, status of eyes (which eye received the IOL or both eyes, for example) to conclude that a blue light filtering optic would reduce glare in the Medicare population?
- What kind of study design would be appropriate to prove the claim of significant clinical benefit due to glare reduction on which the new class would be based?
- Are the submitted data enough to clarify that the blue filtering optic is responsible for reduction in glare disability as asserted by applicant?

We welcome public comments and relevant data specifically addressing whether use of the Alcon Acrysof® Natural IOLs result in measurable, clinically meaningful, improved outcomes in comparison with use of currently available IOLs. Additionally, in accordance with our established NTIOL review process, we are seeking public comments on all of the review criteria for establishing a new NTIOL class that would be based on the ability of the Acrysof® Natural IOLs to filter blue light and subsequently help beneficiaries avoid hazards that can be caused by glare while driving. All comments on this request must be received by September 2, 2010. The announcement of CMS's determination regarding this request will appear in the CY 2011 OPPS/ASC final rule with comment period. If a determination of membership of the candidate lens in a new or currently active NTIOL class is made, this determination will be effective 30 days following the date that the final rule with comment period is published in the **Federal Register**.

4. Proposed Payment Adjustment

The current payment adjustment for a 5-year period from the implementation date of a new NTIOL class is $50. In the CY 2007 OPPS/ASC final rule with comment period, we revised § 416.200(a) through (c) to clarify how the IOL payment adjustment is made and how an NTIOL is paid after expiration of the payment adjustment, and made minor editorial changes to § 416.200(d). For CY 2008, CY 2009, and CY 2010, we did not revise the payment adjustment amount, and we are not proposing to revise the payment adjustment amount for CY 2011 in light of our limited experience with the revised ASC payment system, implemented initially on January 1, 2008.

5. Proposed ASC Payment for Insertion of IOLs

In accordance with the final policies of the revised ASC payment system, for CY 2011, payment for IOL insertion procedures is established according to the standard payment methodology of the revised payment system, which multiplies the ASC conversion factor by the ASC payment weight for the surgical procedure to implant the IOL. CY 2011 ASC payment for the cost of a conventional lens is packaged into the payment for the associated covered surgical procedures performed by the ASC. The HCPCS codes for IOL insertion procedures were included in Table 53 below, and their proposed CY 2011 payment rates may be found in Addendum AA to this proposed rule.

TABLE 53.--INSERTION OF IOL PROCEDURES

CY 2010 HCPCS Code	CY 2010 Long Descriptor
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
66986	Exchange of intraocular lens

F. Proposed ASC Payment and Comment Indicators

1. Background

In addition to the payment indicators that we introduced in the August 2, 2007 final rule, we also created final comment indicators for the ASC payment system in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66855). We created Addendum DD1 to define ASC payment indicators that we use in Addenda AA and BB to provide payment information regarding covered surgical procedures and covered ancillary services, respectively, under the revised ASC payment system. The ASC payment indicators in Addendum DD1 are intended to capture policy-relevant characteristics of HCPCS codes that may receive packaged or separate payment in ASCs, such as whether they were on the ASC list of covered services prior to CY 2008; payment designation, such as device-intensive or office-based and the corresponding ASC payment methodology; and their classification as separately payable ancillary services including radiology services, brachytherapy sources, OPPS pass-through devices, corneal tissue acquisition services, drugs or biologicals, or NTIOLs.

We also created Addendum DD2 that lists the ASC comment indicators. The ASC comment indicators used in Addenda AA and BB to the proposed rules and final rules with comment period serve to identify, for the revised ASC payment system, the status of a specific HCPCS code and its payment indicator with respect to the timeframe when comments will be accepted. The comment indicator "NI" is used in the OPPS/ASC final rule with comment period to indicate new HCPCS codes for the next calendar year for which the interim payment indicator assigned is subject to comment. The comment indicator "NI" is also assigned to existing codes with substantial revisions to their descriptors such that we consider them to be describing new services, as discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60622). We will respond to public comments and finalize the ASC treatment of all codes labeled with comment indicator "NI" in the CY 2011 OPPS/ASC final rule with comment period.

The "CH" comment indicator is used in Addenda AA and BB to this CY 2011 proposed rule to indicate that a new payment indicator (in comparison with the indicator for the CY 2010 ASC April quarterly update) is proposed for assignment to an active HCPCS code for the next calendar year; an active HCPCS code is proposed for addition to the list of procedures or services payable in ASCs; or an active HCPCS code is proposed for deletion at the end of the current calendar year. The "CH" comment indicators that are published in the final rule with comment period are provided to alert readers that a change has been made from one calendar year to the next, but do not indicate that the change is subject to comment. The full definitions of the payment indicators and comment indicators are provided in Addenda DD1 and DD2 to this proposed rule.

2. Proposed ASC Payment and Comment Indicators

We are not proposing any changes to the definitions of the ASC payment and comment indicators for CY 2011. We will consider proposing to modify the payment indicators for procedures that were subject to transitional payment prior to CY 2011 in future rulemaking. We refer readers to Addenda DD1 and DD2 to this proposed rule for the complete list.

G. ASC Policy and Payment Recommendations

MedPAC was established under section 1805 of the Act to advise Congress on issues affecting the Medicare program. Subparagraphs (B), (C), and (D) of sections 1805(b)(1 of the Act require MedPAC to submit reports to Congress not later than March 1 and June 15 of each year that present its Medicare payment policy reviews and recommendations. The following section describes a recent MedPAC recommendation that is relevant to the ASC payment system.

The March 2010 MedPAC "Report to the Congress: Medicare Payment Policy" included the following recommendation relating specifically to the ASC payment system for CY 2011:

Recommendation 2C: The Congress should implement a 0.6 percent increase in payment rates for ambulatory surgical center services in calendar year 2011 concurrent with requiring ambulatory surgical centers to submit cost and quality data.

CMS Response: In the August 2, 2007 final rule (72 FR 42518 through 42519), we adopted a policy to update the ASC conversion factor for consistency with section 1833(i)(2)(C) of the Act, which requires that, if the Secretary has not updated the ASC payment amounts in a calendar year, the payment amounts shall be increased by the percentage increase in the Consumer Price Index for All Urban Consumers (CPI–U) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. The statute set the update at zero for CY 2008 and CY 2009. We indicated that we planned to implement the annual updates through an adjustment to the conversion factor under the ASC payment system beginning in CY 2010 when the statutory requirement for a zero update no longer applies. Further, we noted that that we would update the conversion factor for the CY 2010 ASC payment system by the percentage increase in the CPI–U, consistent with our policy as codified under § 416.171(a)(2).

As we indicated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60622), we did not require ASCs to submit cost data to the Secretary for CY 2010. We explained that the 2006 GAO report, "Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System" (GAO–07–86), concluded that the APC groups in the OPPS reflect the relative costs of surgical procedures performed in ASCs in the same way they reflect the relative costs of the same procedures when they are performed in HOPDs. Consistent with the GAO findings, CMS is using the OPPS as the basis for the ASC payment system, which provides for an annual revision of the ASC payment rates under the budget neutral ASC payment system. In addition, we noted that, under the methodology of the revised ASC payment system, we do not utilize ASC cost information to set and revise the payment rates for ASCs but, instead, rely on the relativity of hospital outpatient costs developed for the OPPS, consistent with the recommendation of the GAO. Furthermore, we explained that we have never required ASCs to routinely submit cost data and expressed our concern that a new Medicare requirement for ASCs to do so could be administratively burdensome for ASCs. In 2009, MedPAC made a similar recommendation to that made in Recommendation 2C above. In light of that MedPAC recommendation, in the CY 2010 OPPS/ASC proposed rule (74 FR 35391), we solicited public comment on the feasibility of ASCs submitting cost information to CMS, including whether costs should be collected from a sample or the universe of ASCs, the administrative burden associated with such an activity, the form that such a submission could take considering existing Medicare requirements for other types of facilities and the scope of ASC services, the expected accuracy of such cost information, and any other issues or

concerns of interest to the public on this topic.

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60623), we summarized and responded to these comments. As noted in that final rule with comment period, commenters' expressed varied opinions regarding the feasibility of requiring ASCs to submit cost data to the Secretary. Some commenters believed that requiring ASC to submit such data would not be an insurmountable obstacle and pointed out that other small facilities submit cost reports to CMS. They stated that ASC cost reports are necessary to assess the adequacy of Medicare payments and evaluate the ASC update. Other commenters, however, opposed the requirement that ASCs submit cost data to CMS because they believed such a requirement would be unnecessary and administratively burdensome. Commenters generally supported a requirement that ASCs report quality data. We refer readers to the CY 2010 OPPS/ASC final rule with comment period for a full discussion of the comments we received on the feasibility of requiring ASCs to report cost and quality data (74 FR 60623). We responded that we would keep the commenters' perspectives in mind as we further consider the adequacy of the Medicare ASC payment rates and move toward implementation of ASC quality reporting.

Consistent with our CY 2010 policy, we are proposing not to require ASCs to submit cost data to the Secretary for CY 2011. We continue to believe that our established methodology results in appropriate payment rates for ASCs. As noted in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60623), section 109(b) of the MIEA–TRHCA (Pub. L. 109–432) gives the Secretary the authority to implement ASC quality measure reporting and to reduce the payment update for ASCs that fail to report those required measures. We restate our belief that promoting high quality care in the ASC setting through quality reporting is highly desirable and fully in line with our efforts under other payment systems. As discussed in section XVI.H. of this proposed rule, we are proposing not to require ASC quality data reporting for CY 2011, but our intention is to implement ASC quality reporting in a future rulemaking.

Section 3006(f) of the Affordable Care Act, as added by section 10301(a) of the Affordable Care Act, requires CMS to develop a plan on implementing a value-based purchasing program for ASCs that will consider measures of quality and efficiency in ASCs, among other requirements. The Secretary must submit a report to Congress containing this plan not later than January 1, 2011.

H. Calculation of the ASC Conversion Factor and ASC Payment Rates

1. Background

In the August 2, 2007 final rule (72 FR 42493), we established our policy to base ASC relative payment weights and payment rates under the revised ASC payment system on APC groups and relative payment weights. Consistent with that policy and the requirement at section 1833(i)(2)(D)(ii) of the Act that the revised payment system be implemented so that it would be budget neutral, the initial ASC conversion factor (CY 2008) was calculated so that estimated total Medicare payments under the revised ASC payment system in the first year would be budget neutral to estimated total Medicare payments under the prior (CY 2007) ASC payment system. That is, application of the ASC conversion factor was designed to result in aggregate Medicare expenditures under the revised ASC payment system in CY 2008 equal to aggregate Medicare expenditures that would have occurred in CY 2008 in the absence of the revised system, taking into consideration the cap on ASC payments in CY 2007 as required under section 1833(i)(2)(E) of the Act (72 FR 42522).

We note that we consider the term "expenditures" in the context of the budget neutrality requirement under section 1833(i)(2)(D)(ii) of the Act to mean expenditures from the Medicare Part B Trust Fund. We do not consider expenditures to include beneficiary coinsurance and copayments. This distinction was important for the CY 2008 ASC budget neutrality model that considered payments across hospital outpatient, ASC, and MPFS payment systems. However, because coinsurance is almost always 20 percent for ASC services, this interpretation of expenditures has minimal impact for subsequent budget neutrality adjustments calculated within the revised ASC payment system.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66857 through 66858), we set out a step-by-step illustration of the final budget neutrality adjustment calculation based on the methodology finalized in the August 2, 2007 final rule (72 FR 42521 through 42531) and as applied to updated data available for the CY 2008 OPPS/ASC final rule with comment period. The application of that methodology to the data available for the CY 2008 OPPS/ASC final rule with comment period resulted in a budget neutrality adjustment of 0.65.

For CY 2008, we adopted the OPPS relative payment weights as the ASC relative payment weights for most services and, consistent with the final policy, we calculated the CY 2008 ASC payment rates by multiplying the ASC relative payment weights by the final CY 2008 ASC conversion factor of $41.401. For covered office-based surgical procedures and covered ancillary radiology services, the established policy is to set the relative payment weights so that the national unadjusted ASC payment rate does not exceed the MPFS unadjusted non-facility PE RVU amount. Further, as discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66841 through 66843), we also adopted alternative rate setting methodologies for specific types of services (for example, device-intensive procedures).

As discussed in the August 2, 2007 final rule (72 FR 42518) and as codified under § 416.172(c) of the regulations, the revised ASC payment system accounts for geographic wage variation when calculating individual ASC payments by applying the pre-floor and pre-reclassified hospital wage indices to the labor-related share, which is 50 percent of the ASC payment amount. Beginning in CY 2008, CMS accounted for geographic wage variation in labor cost when calculating individual ASC payments by applying the pre-floor and pre-reclassified hospital wage index values that CMS calculates for payment, using updated Core Based Statistical Areas (CBSAs) issued by the Office of Management and Budget in June 2003. The reclassification provision provided at section 1886(d)(10) of the Act is specific to hospitals. We believe the use of the most recent available raw pre-floor and pre-reclassified hospital wage indices results in the most appropriate adjustment to the labor portion of ASC costs. In addition, use of the unadjusted hospital wage data avoids further reductions in certain rural statewide wage index values that result from reclassification. We continue to believe that the unadjusted hospital wage indices, which are updated yearly and are used by many other Medicare payment systems, appropriately account for geographic variation in labor costs for ASCs.

We note that in certain instances there might be urban or rural areas for which there is no IPPS hospital whose wage index data would be used to set the wage index for that area. For these areas, our policy has been to use the average of the wage indices for CBSAs (or metropolitan divisions as applicable)

that are contiguous to the area that has no wage index (where "contiguous" is defined as sharing a border). We have applied a proxy wage index based on this methodology to ASCs located in CBSA 25980 Hinesville-Fort Stewart, GA, and CBSA 22 Rural Massachusetts. For CY 2011, we have identified another area, specifically, CBSA 11340 Anderson, SC for which there is no IPPS hospital whose wage index data would be used to set the wage index for that area. Generally, we would use the methodology described above; however in this situation all of the areas contiguous to CBSA 11340 Anderson, SC are rural. Therefore, for this type of unique situation, we are proposing to set the ASC wage index by calculating the average of all wage indices for urban areas in the state. In other situations, where there are no IPPS hospitals located in a relevant labor market area, we would continue our current policy of calculating an urban or rural area's wage index by calculating the average of the wage indices for CBSAs (or metropolitan divisions where applicable) that are contiguous to the area with no wage index.

2. Proposed Calculation of the ASC Payment Rates

a. Updating the ASC Relative Payment Weights for CY 2011 and Future Years

We update the ASC relative payment weights each year using the national OPPS relative payment weights (and MPFS non-facility PE RVU amounts, as applicable) for that same calendar year and uniformly scale the ASC relative payment weights for each update year to make them budget neutral (72 FR 42531 through 42532). Consistent with our established policy, we are proposing to scale the CY 2011 relative payment weights for ASCs according to the following method. Holding ASC utilization and the mix of services constant from CY 2008 for CY 2011, we are proposing to compare the total payment weight using the CY 2010 ASC relative payment weights under the 75/25 blend (of the CY 2007 payment rate calculated under the ASC standard ratesetting methodology and the ASC payment rate calculated under the ASC standard methodology) with the total payment weight using the CY 2011 ASC relative payment weights (calculated under the ASC standard rate setting methodology) to take into account the changes in the OPPS relative payment weights between CY 2010 and CY 2011. We would use the ratio of CY 2010 to CY 2011 total payment weight (the weight scaler) to scale the ASC relative payment weights for CY 2011. The proposed CY 2011 ASC scaler is 0.9090 and scaling would apply to the ASC relative payment weights of the covered surgical procedures and covered ancillary radiology services for which the ASC payment rates are based on OPPS relative payment weights.

Scaling would not apply in the case of ASC payment for separately payable covered ancillary services that have a predetermined national payment amount (that is, their national ASC payment amounts are not based on OPPS relative payment weights), such as drugs and biologicals that are separately paid or services that are contractor-priced or paid at reasonable cost in ASCs. Any service with a predetermined national payment amount would be included in the ASC budget neutrality comparison, but scaling of the ASC relative payment weights would not apply to those services. The ASC payment weights for those services without predetermined national payment amounts (that is, those services with national payment amounts that would be based on OPPS relative payment weights if a payment limitation did not apply) would be scaled to eliminate any difference in the total payment weight between the current year and the update year.

For any given year's ratesetting, we typically use the most recent full calendar year of claims data to model budget neutrality adjustments. We currently have available 98 percent of CY 2009 ASC claims data. To create an analytic file to support calculation of the weight scaler and budget neutrality adjustment for the wage index (discussed below), we summarized available CY 2009 ASC claims by provider and by HCPCS code. We created a unique supplier identifier solely for the purpose of identifying unique ASCs within the CY 2009 claims data. We used the supplier zip code reported on the claim to associate State, county, and CBSA with each ASC. This file, available to the public as a supporting data file for this proposed rule, is posted on the CMS Web site at: *http://www.cms.gov/ASCPayment/01_Overview.asp#TopOfPage*.

b. Updating the ASC Conversion Factor

Under the OPPS, we typically apply a budget neutrality adjustment for provider-level changes, most notably a change in the wage index values for the upcoming year, to the conversion factor. Consistent with our final ASC payment policy, for the CY 2011 ASC payment system, we are proposing to calculate and apply the pre-floor and pre-reclassified hospital wage indices that are used for ASC payment adjustment to the ASC conversion factor, just as the OPPS wage index adjustment is calculated and applied to the OPPS conversion factor (73 FR 41539). For CY 2011, we calculated this proposed adjustment for the ASC payment system by using the most recent CY 2009 claims data available and estimating the difference in total payment that would be created by introducing the CY 2011 pre-floor and pre-reclassified hospital wage indices. Specifically, holding CY 2009 ASC utilization and service-mix and CY 2010 national payment rates after application of the weight scaler constant, we calculated the total adjusted payment using the CY 2010 pre-floor and pre-reclassified hospital wage indices and the total adjusted payment using the proposed CY 2011 pre-floor and pre-reclassified hospital wage indices. We used the 50-percent labor-related share for both total adjusted payment calculations. We then compared the total adjusted payment calculated with the CY 2010 pre-floor and pre-reclassified hospital wage indices to the total adjusted payment calculated with the proposed CY 2011 pre-floor and pre-reclassified hospital wage indices and applied the resulting ratio of 1.0006 (the proposed CY 2011 ASC wage index budget neutrality adjustment) to the CY 2010 ASC conversion factor to calculate the proposed CY 2011 ASC conversion factor.

Section 1833(i)(2)(C) of the Act requires that, if the Secretary has not updated the ASC payment amounts in a calendar year, the payment amounts shall be increased by the percentage increase in the CPI–U as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. Because the Secretary does update the ASC payment amounts annually, we adopted a policy, which we codified at § 416.171(a)(2)(ii), to update the ASC conversion factor using the CPI–U for CY 2010 and subsequent calendar years. Therefore, the annual update to the ASC payment system is the CPI–U (referred to as the CPI–U update factor). Section 3401(k) of the Affordable Care Act amends section 1833(i)(2)(D) of the Act by adding a new clause (v) which requires that "any annual update under [the ASC payment] system for the year * * * shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)" (which we refer to as the MFP adjustment) effective with the calendar year beginning January 1, 2011. Section 3401(k) of the Affordable Care Act states that application of the MFP adjustment to the ASC payment

system may result in the update to the ASC payment system being less than zero for a year and may result in payment rates under the ASC payment system for a year being less than such payment rates for the preceding year. We are proposing to revise § 416.160 and § 416.171 to reflect this provision of the Affordable Care Act.

In accordance with section 1833(i)(2)(C)(i) of the Act, before applying the MFP adjustment, the Secretary first determines the "percentage increase" in the CPI–U, which we interpret cannot be a negative number. Thus, in the instance where the percentage change in the CPI–U for a year is negative, we are proposing to hold the CPI–U update factor for the ASC payment system to zero. Section 1833(i)(2)(D)(v) of the Act, as added by section 3401(k) of the Affordable Care Act, then requires that the Secretary reduce the CPI–U update factor (which would be held to zero if the CPI–U percentage change is negative) by the MFP adjustment, and states that application of the MFP adjustment may reduce this percentage change below zero. If the application of the MFP adjustment to the CPI–U percentage increase would result in a MFP-adjusted CPI–U update factor that is less than zero, then the annual update to the ASC payment rates would be negative and payments would decrease relative to the prior year.

Table 54 provides illustrative examples of how the MFP would be applied to the ASC payment system. These examples show the implication of a positive CPI–U update factor with a small MFP, a positive CPI–U update factor with a large MFP adjustment, and a CPI–U update factor of 0. We discuss in greater detail the methodology for calculating the MFP for the ASC payment system and the other payment systems affected by the MFP adjustment (found in section 1886(b)(3)(B)(xi)(II) of the Act, as added by section 3401(a) of the Affordable Care Act) in the CY 2011 MPFS proposed rule. Comments on the specific mathematical calculation of the MFP should be made to that proposed rule. Comments on the application of the MFP to the CPI–U update factor under the ASC payment system should be made to this proposed rule.

TABLE 54: MULTIFACTOR PRODUCTIVITY ADJUSTED PAYMENT UPDATE: ILLUSTRATIVE EXAMPLES

CPI-U (Percent)	MFP (Percent)	MFP- Adjusted CPI-U Update Factor (Percent)
4.0	1.3	2.7
4.0	4.7	-0.7
0.0	0.2	-0.2

NOTE: Numbers may not sum due to rounding.

For this proposed rule, for the 12-month period ending with the midpoint of CY 2011, the Secretary estimates that the CPI–U is 1.6 percent. The Secretary estimates that the MFP adjustment is 1.6. As discussed in the CY 2011 MPFS proposed rule, we are proposing to reduce the CPI–U of 1.6 percent by the MFP adjustment specific to this CPI–U, resulting in an MFP-adjusted CPI–U updated factor of 0 percent. Therefore, we are proposing to apply to the ASC conversion factor a 0 percent MFP-adjusted update.

For CY 2011, we also are proposing to adjust the CY 2010 ASC conversion factor ($41.873) by the wage adjustment for budget neutrality of 1.0006 in addition to the MFP-adjusted update factor of 0 discussed above, which results in a proposed CY 2011 ASC conversion factor of $41.898.

3. Display of Proposed ASC Payment Rates

Addenda AA and BB to this proposed rule display the proposed updated ASC payment rates for CY 2011 for covered surgical procedures and covered ancillary services, respectively. These addenda contain several types of information related to the proposed CY 2011 payment rates. Specifically, in Addendum AA, a "Y" in the column titled "Subject to Multiple Procedure Discounting" indicates that the surgical procedure would be subject to the multiple procedure payment reduction policy. As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66829 through 66830), most covered surgical procedures are subject to a 50-percent reduction in the ASC payment for the lower-paying procedure when more than one procedure is performed in a single operative session. Display of the comment indicator "CH" in the column titled "Comment Indicator" indicates a proposed change in payment policy for the item or service, including identifying discontinued HCPCS codes, designating items or services newly payable under the ASC payment system, and identifying items or services with changes in the ASC payment indicator for CY 2011.

The values displayed in the column titled "CY 2011 Payment Weight" are the proposed relative payment weights for each of the listed services for CY 2011. The payment weights for all covered surgical procedures and covered ancillary services whose ASC payment rates are based on OPPS relative payment weights are scaled for budget neutrality. Thus, scaling was not applied to the device portion of the device intensive procedures, services that are paid at the MPFS nonfacility PE RVU amount, separately payable covered ancillary services that have a predetermined national payment amount, such as drugs and biologicals that are separately paid under the OPPS, or services that are contractor-priced or paid at reasonable cost in ASCs.

To derive the proposed CY 2011 payment rate displayed in the "CY 2011 Payment" column, each ASC payment weight in the "CY 2011 Payment Weight" column is multiplied by the proposed CY 2011 conversion factor of $41.898. The conversion factor includes a budget neutrality adjustment for changes in the wage index values and the CPI–U update factor as reduced by the productivity adjustment (as discussed in section XV.H.2.b. of this proposed rule).

In Addendum BB, there are no relative payment weights displayed in the "CY 2011 Payment Weight" column for items and services with predetermined national payment

amounts, such as separately payable drugs and biologicals. The "CY 2011 Payment" column displays the proposed CY 2011 national unadjusted ASC payment rates for all items and services. The proposed CY 2011 ASC payment rates listed in the Addendum AA for separately payable drugs and biologicals are based on ASP data used for payment in physicians' offices in April 2010.

XVI. Reporting Quality Data for Annual Payment Rate Updates

A. Background

1. Overview

CMS has implemented quality measure reporting programs for multiple settings of care. These programs promote higher quality, more efficient health care for Medicare beneficiaries. The quality data reporting program for hospital outpatient care, known as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), has been generally modeled after the program for hospital inpatient services, the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. Both of these quality reporting programs for hospital services, as well as the program for physicians and other eligible professionals, known as the Physician Quality Reporting Initiative (PQRI), have financial incentives for the reporting of quality data to CMS. CMS also has implemented quality reporting programs for home health agencies and skilled nursing facilities that are based on conditions of participation, and an end-stage renal disease quality reporting program that is based on conditions for coverage.

2. Hospital Outpatient Quality Data Reporting Under Section 109(a) of MIEA–TRHCA

Section 109(a) of the MIEA–TRHCA (Pub. L. 109–432) amended section 1833(t) of the Act by adding a new paragraph (17) which affects the annual payment update factor applicable to OPPS payments for services furnished by hospitals in outpatient settings on or after January 1, 2009. Section 1833(t)(17)(A) of the Act states that subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Act) that fail to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act will incur a 2.0 percentage point reduction to their annual payment update factor. Section 1833(t)(17)(B) of the Act requires that hospitals submit quality data in a form and manner, and at a time, that the Secretary specifies. Section 1833(t)(17)(A)(ii) of the Act specifies that any reduction would apply only to the payment year involved and would not be taken into account in computing the applicable annual payment update factor for a subsequent payment year.

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. The National Quality Forum (NQF) is a voluntary consensus standard setting organization that is composed of a diverse representation of consumer, purchaser, provider, academic, clinical, and other health care stakeholder organizations. NQF was established to standardize health care quality measurement and reporting through its consensus development process. We generally prefer to adopt NQF-endorsed measures for CMS quality reporting programs. However, we believe that consensus among affected parties also can be reflected by other means, including: consensus achieved during the measure development process; consensus shown through broad acceptance and use of measures; and consensus through public comment. We also note that section 1833(t)(17) of the Act does not require that each measure we adopt for the HOP QDRP be endorsed by a national consensus building entity, or by the NQF specifically.

Section 1833(t)(17)(C)(ii) of the Act allows the Secretary to "[select] measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1886(b)(3)(B)(viii)" of the Act (the RHQDAPU program). As we stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68758 through 68759), we do not believe that we should, without further analysis, adopt the RHQDAPU program measures as the measures for the HOP QDRP. We continue to believe that it is most appropriate and desirable to adopt measures that specifically apply to the hospital outpatient setting for the HOP QDRP.

Section 1833(t)(17)(D) of the Act gives the Secretary the authority to replace measures or indicators as appropriate, such as when all hospitals are effectively in compliance or when the measures or indicators have been subsequently shown not to represent the best clinical practice. Section 1833(t)(17)(E) of the Act requires the Secretary to establish procedures for making data submitted under the HOP QDRP available to the public. Such procedures include providing hospitals with the opportunity to review their data before these data are released to the public.

3. ASC Quality Data Reporting Under Section 109(b) of MIEA–TRHCA

Section 109(b) of the MIEA–TRHCA amended section 1833(i) of the Act by redesignating clause (iv) as clause (v) and adding new clause (iv) to paragraph (2)(D) and by adding new paragraph (7). Section 1833(i)(2)(D)(iv) of the Act authorizes, but does not require, the Secretary to implement the revised ASC payment system "so as to provide for a reduction in any annual update for failure to report on quality measures" beginning with payment for ASC services furnished on or after January 1, 2009.

Section 1833(i)(7)(A) of the Act states that the Secretary may provide that any ASC that fails to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(i)(7) of the Act will incur a reduction in any annual payment update of 2.0 percentage points. Section 1833(i)(7)(A) of the Act also specifies that a reduction for one year cannot be taken into account in computing the annual ASC payment update for a subsequent year.

Section 1833(i)(7)(B) of the Act provides that, "[e]xcept as the Secretary may otherwise provide," the hospital outpatient quality data provisions of subparagraphs (B) through (E) of section 1833(t)(17) of the Act, summarized above, shall apply to ASCs in a similar manner to the manner in which they apply under these paragraphs to hospitals under the HOP QDRP. We did not implement an ASC quality reporting program for CY 2008 (72 FR 66875) or for CY 2009 (73 FR 68780), or for CY 2010 (74 FR 60656).

We refer readers to section XVI.F. of this proposed rule for further discussion of ASC quality data reporting.

4. HOP QDRP Quality Measures for the CY 2009 Payment Determination

For the CY 2009 annual payment update, we required HOP QDRP reporting using seven quality measures—five Emergency Department (ED) Acute Myocardial Infarction (AMI) Cardiac Care measures and two Surgical Care measures. These measures address care provided to a large number of adult patients in hospital outpatient settings across a diverse set of conditions, and

were selected for the initial set of HOP QDRP measures based on their relevance as a set to all HOPDs.

Specifically, in order for hospitals to receive the full OPPS payment update for services furnished in CY 2009, in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66865 and 66871), we required that subsection (d) hospitals paid under the OPPS submit data on the following seven measures for hospital outpatient services furnished on or after April 1, 2008: (1) ED–AMI–1: Aspirin at Arrival; (2) ED–AMI–2: Median Time to Fibrinolysis; (3) ED–AMI–3: Fibrinolytic Therapy Received within 30 Minutes of Arrival; (4) ED–AMI–4: Median Time to Electrocardiogram (ECG); (5) ED–AMI–5: Median Time to Transfer for Primary PCI; (6) PQRI #20: Surgical Care-Timing of Antibiotic Prophylaxis; and (7) PQRI #21: Surgical Care-Selection of Antibiotic.

5. HOP QDRP Quality Measures for the CY 2010 Payment Determination

For the CY 2010 payment update, we required continued submission of data on the existing seven measures discussed above (73 FR 68761), and adopted four new imaging measures (73 FR 68766). For CY 2010, we also changed the measure designations for the existing seven measures to an "OP-#" format. For example, the designations of ED–AMI–2 and ED–AMI–3 were changed to OP–1 and OP–2 so that the eleven measures for the CY 2010 payment update were designated as OP–1 through OP–11. This change allowed us to maintain a consistent sequential designation system that we could expand as we add additional measures.

The four imaging measures that we adopted beginning with the CY 2010 payment determination (OP–8: MRI Lumbar Spine for Low Back Pain, OP–9: Mammography Follow-up Rates, OP–10: Abdomen CT—Use of Contrast Material, and OP–11: Thorax CT—Use of Contrast Material) are claims-based measures that CMS will calculate using Medicare Part B claims data without imposing upon hospitals the burden of additional chart abstraction. For purposes of the CY 2010 payment determination, we will calculate these measures using CY 2008 Medicare administrative claims data.

In the CY 2009 OPPS/ASC proposed rule, OP–10 had two submeasures listed: OP–10a: CT Abdomen—Use of contrast material excluding calculi of the kidneys, ureter, and/or urinary tract, and OP–10b: CT Abdomen—Use of contrast material for diagnosis of calculi in the kidneys, ureter, and or urinary tract. In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68766), we finalized OP–10 (previously known as OP–10a): Abdomen CT—Use of Contrast Material. To clarify, we are calculating OP–10 excluding patients with impaired renal functions because they are not candidates for an abdominal CT with contrast. This exclusion is described in greater detail in the *Specifications Manual for Hospital Outpatient Department Quality Measures (HOPD Specifications Manual)* located at the QualityNet Web site (*http://www.QualityNet.org*).

The complete set of 11 measures to be used for the CY 2010 payment determination is listed at 73 FR 68766.

6. HOP QDRP Quality Measures, Technical Specification Updates, and Data Publication for the CY 2011 Payment Determination

a. Quality Measures

For the CY 2011 payment determination, we required hospitals to continue to submit data on the existing 11 HOP QDRP measures. These measures continue to address areas of topical importance regarding the quality of care provided in HOPDs, and reflect consensus among affected parties. Seven of these 11 measures are chart-abstracted measures in two areas of importance that are also measured for the inpatient setting: AMI cardiac care and surgical care. The remaining four measures address imaging efficiency in HOPDs.

For the CY 2011 payment determination, we did not add any new HOP QDRP measures. We indicated our sensitivity to the burden upon HOPDs associated with chart abstraction and stated that we seek to minimize the collection burden associated with quality measurement. We also stated that we will continue to assess whether we can collect data on additional quality measures through mechanisms other than chart abstraction, such as from Medicare administrative claims data and EHRs.

The complete set of 11 measures that will be used for the CY 2011 payment determination is listed at 74 FR 60637.

b. Maintenance of Technical Specifications for Quality Measures

Technical specifications for each HOP QDRP measure are listed in the *HOPD Specifications Manual*, which is posted on the CMS QualityNet Web site at *http://www.QualityNet.org.* We maintain the technical specifications for the measures by updating this HOPD Specifications Manual and including detailed instructions and calculation algorithms. In some cases where the specifications are available elsewhere, we may include links to Web sites hosting technical specifications. These resources are for hospitals to use when collecting and submitting data on required measures.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68766 through 68767), we established a subregulatory process for updates to the technical specifications that we use to calculate HOP QDRP measures. This process is used when changes to the measure specifications are necessary due to changes in scientific evidence or in the measure as endorsed by the consensus entity. Changes of this nature may not coincide with the timing of our regulatory actions, but nevertheless require inclusion in the measure specifications so that the HOP QDRP measures are calculated based on the most up-to-date scientific and consensus standards. We indicated that notification of changes to the measure specifications on the QualityNet Web site, *http://www.QualityNet.org,* and in the HOPD Specifications Manual that occurred as a result of changes in scientific evidence or national consensus would occur no less than 3 months before any changes become effective for purposes of reporting under the HOP QDRP.

The HOPD Specifications Manual is released every 6 months and addenda are released as necessary providing at least 3 months of advance notice for insubstantial changes such as changes to ICD–9, CPT, NUBC, and HCPCS codes, and at least 6 months notice for substantive changes to data elements that would require significant systems changes.

c. Publication of HOP QDRP Data

Section 1833(t)(17)(E) of the Act requires that the Secretary establish procedures to make data collected under the HOP QDRP program available to the public. It also states that such procedures must ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. To meet these requirements, data that a hospital has submitted for the HOP QDRP are typically displayed on CMS Web sites such as the *Hospital Compare* Web site, *http://www.hospitalcompare.hhs.gov* after a preview period. The *Hospital Compare* Web site is an interactive Web tool that assists beneficiaries by providing information on hospital quality of care. This information encourages beneficiaries to work with their doctors and hospitals to discuss the quality of care hospitals provide to

patients, thereby providing an additional incentive to hospitals to improve the quality of care that they furnish.

In general, we strive to display hospital quality measures on the *Hospital Compare* Web site as soon as possible after they have been adopted and are available to CMS for reporting. However, information that may not be easily understood by the public and information with unresolved display issues or pending design considerations may be made available on other non-interactive CMS Web sites such as *http://www.cms.hhs.gov/HospitalQualityInits/.* Publicly reporting the information in this manner, though not on the *Hospital Compare* Web site, allows CMS to meet the requirement under section 1833(t)(17)(E) of the Act for establishing procedures to make quality data submitted available to the public following a preview period. We are proposing that, under circumstances when we have to display hospital quality information on non-interactive CMS Web sites for reasons discussed earlier, affected parties would be notified via CMS listserves, CMS e-mail blasts, national provider calls, and QualityNet announcements regarding the release of preview reports followed by the posting of data on a Web site other than *Hospital Compare.* The release of preview reports allows CMS to meet the requirement under section 1833(t)(17)(E) of the Act for establishing procedures to make quality data submitted available to the public following a preview period.

CMS also requires hospitals to complete and submit a registration form ("participation form") in order to participate in the HOP QDRP. With submission of this form, participating hospitals agree that they will allow CMS to publicly report the quality measures, including those that CMS calculates using Medicare claims, as required by the Act and the HOP QDRP.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68778), we established that, for CY 2010, hospitals sharing the same CMS Certification Number (CCN, previously known as the Medicare Provider Number (MPN)) must combine data collection and submission across their multiple campuses for the clinical measures for public reporting purposes. We finalized the policy that, under the HOP QDRP, we will publish quality data by the corresponding CCN. This approach is consistent with the approach taken under the RHQDAPU program. In the CY 2009 OPPS/ASC final rule with comment period, we also stated that we intend to indicate instances where data from two or more hospitals are combined to form the publicly reported measures on the Web site.

In the CY 2010 OPPS/ASC final rule with comment period, we finalized our CY 2010 policy regarding publication of HOP QDRP data (74 FR 60652 through 60654). Section 1833(t)(17)(E) of the Act requires that the Secretary establish procedures to make data collected under the HOP QDRP available to the public; however, this section does not require that such data be validated before it is made public. We explained that, initially, we decided not to post "[i]nformation from non-validated data, including the initial reporting period (April—June 2008)" as discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66874). We noted, however, that data submitted by hospitals are publicly reported regardless of whether those data are successfully validated for payment determination purposes under existing procedures for the RHQDAPU program. We also noted that, in the CY 2009 OPPS/ASC final rule with comment period, we stated that we intended to make the information collected under the HOP QDRP available to the public in 2010 (73 FR 68778).

In the CY 2010 OPPS/ASC proposed rule (74 FR 35404), we proposed to make data collected for quarters beginning with the third quarter of CY 2008 (July—September 2008) under the HOP QDRP publicly available, regardless of whether those data have been validated for payment determination purposes. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60654), we finalized our proposal to publicly report HOP QDRP data on *Hospital Compare* in 2010 with some modifications in the periods of time to be reported. For measures OP–1 through OP–5, we will publicly report data periods beginning with the 3rd quarter of 2008. For measures OP–6 and OP–7, we will publicly report data periods beginning with the 3rd quarter of 2009. For measures OP–8 through OP–11, we will report CY 2010 payment determination calculations using CY 2008 claims.

B. Proposed Expansion of HOP QDRP Quality Measures for the CY 2012, CY 2013, and CY 2014 Payment Determinations

1. Considerations in Expanding and Updating Quality Measures Under the HOP QDRP

In general, when selecting measures for the HOP QDRP program, we take into account several considerations and goals. These include: (a) Expanding the types of measures beyond process of care measures to include an increased number of outcome measures, efficiency measures, and patients' experience-of-care measures; (b) expanding the scope of hospital services to which the measures apply; (c) considering the burden on hospitals in collecting chart-abstracted data; (d) harmonizing the measures used in the HOP QDRP program with other CMS quality programs to align incentives and promote coordinated efforts to improve quality; (e) seeking to use measures based on alternative sources of data that do not require chart abstraction or that utilize data already being reported by many hospitals, such as data that hospitals report to clinical data registries, or all-payer claims data bases; and (f) weighing the relevance and utility of the measures compared to the burden on hospitals in submitting data under the HOP QDRP program.

Specifically, we give priority to quality measures that assess performance on: (a) Conditions that result in the greatest mortality and morbidity in the Medicare population; (b) conditions that are high volume and high cost for the Medicare program; and (c) conditions for which wide cost and treatment variations have been reported, despite established clinical guidelines. We have used and continue to use these criteria to guide our decisions regarding what measures to add to the HOP QDRP measure set.

In the CY 2009 OPPS/ASC final rule with comment period, we adopted four claims-based quality measures that do not require a hospital to submit chart-abstracted clinical data (73 FR 68766). This supports our goal of expanding the measures for the HOP QDRP while minimizing the burden upon hospitals and, in particular, without significantly increasing the chart abstraction burden. In addition to claims-based measures, we are considering registries [1] and EHRs as alternative ways to collect data from hospitals. Many hospitals submit data to and participate in existing registries. In addition, registries often capture outcome information and provide ongoing quality improvement feedback to registry participants. Instead of requiring hospitals to submit the same data to CMS that they are already submitting to registries, we could collect the data directly from the registries with the permission of the hospital, thereby enabling us to expand the HOP QDRP measure set without increasing the burden of data collection for those

[1] A registry is a collection of clinical data for purposes of assessing clinical performance, quality of care, and opportunities for quality improvement.

hospitals participating in the registries. The data that we would receive from registries would be used to calculate quality measures required under the HOP QDRP, and would be publicly reported like other HOP QDRP quality measures, encouraging improvements in the quality of care. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60633), we responded to public comments on such an approach.

In the CY 2009 OPPS/ASC final rule with comment period, we also stated our intention to explore mechanisms for data submission using EHRs (73 FR 68769). CMS has adopted the definition of Qualified EHR set forth by the Office of the National Coordinator for Health Information Technology (ONC) which has adopted the statutory definition of Qualified EHR as follows: Section 3000(13) of the PHSA defines Qualified EHR as an electronic record of health-related information on an individual that: (A) Includes patient demographic and clinical health information, such as medical history and problem lists; and (B) has the capacity: (i) To provide clinical decision support; (ii) to support physician order entry; (iii) to capture and query information relevant to health care quality; and (iv) to exchange electronic health information with, and integrate such information from other sources." CMS has also adopted the definition of Certified EHR by ONC as follows: Certified EHR technology means a complete EHR or a combination of EHR Modules, each of which: (1) Meets the requirements included in the definition of a Qualified EHR; and (2) has been tested and certified in accordance with the certification program established by the ONC as having met all applicable certification criteria adopted by the Secretary. Establishing a data submission mechanism using EHRs system will require interoperability between EHRs and CMS data collection systems, additional infrastructure development on the part of hospitals and CMS, and the adoption of standards for the capturing, formatting, and transmission of data elements that make up the measures. However, once these activities are accomplished, the adoption of measures that rely on data obtained directly from EHRs would enable us to expand the HOP QDRP measure set with less cost and burden to hospitals. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60633 through 60634), we responded to public comments on such an approach.

In prior years, we have proposed measures for one payment determination in a given rulemaking cycle. In prior rules, we have identified measures for future consideration, but have not proposed or finalized measures beyond those to be collected and used for the next sequential payment determination. In this CY 2011 rulemaking cycle, we are proposing the addition of new measures over a three year period of time for CY 2012, CY 2013, and CY 2014 payment determinations. We believe this proposed process would assist hospitals in planning, meeting future reporting requirements, and implementing quality improvement efforts. We also would have more time to develop, align, and implement the infrastructure necessary to collect data on the measures and make payment determinations. To the extent that we choose to finalize some or all of these measures for the CY 2012, CY 2013 and CY 2014 payment determinations, this would not preclude us from proposing additional measures or changing the list of measures for future payment determinations through subsequent rulemaking cycles that affect these future payment determinations. We invite comments on our intention to propose measures for more than one payment determination in a single rulemaking cycle.

2. Retirement of HOP QDRP Quality Measures

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we finalized a process for immediate retirement of RHQDAPU program measures based on evidence that the continued use of the measure as specified raises patient safety concerns (74 FR 43864 through 43865). In circumstances such as those prompting immediate retirement of the AMI–6 measure from the RHQDAPU program in December 2008 as discussed in the FY 2010 IPPS/LTCH final rule (74 FR 43864 through 43865) we do not believe that it would be appropriate to wait for the annual rulemaking cycle to retire a measure. We adopted this same immediate retirement policy for the HOP QDRP in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60635).

Specifically, we stated that if we receive evidence that continued collection of a measure that has been adopted for the HOP QDRP raises patient safety concerns, we would promptly retire the measure and notify hospitals and the public of the retirement of the measure and the reasons for its retirement through the usual means by which we communicate with hospitals, including but not limited to hospital e-mail blasts and the QualityNet Web site. We also stated that we would confirm the retirement of a measure retired in this manner in the next OPPS rulemaking cycle. However, for other circumstances in which we do not believe that continued use of a measure raises specific patient safety concerns, we stated that we intend to use the regular rulemaking process to retire a measure.

3. Proposed HOP QDRP Quality Measures for the CY 2012 Payment Determination

a. Proposed Retention of Existing HOP QDRP Measures for the CY 2012 Payment Determination

For the CY 2012 payment determination, we are proposing to retain the existing 11 HOP QDRP measures. These measures continue to address areas of topical importance regarding the quality of care provided in HOPDs, and reflect consensus among affected parties. Seven of these 11 measures are chart-abstracted measures in two areas of importance that are also measured for the inpatient setting: AMI cardiac care and surgical care. The remaining four measures are claims-based measures that address imaging efficiency in HOPDs.

We invite public comment on our proposal to retain the existing 11 HOP QDRP measures for the CY 2012 payment determination.

b. Proposed New Structural Measure for CY 2012 Payment Determination

For the CY 2012 payment determination, we are proposing to add one structural measure: "Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data" (NQF # 0489). Structural measures allow the assessment of the conduciveness of the provider environment to processes and technologies that enable delivery of high quality care. This particular structural measure assesses the extent to which a provider uses a certified/qualified EHR system that incorporates an electronic data interchange with one or more laboratories allowing for direct electronic transmission of laboratory data into the EHR as discrete searchable data elements. We believe that electronic transmission of laboratory data into EHRs would enable greater timeliness of results reporting, because the results of the reports would be transmitted to the HOPD as soon as the laboratory data are available and be merged with clinical information for more timely clinical assessments, and laboratory value alerts. Electronic transmission of laboratory data would also lead to cost efficiency, expedite the

clinical decision process, and reduce redundancy of laboratory orders, and reduce human errors. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this structural measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed in 2008 as part of an NQF project entitled "National Voluntary Consensus Standards for Health Information Technology: Structural Measures." Additionally, this measure was conditionally adopted by the Hospital Quality Alliance (HQA) in 2010. (The HQA is a public-private collaboration to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care.)

We are proposing that this structural measure would be submitted by HOPDs beginning with January 1, 2011 discharges via a Web-based tool available on the QualityNet Web site that is currently employed for the collection of structural measures for the RHQDAPU program. For this structural measure, HOPDs would submit the number of encounters out of all encounters for which laboratory results were documented in the EHR. We invite comments on our proposal to add this new structural measure to the HOP QDRP measurement set and the submission process for the CY 2012 payment determination.

c. Proposed New Claim-Based Measures for CY 2012 Payment Determination

For the CY 2012 payment determination, we are proposing to add four new claims-based imaging efficiency measures to the HOP QDRP measurement set, all of which were listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641). Imaging efficiency is a new area of measurement that we first implemented in the HOP QDRP for the CY 2010 payment determination and subsequently retained for the CY 2011 payment determination. There are currently four existing claims-based imaging efficiency measures in the HOP QDRP measurement set (OP–8 through OP–11). The four new proposed imaging efficiency measures for the CY 2012 payment determination are: (1) Pre-operative Evaluation for Low-Risk Non-Cardiac Surgery Risk Assessment, (2) Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI post CABG, (3) Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT), and (4) Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache.

Like the current imaging efficiency measures in the HOP QDRP measurement set, these four measures are based on Medicare claims and will not require additional data submission on the part of hospitals. All four of these proposed measures are currently undergoing NQF review, and specifications for these measures are available at *www.imagingmeasures.com.*

The first new proposed imaging efficiency measure for the CY 2012 payment determination seeks to calculate relative use of stress echocardiography, stress MRI, and SPECT MPI prior to low-risk non-cardiac surgical procedures in the 30 days preceding the surgery. The second new proposed claims-based imaging efficiency measure for the CY 2012 payment determination seeks to estimate relative use of stress echocardiography and SPECT MPI in asymptomatic patients less than five years after a coronary artery bypass graft (CABG) procedure.

Cardiac imaging is a gap area that was not addressed in CMS' first set of Outpatient Imaging Efficiency measures. It is among the most common imaging services in the Medicare population. In the hospital outpatient setting, 762,419 SPECT MPI, Stress MRI and Stress Echocardiography procedures were performed in 2008 alone.[2] Further, between 1998 and 2006, the rate of myocardial perfusion imaging (MPI) use in Medicare beneficiaries increased 51 percent among cardiologists in the hospital setting, and by 215 percent in private offices. During the same time period, total Medicare Part B payments for MPI across all settings of care increased by 227 percent.[3]

SPECT MPI, Stress MRI, and Stress Echocardiography are specific procedures that must be ordered by a physician to be performed. Therefore, there is a distinct opportunity for the physician to order this procedure prudently based on best practices. While SPECT MPI, Stress MRI, and Stress Echocardiography enhance the quality of care when used appropriately, inappropriate usage of imaging would cause unnecessary waste of services, contribute no benefit to the quality of care, and could increase the patient's risk of cancer. An analysis by Gibbons et al.[4] found that, of all SPECT MPI procedures performed at the Mayo Clinic Rochester in May 2005, 14 percent were considered inappropriate using criteria published by the American College of Cardiology Foundation and the American Society of Nuclear Cardiology, and an additional 11 percent were of indeterminate appropriateness.[4] This study also found that during the same time period, 18 percent of all stress echocardiograms performed were inappropriate, and an additional 9 percent were indeterminate.

The third and fourth new proposed imaging efficiency measures for the CY 2012 payment determination pertain to appropriate use of Brain CT imaging in HOPDs. These are "Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)," and "Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache."

A recent report in the New England Journal of Medicine[5] raised serious concerns about the use and overuse of CT scanning, stating that for an estimated 62 million CT scans being performed per year, a third are unnecessary, resulting in patient safety issues including unnecessary radiation and contrast material exposure, and the danger associated with "false positive" findings. A CT scan exposes the patient to higher doses of radiation than a conventional x-ray and increases the patient's risk of cancer.

Brain CTs are often ordered in addition to a sinus CT for patients with sinusitis because headache is a common symptom related to sinusitis. However, simultaneous CT sinus and brain imaging for headache without suspected complications is generally considered inappropriate, as the standard anatomic coverage of a CT of the head includes

[2] The Lewin Group analysis of Medicare Calendar Year 2007 claims data prepared for the Centers for Medicare & Medicaid Services, HHS Contract No: HHSM–500–2005–0024I, Order No. 0002.

[3] Levin DC, Rao VM, Parker L, et al. Recent payment and utilization trends in radionuclide myocardial perfusion imaging: Comparison between self-referral and referral to radiologists. J Am Coll Radiol 2009;6:437–441.

[4] Gibbons RJ, Miller TD, Hodge D, et al. Application of appropriateness criteria to stress single-photon emission computed tomography sestamibi studies and stress echocardiograms in an academic medical center. J Am Coll Cardiology 2008;51:1283–9.

[5] Brenner DJ, Hall EJ. November 29, 2007. Computer Tomography—An Increasing Source of Radiation Exposure. New England J of Medicine 2007:357(22): 2277–84.

large portions of the paranasal sinuses; thus, ordering both procedures is duplicative and inefficient.[5, 6] The third new proposed imaging efficiency measure for the CY 2012 payment determination "Simultaneous Use of Brain CT and Sinus CT" assesses the extent to which patients with a headache who have a brain CT also have a sinus CT performed on the same date at the same facility. The measure excludes patients with trauma diagnoses, tumors or orbital cellulitis.

The fourth new proposed imaging efficiency measure for the CY 2012 payment determination, "Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache," assesses the extent to which patients presenting with a headache receive brain CT studies. The measure excludes patients admitted or transferred to an acute care hospital, patients with lumbar punctures, dizziness, paresthesia, lack of coordination, subarachnoid hemorrhage or thunderclap headaches. The lifetime prevalence of headache is over 90 percent for men and women and according to some studies, headache accounts for 16 million physician visits in the U.S. annually.[7] According to a study conducted by Goldstein et al. (2006) on U.S. emergency departments (EDs) from 1992 to 2001, headaches represent approximately 2 percent of U.S. ED visits.[8] An analysis of 2007 Medicare claims data found that approximately 200,000 Medicare beneficiaries had a visit to an ED with a primary diagnosis of headache with about half of these patients (not taking into account the previously mentioned exclusion of lumbar punctures, dizziness, paresthesia, lack of coordination, subarachnoid hemorrhage or thunderclap headaches) receiving a Brain CT coincident with the ED visit.[9] Unnecessary or duplicative studies are inefficient and detrimental to the patient because CT exposes the patient to higher doses of radiation than conventional x-ray and increases the patient's risk for cancer.[10]

Concern over the inappropriate use of CT Imaging in the ED setting has been driven by three primary factors: False positive interpretations, radiation exposure, and cost. There is generally a lower threshold for ordering neuro-imaging for headache in the ED because of physician time constraints and lack of ED physician familiarity with headache presentation.[11] Because of this lower threshold, the measurement of the use of CT Brain in the ED for patients with a diagnosis of atraumatic headache can help to raise the awareness of the need for quality improvement on the appropriate use of CT brain imaging in the ED and, as a result improve patient safety through reduction in unnecessary radiation exposure.

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, these measures are appropriate for measuring quality of care in the hospital outpatient department setting. These measures also meet the consensus requirement because these measures underwent development through a consensus-based measure development process involving stakeholder input. We anticipate that they will be endorsed by the NQF.

For the CY 2012 payment determination, we are proposing to calculate these four measures using Medicare claims from CY 2010. We invite comments on our proposal to add these four new imaging efficiency measures to the HOP QDRP measurement set based on Medicare claims from CY 2010 for the CY 2012 payment determination.

d. Proposed New Chart-Abstracted Measures for CY 2012 Payment Determination

We are proposing to add one new chart-abstracted measure to the HOP QDRP measurement set for the CY 2012 payment determination: "Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with *Probable Cardiac Chest Pain*) Received within 60 minutes of arrival." Troponin is used to help diagnose a heart attack, to detect and evaluate mild to severe heart injury, and to distinguish chest pain that may be due to other causes.

This measure is based upon the existing ED–AMI/Chest Pain populations for which we have adopted five measures in the current HOP QDRP measurement set. This measure is currently undergoing NQF review.

Both patients and clinicians are impacted by the timeliness of laboratory reporting.[12] Decreasing laboratory turnaround times increases ED efficiency, specifically by decreasing diversion time from treatment of patients and decreasing length of stay.[13] Decreasing the numbers of hours a day on diversion as well as decreasing patients' lengths of stay in EDs allows for the treatment of a greater number of patients. Studies have found correlations between the length of stay and mean turnaround times.[14] Efficiencies in throughput with tasks can lead to less diversion, less overcrowding, less elopements and less financial loss.[15] Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because this measure underwent development through a consensus-based measure development process involving stakeholder input. We anticipate that

[5] Brenner DJ, Hall EJ. November 29, 2007. Computer Tomography—An Increasing Source of Radiation Exposure. New England J of Medicine: 357(22): 2277–84.

[6] Appropriateness Criteria—Headache. Reston, VA: American College of Radiology, 2009. Accessed November 25, 2009 at *http://www.acr.org/SecondaryMainMenuCategories/quality_safety/app_criteria.aspx.*

[7] Mellion ML, Jayaraman MV. August 2007. Use of neuroimaging in the workup of headache. Med Health R I.; 90(8):249–50.

[8] Goldstein JN, CA Camargo, AJ Pelletier, JA Edlow. 2006. Headache in the United States Emergency Departments: demographics, work-up and frequency of pathological diagnoses. Cephalalgia; 26(6) 684.

[9] The Lewin Group analysis of Medicare Calendar Year 2007 claims data prepared for the Centers for Medicare & Medicaid Services, HHS Contract No: HHSM–500–2005–0024I, Order No. 0002.

[10] Brenner DJ and Hall EJ. November 29, 2007. Computed Tomography—An Increasing Source of Radiation Exposure. N Engl J Med;357(22):2277–84.

[11] Ward TN, Leven M, Phillips JM. Evaluation and management of headache in the emergency department. Med Clin N Am 2001; 85(4) 971–85.

[12] Howanitz JH, and Howanitz PJ. Laboratory results: Timeliness as a quality attribute and strategy. Am J Clin Pathol. 2002 Sep; 116 (3):311–5.

[13] Storrow AB, Zhou C, Gaddis G, Han JH, Miller K, Klubert D, Laidig A, and Aronsky D. Decreasing lab turnaround time improves emergency department throughput and decreases emergency medical services diversion: A simulation model. Acad Emerg Med. 2008 Nov; 15 (11):1130–5.

[14] Holland LL, Smith LL, and Blick KE. Reducing laboratory turnaround time outliers can reduce emergency department length of stay: An 11-hospital study. Am J Clin Pathol. 2005 Nov; 124 (5):672–4.

[15] Falvo T, Grove L, Stachura R, and Zirkin W. The financial impact of ambulance diversions and patient elopements. Acad Emerg Med. 2007 Jan; 14 (1):58–62.

this measure will be endorsed by the NQF.

If adopted, data collection for this measure would begin with January 1, 2011 discharges, and data would be submitted quarterly beginning with the first quarter of 2011, as with all other chart-abstracted measures.

We invite public comment on our proposal to add this new chart-abstracted measure to the HOP QDRP measurement set and the submission process for the CY 2012 payment determination.

In summary, for the CY 2012 payment determination, we are proposing to retain the 11 existing HOP QDRP measures for the CY 2011 payment determination, to add one new structural measure, four new claims-based imaging efficiency measures, and one new chart-abstracted measure for the ED AMI population. Submission of data regarding the new structural measure would begin with January 1, 2011 discharges using a Web-based collection tool available on the QualityNet Web site. We are proposing to calculate the four imaging measures using Medicare claims from calendar year 2010. Data collection for the chart-abstracted measure would begin with January 1, 2011 discharges, and data would be submitted quaterly beginning with the first quarter of 2011, as with all other chart-abstracted measures. We invite public comment on this proposal for the CY 2012 payment determination.

The complete list of 17 proposed measures for the CY 2012 payment determination is shown below.

Proposed HOP QDRP Measurement Set to be Used for the CY 2012 Payment Determination
OP-1: Median Time to Fibrinolysis
OP-2: Fibrinolytic Therapy Received Within 30 Minutes
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4: Aspirin at Arrival
OP-5: Median Time to ECG
OP-6: Timing of Antibiotic Prophylaxis
OP-7: Prophylactic Antibiotic Selection for Surgical Patients
OP-8: MRI Lumbar Spine for Low Back Pain
OP-9: Mammography Follow-up Rates
OP-10: Abdomen CT – Use of Contrast Material
OP-11: Thorax CT – Use of Contrast Material
The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data*
Preoperative Evaluation for Low Risk Non Cardiac Surgery Risk Assessment*
Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI post CABG*
Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)*
Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*
Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) Received within 60 minutes of arrival.*

* Proposed new measure for CY 2012 payment determination

4. Proposed HOP QDRP Quality Measures for the CY 2013 Payment Determination

a. Proposed Retention of CY 2012 HOP QDRP Measures for the CY 2013 Payment Determination

In general, unless otherwise specified in the retirement section of a rule, we retain measures from one payment determination to another. For the CY 2013 payment determination, we are proposing to retain all of the measures adopted for the CY 2012 payment determination. We invite public comment on this proposal for the CY 2013 payment determination.

b. Proposed New Structural Measure for the CY 2013 Payment Determination

We are proposing to add one structural measure to the HOP QDRP measurement set for the CY 2013 payment determination: Tracking Clinical Results between Visits. EHRs enable providers to issue reminders when clinical results are not received within a predefined timeframe. This measure assesses the extent to which a provider uses a certified/qualified EHR system to track pending laboratory tests, diagnostic studies (including common preventive screenings) or patient referrals. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures

set forth by one or more national consensus building entities. As discussed above, this structural measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed as part of an NQF Project entitled "National Voluntary Consensus Standards for Health IT" (NQF #0491). Additionally, this measure was conditionally approved by the HQA in March of 2010.

Submission of this measure would begin with first quarter CY 2012 discharges to be submitted via the Web-based tool used to collect other structural measures, such as the registry participation structural measures for the RHQDAPU program. We invite comments on this proposal to add this new structural measure to the HOP QDRP measurement set and the submission process for the CY 2013 payment determination.

c. Proposed New Chart-Abstracted Measures for the CY 2013 Payment Determination

We are proposing to add six new chart-abstracted measures to the HOP QDRP measurement set for the CY 2013 payment determination.

The six new chart-abstracted measures we are proposing for the CY 2013 payment determination are: (1) Median Time from ED Arrival to ED Departure for Discharged ED Patients; (2) Transition Record with Specified Elements Received by Discharged Patients; (3) Door to Diagnostic Evaluation by a Qualified Medical Professional; (4) ED-Median Time to Pain Management for Long Bone Fracture; (5) ED-Patient Left Before Being Seen; and (6) ED-Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Who Received Head CT Scan Interpretation Within 45 minutes of Arrival. The topics addressed by these measures include ED efficiency, Imaging Efficiency, and care coordination/transition for hospital outpatient departments. Many of these measures would expand the chart-abstraction population for the HOP QDRP measurement set beyond the current ED-AMI/Chest Pain, and Surgical Care patients for which we have currently adopted seven measures in the HOP QDRP measurement set. However, this population expansion would be occurring at a time when subsection (d) hospitals would begin collection of more global ED population measures for the RHQDAPU program. Thus, we have timed the expansion of the chart-abstracted measures for HOP QDRP to coincide with expansions that will be occurring for the RHQDAPU program in order to reduce the burden associated with expansion. We also anticipate that, in the future, these measures could be captured and submitted via EHRs, eliminating the chart abstraction burden associated with these measures. These measures are discussed below:

(1) Median Time From ED Arrival to ED Departure for Discharged ED Patients

This measure, which was listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641), addresses ED efficiency in the form of the median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department. Reducing the time patients spend in the ED can improve quality of care. Reducing this time potentially improves access for more patients needing emergency care and increases hospitals' capability to provide additional treatment as necessary. Overcrowding and heavy emergency resource demand have led to a number of problems, including ambulance refusals, prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes. ED crowding may result in delays in the administration of medication such as antibiotics for pneumonia and has been associated with perceptions of delayed emergency care. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this chart-abstracted measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed in 2009 (NQF #0496) as part of an NQF project entitled "National Voluntary Consensus Standards for Emergency Care." Additionally, this measure was conditionally approved by the HQA in March of 2010.

(2) Transition Record With Specified Elements Received by Discharged Patients

This chart-abstracted measure assesses the percentage of patients, regardless of age, discharged from an ED to ambulatory care or home healthcare, or their caregiver(s), who received a transition record at the time of ED discharge including at a minimum, the following elements: major procedures and tests performed during the ED visit; principal diagnosis at discharge or chief complaint; patient instructions; plan for follow-up care (or statement that none is required)—including primary physician, other health care professional, or site designated for follow-up care; and list of new medications and changes to continued medications that patient should take after ED discharge, with the quantity prescribed and/or dispensed (or intended duration) and instructions for each. Transitions of care are a weakness in maintaining continuity of care and proper adherence/compliance with follow up instructions. Hand-offs between settings should be accompanied by clear instructions for medications and follow-up care. Information should be provided about the care delivered while in each setting, and for what reasons, not only for the benefit of the patient and their caregivers, but for practitioners that will be following up with the patient after they leave an acute care setting.

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed by the NQF as part of a Project entitled "Endorsing Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination" (NQF #0649). This measure was conditionally approved by the HQA in March of 2010.

(3) Door to Diagnostic Evaluation by a Qualified Medical Professional (Door to Provider)

This measure assesses mean time between patient presentation to the ED and the first moment the patient is seen by a person who can initiate a

diagnostic evaluation or therapeutic plan (for example, medical student, resident, nurse practitioner; excludes triage personnel). Long wait times in the ED before diagnosis increases the likelihood that someone will leave the ED without treatment for a serious condition, and can worsen the severity of the condition with which they presented. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it gained NQF endorsement as part of the project entitled "National Voluntary Consensus Standards for Emergency Care" (NQF #0498). This measure was conditionally approved by the HQA in March of 2010.

(4) ED-Median Time to Pain Management for Long Bone Fracture

This chart-abstracted measure addresses the topic of efficient pain management in the ED, and is currently being reviewed by NQF. Pain management in patients with long bone fractures is currently undertreated in emergency departments.[16] Patients with bone fractures continue to lack administration of pain medication as part of treatment regimens.[17] When standards are implemented for pain management of these patients, treatment for pain improve.[18] Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it underwent development through a consensus-based measure development process involving stakeholder input. We anticipate that this measure will be endorsed by the NQF.

(5) ED-Patient Left Without Being Seen

This measure is the sum of all patients leaving an ED who were not seen by a provider (for example, medical student, resident, nurse practitioner). A patient leaving before being seen is an indicator of emergency department overcrowding.[19] Patients who leave before being seen may not receive appropriate medical care and this lack of care may result in adverse outcomes.[20] National estimates for patients who leave before being seen by a provider average 1.9 percent.[21] Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed by the NQF (NQF #0499) as part of the National Voluntary Consensus Standards for Emergency Care.

(6) ED-Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Who Received Head CT Scan Interpretation Within 45 Minutes of Arrival

This measure assesses whether head CT scan results for acute ischemic stroke or hemorrhagic stroke patients who received head CT scans in the ED were interpreted within 45 minutes of arrival. This chart-abstracted measure is currently under NQF review. Improved access to diagnostics assists clinicians in decisionmaking. Delayed diagnostic imaging and laboratory reports are expected to slow down clinical decision making process and subsequently increase length of stay in the ED. Similarly, decreasing radiology report turnaround times can have impacts across the facility and can assist in reducing the length of stay in the ED. It also can enhance decisionmaking capabilities for patient treatment plans because timely diagnostic imaging is available.[22] The Food and Drug Administration (FDA) approved the use of tissue plasminogen activator (t–PA) for treatment of acute ischemic stroke, which comprise 87 percent of stokes, when given within three hours of stroke symptom onset.[23] [24] Because of the therapeutic time window for treatment possibilities, timely completion and results of the CT scan are imperative for timely clinical decisionmaking and favorable outcomes. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because this measure underwent development through a consensus-based measure development process involving stakeholder input. We anticipate that this measure will be endorsed by the NQF.

The submission of the new chart-abstracted measures for the CY 2013 payment determination will begin with first quarter 2012 discharges, and data would be submitted quarterly, as with all other chart-abstracted measures. We invite comments on this proposal to add these new measures to the HOP QDRP measurement set and on the submission

[16] Ritsema, T.S., Kelen, G.D., Pronovost, R.J., and Pham, J.C.: The national trend in quality of emergency department pain management of long bone fractures. Acad Emerg Med. 2007 Feb 14; 14(2):163–9.

[17] Brown, J.C., Klein, E.J., Lewis, C.W., Johnston, B.D., and Cummings, P.: Emergency department analgesia for fracture pain. Ann Emerg Med. 2003 Aug; 42(2):197–205.

[18] Titler, M.G., Herr, K., Brooks, J.M., Xie, X.J., Ardery, G., Schilling, M.L., Marsh, J.L., Everett, L.Q., Clark, W.R.: Translating research into practice intervention improves management of acute pain in older hip fracture patients. Health Serv Res. 2009; 44(1), 264–87.

[19] United States General Accounting Office. Hospital emergency departments: Crowded conditions vary among hospitals and communities. Publication GAO–03–460, 2003.

[20] Rowe, B.H., Channan, P., Bullard, M., Blitz, S., Saunders, L.D., Rosychuk, R.J., Lari, H., Craig, W.R., Holroyd, B.R.: Characteristics of patients who leave emergency departments without being seen. Acad Emerg Med. 2006 Aug; 13(8):848–52.

[21] McCaig, L.F., Nawar, E.W.: National hospital ambulatory medical care survey: 2004 Emergency department summary. Adv Data. 2006 Jun 23; (372):1–29.

[22] Marquez L.O. Improving medical imaging report turnaround times. Radiol Mange. 2005 Jan–Feb; 27(1):34–7.

[23] National Stroke Association. STROKE the First Hours Guidelines for Acute Treatment, 2000.

[24] The ATLANTIS, ECASS, and NINDS rt–PA Study Group Investigators. Association of Outcome with early stroke treatment: pooled analysis of ATLANTIS, ECASS, and NINDS rt–PA stroke Trials. Lancet 2004; 363:768–774.

process for the CY 2013 payment determination.

In summary, for the CY 2013 payment determination, we are proposing to retain all of the measures adopted for the CY 2012 payment determination, and to adopt one new structural measure, and six new chart-abstracted measures for the CY 2013 payment determination on the topics of HOPD care transitions and ED efficiency. Submission of the new structural measure would begin with first quarter CY 2012 discharges to be submitted via a Web-based tool on the QualityNet Web site in 2012. The submission of the new chart-abstracted measures for the CY 2013 payment determination would begin with first quarter CY 2012 discharges, to be submitted in 2012. We invite comments on this proposal for the CY 2013 payment determination.

The complete list of 24 proposed measures for the CY 2013 payment determination is shown below.

BILLING CODE 4120–01–P

Proposed HOP QDRP Measurement Set to be Used for the CY 2013 Payment Determination
OP-1: Median Time to Fibrinolysis
OP-2: Fibrinolytic Therapy Received Within 30 Minutes
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4: Aspirin at Arrival
OP-5: Median Time to ECG
OP-6: Timing of Antibiotic Prophylaxis
OP-7: Prophylactic Antibiotic Selection for Surgical Patients
OP-8: MRI Lumbar Spine for Low Back Pain
OP-9: Mammography Follow-up Rates
OP-10: Abdomen CT – Use of Contrast Material
OP-11: Thorax CT – Use of Contrast Material
The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data*
Preoperative Evaluation for Low Risk Non Cardiac Surgery Risk Assessment*
Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI post CABG*
Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)*
Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*
Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) Received within 60 minutes of arrival *
Tracking Clinical Results between Visits**
Median Time from ED Arrival to ED Departure for Discharged ED Patients**
Transition Record with Specified Elements Received by Discharged Patients**
Door to Diagnostic Evaluation by a Qualified Medical Professional**
ED- Median Time to Pain Management for Long Bone Fracture **
ED- Patient Left Before Being Seen**
ED- Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival **

* Proposed new measure for CY 2012 payment determination

** Proposed new measure for CY 2013 payment determination

BILLING CODE 4120–01–C

5. Proposed HOP QDRP Quality Measures for the CY 2014 Payment Determination

a. Proposed Retention of CY 2013 HOP QDRP Measures for the CY 2014 Payment Determination

In general, unless otherwise specified in the retirement section of a rule, we retain measures from one payment determination to another. For the CY 2014 payment determination, we are proposing to retain all of the measures adopted for the CY 2013 payment determination. We invite comment on this proposal.

b. Proposed New Chart-Abstracted Measures for the CY 2014 Payment Determination

We are proposing to adopt six new chart-abstracted measures for the CY 2014 payment determination. Five of the six measures are Diabetes Care measures for HOPDs, and one measure is an additional imaging efficiency measure. The six measures we are proposing for the CY 2014 payment determination are: (1) Hemoglobin A1c Poor Control in Diabetic Patients; (2) Low Density Lipoprotein (LDL–C) Control in Diabetic Patients; (3) High Blood Pressure Control in Diabetic Patients; (4) Dilated Eye Exam in Diabetic Patients; (5) Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients; and (6) Exposure Time Reported for Procedures Using Fluoroscopy. We are proposing that submission of these measures for the CY 2014 payment determination begin with the first quarter CY 2013 discharges to be submitted in 2013. These measures are discussed below.

(1) Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetic Patients

This NQF-endorsed measure (NQF #0059) measures the percentage of adult patients with diabetes aged 18–75 years with most recent HgA1c level greater than 9 percent (poor control). Glycosylated hemoglobin (HgA1c) assay measures average blood glucose over the preceding two to three months, rather than just one point in time. HgA1c values vary less than fasting glucose values and give clinicians a better integrated view of the patient's average blood sugar over time. High HgA1c is a more reliable indicator of chronic high blood sugar. Lowered HgA1c levels are associated with reduced microvascular and neuropathic complications of diabetes.

In general, diabetes mellitus is a chronic disease that impacts the lives of a large portion of the population and consumes a significant amount of U.S. healthcare dollars. With the prevalence of diabetes in the Medicare-eligible population expected to double, costs are expected to increase almost fourfold to $171 million.[25] Uncontrolled diabetes often leads to biochemical imbalances that can lead to acute life-threatening events, such as diabetic ketoacidosis and hyperosmolar, or nonketotic coma. In patients with insulin-dependent diabetes, the risk of development or progression of retinopathy, nephropathy, and neuropathy can be reduced by 50 to 75 percent by intensive outpatient treatment of hyperglycemia compared to conventional treatment. Early treatment may help slow or halt the progression of diabetic complications, and following the guidelines for screening may assist those patients with no outward sign of diabetic complications to be identified earlier through regular screening tests. HgA1c should be performed during an initial assessment and during follow-up assessments, which should occur at no longer than three-month intervals.[26] Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, it has been endorsed by the NQF.

(2) Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetic Patients

This NQF-endorsed measure (NQF #0064) measures the percentage of adult patients with diabetes aged 18–75 years whose most recent LDL–C test result during the measurement year was <100 mg/dl. LDL–C measures the development of atherosclerotic plague which increases cardiac events risks for diabetic patients whose heart disease death rates are about two to four times higher than non-diabetics.[27] Improved dyslipidemia management helps to mitigate the risk for cardiovascular disease. Lipid-lowering therapy for diabetics has been a consistent recommendation in several guidelines, prompted by randomized trials supporting statin therapy to lower the risk of cardiovascular involvement for this population. Despite the evidence basis and guideline support, only a minority of patients with diabetes are prescribed statin treatment or achieve target LDL–C goals.[28] Early treatment may help slow or halt the progression of cardiovascular disease and impact the quality of the life of the diabetic patient, affecting the patient's life expectancy and decreasing costs involved in treating diabetic complications. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, it has been endorsed by the NQF. We also note that this measure was listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641).

(3) Diabetes Mellitus: High Blood Pressure Control in Diabetic Patients

This NQF-endorsed measure (NQF #0061) measures the percentage of patients visits with blood pressure measurement recorded among all patients visits aged >18 years with diagnosed hypertension. Blood pressure control reduces the risk of cardiovascular disease and microvascular complications in patients with diabetes. Most importantly, early treatment of high blood pressure may help slow or halt the progression of kidney involvement and damage.[29]

[25] Huang, E.S., Basu, A., O'Grady, M., Capretta, J.C.: Projecting the future diabetes population size and related costs for the U.S. Diabetes Care. 2009;32(12):2225–29.

[26] The American Association of Clinical Endocrinologists Medical Guidelines for the Management of Diabetes Mellitus: The AACE System of Intensive Diabetes Self-Management—2002 Update.

[27] American Diabetes Association. Standards of medical care in diabetes. Diabetes Care. 2007 Jan;30 (Suppl 1):S8–15.

[28] Das, S.R., Vaeth, P.A., Stanek, H.G., de Lemos, J.A., Dobbins, R.L., McGuire, D.K.: Increased cardiovascular risk associated with diabetes in Dallas County. Am Heart J 2006;151:1087–93.

[29] Centers for Disease Control and Prevention. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2007. Atlanta, GA: U.S. Department of

Blood pressure is a factor that can be controlled Well-controlled blood pressure impacts the quality of the life of the diabetic patient, affects the patient's life expectancy, and decreases the costs involved in treating diabetic complications. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, it has been endorsed by the NQF.

(4) Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients

This NQF-endorsed measure (NQF #0055) measures the percentage of adult patients with diabetes age 18 to 75 years who received a dilated eye exam or seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist, or imaging to verify diagnosis from stereoscopic photos during the reporting year, or during the prior year, if patient is at low risk for retinopathy. A patient is considered low risk if the patient has no evidence of retinopathy in the prior year. A dilated eye exam helps to detect the risk for vision-threatening diabetic retinopathy which is prevalent among people with diabetes. Data from the 2007 National Diabetes Fact Sheet (using the most recent year of available data) shows that diabetic retinopathy causes up to 24,000 new cases of blindness each year.[30] However, dilated eye exams for diabetic patients can prevent retinopathy through early detection.[31]

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, this measure has been endorsed by the NQF. We note that this measure was listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641).

(5) Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

This NQF-endorsed measure (NQF #0062) measures the percentage of adult diabetic patients aged 18–75 years with at least one test for microalbumin during the measurement year or who had evidence of medical attention for existing nephropathy (diagnosis of nephropathy or documentation of microalbuminuria or albuminuria). Urine screening for microalbumin detects abnormal amount of protein albumin leaks in the urine by the capillaries of the kidney. High levels of blood sugar in uncontrolled diabetes can cause damage to the capillaries in the kidneys. Early urine screenings for microalbumin may prevent kidney disease from worsening to end-stage renal disease (ESRD). Diabetics accounted for 44 percent of new cases of kidney disease. In 2005, a total of 178,689 diabetics with ESRD were on dialysis or received a kidney transplant in the United States and Puerto Rico.[32] In 2009, MedPAC reported costs for the 330,000 Medicare recipients receiving dialysis treatment for ESRD at over 8 billion dollars.[32] Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, it has been endorsed by the NQF. We also note that this measure was listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641).

(6) Exposure Time Reported for Procedures Using Fluoroscopy

This measure documents the percentage of final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time, an important measure for the HOPD setting. This measure is currently specified for physician level data collection through the PQRI program (74 FR 61825), and can be used for the hospital outpatient facility level. This measure evaluates the documentation of radiation exposure or radiation time during fluoroscopy. Data suggests that the lifetime risk for cancer can be increased, albeit by a small amount, with frequent or repeated exposure to ionizing radiation, including procedures using fluoroscopy.[33] To monitor these long term effects, the exposure time or radiation dose that a patient receives as a result of the procedure should be measured and recorded in the patient's record. The American College of Radiology (ACR) encourages practices to record actual fluoroscopy time for all fluoroscopic procedures. The fluoroscopy time for various procedures (for example, upper gastrointestinal, pediatric voiding cystourethrography) should then be compared with benchmark figures.[34] [35] The National Cancer Institute also recommends measuring and recording patient radiation dose, fluoroscopy time and additional available measures: Dose area product, cumulative dose, and skin dose. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care

Health and Human Services, Centers for Disease Control and Prevention, 2008.

[30] Centers for Disease Control and Prevention. National diabetes fact sheet: General information and national estimates on diabetes in the United States, 2007. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008.

[31] American Diabetes Association. Standards of medical care in diabetes. Diabetes Care. 2007 Jan;30 (Suppl 1):S8–15.

[32] Centers for Disease Control and Prevention. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2007. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008.

[32] MedPAC. Outpatient dialysis service: Assessing payment adequacy and updating payments. Report to the Congress; Medicare payment policy. 2009 Mar; 131–56.

[33] National Cancer Institute (NCI), The Society for Pediatric Radiology (SPR). Brochure: Radiation & pediatric computed tomography. A guide for health care providers. 2002. Available at; *http://www/cancer.gov/cancertopics/cause/radiation-risks-pediatric-CT.pdf*

[34] Amis E Jr, Butler P, Applegate K, Birnbaum S, Brateman L, Hevezi J, Mettler F, Morin R, Pentecost M, Smith G. American College of radiology white paper on radiation dose in medicine. Journal of American College of Radiology, 2007:4:272–284

[35] National Cancer Institute. Interventional fluoroscopy: Reducing radiation risks for patients and staff. 2005. Available at: *http://www.cancer.gov/cancertopics/interventionalfluoroscopy.*

furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it is NQF-endorsed (NQF # 0510). Additionally, this measure was conditionally approved by the HQA for the hospital outpatient setting in March of 2010.

In summary, for the CY 2014 payment determination, we are proposing to retain all of the measures adopted for the CY 2013 payment determination, and to adopt six new chart-abstracted measures for the CY 2014 payment determination on the topics of diabetes care and exposure time for procedures using fluoroscopy. We are proposing that submission of the new chart-abstracted measures for the CY 2014 payment determination begin with first quarter CY 2013 discharges to be submitted in 2013. We invite public comment on this proposal for the CY 2014 payment determination.

The complete list of 30 proposed measures for the CY 2014 payment determination is shown below.

BILLING CODE 4120–01–P

Proposed HOP QDRP Measurement Set to be Used for theCY 2014 Payment Determination
OP-1: Median Time to Fibrinolysis
OP-2: Fibrinolytic Therapy Received Within 30 Minutes
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4: Aspirin at Arrival
OP-5: Median Time to ECG
OP-6: Timing of Antibiotic Prophylaxis
OP-7: Prophylactic Antibiotic Selection for Surgical Patients
OP-8: MRI Lumbar Spine for Low Back Pain
OP-9: Mammography Follow-up Rates
OP-10: Abdomen CT – Use of Contrast Material
OP-11: Thorax CT – Use of Contrast Material
The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data*
Preoperative Evaluation for Low Risk Non Cardiac Surgery Risk Assessment*
Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI post CABG*
Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)*
Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*
Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) Received within 60 minutes of arrival *
Tracking Clinical Results between Visits**
Median Time from ED Arrival to ED Departure for Discharged ED Patients**
Transition Record with Specified Elements Received by Discharged Patients**
Door to Diagnostic Evaluation by a Qualified Medical Professional**
ED- Median Time to Pain Management for Long Bone Fracture **
ED- Patient Left Before Being Seen**
ED- Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival **
Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetic Patients***
Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetic Patients***
Diabetes Mellitus: High Blood Pressure Control in Diabetic Patients***
Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients***
Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients***
Exposure Time Reported for Procedures Using Fluoroscopy***

* Proposed new measure for CY 2012 payment determination
** Proposed new measure for CY 2013 payment determination
*** Proposed new measure for CY 2014 payment determination

6. Possible Quality Measures Under Consideration for Future Inclusion in HOP QDRP

In previous years' rulemakings, we have provided lists of quality measures that are under consideration for future adoption into the HOP QRDP measurement set. Below is a list of measures under consideration for future rulemaking cycles.

Measures and Measurement Topics under Consideration for Future Payment Determinations Beginning with CY 2013
Measures for future development:
Adjuvant Chemotherapy is Considered or Administered within 4 Months of Surgery to Patients Under Age 80 with AJCC III Colon Cancer.
Adjuvant Hormonal Therapy for Patients with Breast Cancer
Needle Biopsy to Establish Diagnosis of Cancer Precedes Surgical Excision/Resection.
Pneumococcal Vaccination Status
Influenza Vaccination Status
Cardiac Rehabilitation Referral
Medication Reconciliation
Appropriate surgical site hair removal
Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Heart Failure: Left Ventricular Ejection Fraction Assessment
Heart Failure: Combination Medical Therapy for Left Ventricular Systolic Dysfunction
Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction
Heart Failure: Counseling regarding Implantable Cardioverter-Defibrillator (ICD) Implantation for Patients with Left Ventricular Systolic Dysfunction on Combination Medical Therapy
Heart Failure: Patients with Left Ventricular Systolic Dysfunction on Combination Medical Therapy
Heart Failure: Symptom Management
Heart Failure: Symptom and Activity Assessment
Heart Failure: Patient Education
Heart Failure: End of Life Care Plan
Heart Failure: Overuse of Echocardiography
Heart Failure: Post-Discharge Appointment for Heart Failure Patients
Emergency Department Transfer Communication: Administrative Communications
Emergency Department Transfer Communication: Medication Information
Emergency Department Transfer Communication: Nursing Information
Emergency Department Transfer Communication: Patient Information
Emergency Department Transfer Communication: Physician Information
Emergency Department Transfer Communication: Procedures and Tests
Emergency Department Transfer Communication: Vital Signs

Measures and Measurement Topics under Consideration for Future Payment Determinations Beginning with CY 2013
Measurement Topics for future development:
Chemotherapy
Unplanned Reintubation
Unplanned Inpatient Transfer
Post-discharge follow up
Post-discharge ED visit within 72 hours
Safe Surgery Checklist
Immunization Refusal rate
Breast cancer detection rate

BILLING CODE 4120–01–C

We invite public comment on these quality measures and topics so that we may consider proposing to adopt them beginning with the CY 2013 payment determination. We also are seeking suggestions and rationales to support the adoption of measures and topics for the HOP QDRP which do not appear in the table above.

In addition, we are concerned about the lack of progress in reducing the rates of healthcare associated infections that was recently reported in the 2009 National Healthcare Quality Report (*http://www.ahrq.gov/qual/nhqr09/nhqr09.pdf*). For example, the report found that rates of postoperative sepsis increased by 8 percent. We view healthcare associated infections as a significant priority for quality measurement in order to ensure that health care does not result in avoidable harm and to inform the public about hospitals' performance with respect to these infections. We are inviting public comment on the option to include among our prioritization criteria quality measures that assess performance on healthcare associated infections. Also, while some HOP QDRP measures cover aspects of healthcare associated infections, we are inviting suggestions on additional measures that could be added to those that hospitals would report and that we would make available to the public in order promote improvement in healthcare associated infection rates.

C. Proposed Payment Reduction for Hospitals That Fail To Meet the HOP QDRP Requirements for the CY 2011 Payment Update

1. Background

Section 1833(t)(17)(A) of the Act, which applies to subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Act), requires that hospitals that fail to report data required for the quality measures selected by the Secretary, in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act, incur a 2.0 percentage point reduction to their OPD fee schedule increase factor, that is, the annual payment update factor. Section 1833(t)(17)(A)(ii) of the Act specifies that any reduction would apply only to the payment year involved and would not be taken into account in computing the applicable OPD fee schedule increase factor for a subsequent payment year.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68769 through 68772), we discussed how the payment reduction for failure to meet the administrative, data collection, and data submission requirements of the HOP QDRP affected the CY 2009 payment update applicable to OPPS payments for HOPD services furnished by the hospitals defined under section 1886(d)(1)(B) of the Act to which the program applies. The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that apply to certain outpatient items and services provided by hospitals that are required to report outpatient quality data and that fail to meet the HOP QDRP requirements. All other hospitals paid under the OPPS receive the full OPPS payment update without the reduction.

The national unadjusted payment rates for many services paid under the OPPS equal the product of the OPPS conversion factor and the scaled relative weight for the APC to which the service is assigned. The OPPS conversion factor, which is updated annually by the OPD fee schedule increase factor, is used to calculate the OPPS payment rate for services with the following status indicators (listed in Addendum B to this proposed rule with comment period): "P," "Q1," "Q2," "Q3," "R," "S," "T," "V," "U," or "X." In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68770), we adopted a policy that payment for all services assigned these status indicators would be subject to the reduction of the national unadjusted payment rates for applicable hospitals, with the exception of services assigned to New Technology APCs with assigned status indicator "S" or "T," and brachytherapy sources with assigned status indicator "U," which were paid at charges adjusted to cost in CY 2009. We excluded services assigned to New Technology APCs from the list of services subject to the reduced national unadjusted payment rates because the OPD fee schedule increase factor is not used to update the payment rates for these APCs.

In addition, section 1833(t)(16)(C) of the Act, as amended by section 142 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275), specifically required that brachytherapy sources be paid during CY 2009 on the basis of charges adjusted to cost, rather than under the standard OPPS methodology. Therefore, the reduced conversion factor also was not applicable to CY 2009 payment for brachytherapy sources because payment would not be based on the OPPS conversion factor and, consequently, the payment rates for these services were not updated by the OPD fee schedule increase factor. However, in accordance with section 1833(t)(16)(C) of the Act, as amended by section 142 of the MIPPA, payment for brachytherapy sources at charges adjusted to cost expired on January 1, 2010. Therefore, in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60641), we finalized our CY 2010 proposal, without

modification, to apply the reduction to payment for brachytherapy sources to hospitals that fail to meet the quality data reporting requirements of the HOP QDRP for the CY 2010 OPD fee schedule increase factor.

The OPD fee schedule increase factor, or market basket update, is an input into the OPPS conversion factor, which is used to calculate OPPS payment rates. To implement the requirement to reduce the market basket update for hospitals that fail to meet reporting requirements, we calculate two conversion factors: a full market basket conversion factor (that is, the full conversion factor), and a reduced market basket conversion factor (that is, the reduced conversion factor). We then calculate a reduction ratio by dividing the reduced conversion factor by the full conversion factor. We refer to this reduction ratio as the "reporting ratio" to indicate that it applies to payment for hospitals that fail to meet their reporting requirements. Applying this reporting ratio to the OPPS payment amounts results in reduced national unadjusted payment rates that are mathematically equivalent to the reduced national unadjusted payment rates that would result if we multiplied the scaled OPPS relative weights by the reduced conversion factor. To determine the reduced national unadjusted payment rates that applied to hospitals that failed to meet their quality reporting requirements for the CY 2010 OPPS, we multiply the final full national unadjusted payment rate in Addendum B to the CY 2010 OPPS/ASC final rule with comment period by the CY 2010 OPPS final reporting ratio of 0.980 (74 FR 60642).

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68771 through 68772), we established a policy that the Medicare beneficiary's minimum unadjusted copayment and national unadjusted copayment for a service to which a reduced national unadjusted payment rate applies would each equal the product of the reporting ratio and the national unadjusted copayment or the minimum unadjusted copayment, as applicable, for the service. Under this policy, we apply the reporting ratio to both the minimum unadjusted copayment and national unadjusted copayment for those hospitals that receive the payment reduction for failure to meet the HOP QDRP reporting requirements. This application of the reporting ratio to the national unadjusted and minimum unadjusted copayments is calculated according to § 419.41 of our regulations, prior to any adjustment for hospitals' failure to meet the quality reporting standards according to § 419.43(h). Beneficiaries and secondary payers thereby share in the reduction of payments to these hospitals.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68772), we established the policy that all other applicable adjustments to the OPPS national unadjusted payment rates apply in those cases when the OPD fee schedule increase factor is reduced for hospitals that fail to meet the requirements of the HOP QDRP. For example, the following standard adjustments apply to the reduced national unadjusted payment rates: the wage index adjustment; the multiple procedure adjustment; the interrupted procedure adjustment; the rural sole community hospital adjustment; and the adjustment for devices furnished with full or partial credit or without cost. We believe that these adjustments continue to be equally applicable to payments for hospitals that do not meet the HOP QDRP requirements. Similarly, outlier payments will continue to be made when the criteria are met. For hospitals that fail to meet the quality data reporting requirements, the hospitals' costs are compared to the reduced payments for purposes of outlier eligibility and payment calculation. This policy conforms to current practice under the IPPS. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60642), we continued this policy. For a complete discussion of the OPPS outlier calculation and eligibility criteria, we refer readers to section II.G. of this CY 2011 OPPS/ASC proposed rule.

2. Proposed Reporting Ratio Application and Associated Adjustment Policy for CY 2011

We are proposing to continue our established policy of applying the reduction of the OPD fee schedule increase factor through the use of a reporting ratio for those hospitals that fail to meet the HOP QDRP requirements for the full CY 2011 annual payment update factor. For the CY 2011 OPPS, the proposed reporting ratio is 0.980, calculated by dividing the reduced conversion factor of $66.930 by the full conversion factor of $68.267. We are proposing to continue to apply the reporting ratio to all services calculated using the OPPS conversion factor. For the CY 2011 OPPS, we are proposing to apply the reporting ratio, when applicable, to all HCPCS codes to which we have assigned status indicators "P," "Q1," "Q2," "Q3," "R," "S," "T," "V," "U," and "X." We are proposing to continue to exclude services paid under New Technology APCs. We are proposing to continue to apply the reporting ratio to the national unadjusted payment rates and the minimum unadjusted and national unadjusted copayment rates of all applicable services for those hospitals that fail to meet the HOP QDRP reporting requirements. We also are proposing to continue to apply all other applicable standard adjustments to the OPPS national unadjusted payment rates for hospitals that fail to meet the requirements of the HOP QDRP. Similarly, we are proposing to continue to calculate OPPS outlier eligibility and outlier payment based on the reduced payment rates for those hospitals that fail to meet the reporting requirements.

D. Proposed Requirements for HOPD Quality Data Reporting for CY 2012 and Subsequent Years

In order to participate in the HOP QDRP, hospitals must meet administrative, data collection and submission, and data validation requirements (if applicable). Hospitals that do not meet the requirements of the HOP QDRP, as well as hospitals not participating in the program and hospitals that withdraw from the program, will not receive the full OPPS payment rate update. Instead, in accordance with section 1833(t)(17)(A) of the Act, those hospitals will receive a reduction of 2.0 percentage points in their annual payment update factor for the applicable payment year. We established the payment determination requirements for the CY 2011 payment update in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60642 through 60652).

For payment determinations affecting the CY 2012 payment update, we are proposing to implement the requirements listed below. Most of these requirements are the same as the requirements we implemented for the CY 2011 payment determination, with some proposed modifications.

1. Administrative Requirements

To participate in the HOP QDRP, we are proposing that several administrative steps be completed. These steps would require the hospital to:

- Identify a QualityNet security administrator who follows the registration process located on the QualityNet Web site *(http://www.QualityNet.org)* and submits the information to the appropriate CMS-designated contractor. All CMS-designated contractors would be identified on the QualityNet Web site. The same person may be the QualityNet security administrator for both the RHQDAPU program and the HOP

QDRP. From our experience, we believe that the QualityNet security administrator typically fulfills a variety of tasks related to the hospital's ability to participate in the HOP QDRP, such as: creating, approving, editing and/or terminating QualityNet user accounts within the organization; monitoring QualityNet usage to maintain proper security and confidentiality measures; and serving as a point of contact for information regarding QualityNet and the HOP QDRP. The hospital would be required to maintain a current QualityNet security administrator for as long as the hospital participates in the program due to CMS information systems security requirements. While only a single QualityNet security administrator would be required for program purposes, we suggest to hospitals that it may be beneficial to have more than one QualityNet security administrator for back-up purposes.

- Register with QualityNet, regardless of the method used for data submission.
- Complete and submit an online participation form if this form (or a paper Notice of Participation form) has not been previously completed, if a hospital has previously withdrawn, or if the hospital acquires a new CCN. For HOP QDRP decisions affecting the CY 2012 payment determination, hospitals that share the same CCN would be required to complete a single online participation form. In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68772), we implemented an online registration form and eliminated the paper form. At this time, the participation form for the HOP QDRP is separate from the RHQDAPU program and completing a form for each program is required. Agreeing to participate includes acknowledging that the data submitted to the CMS-designated contractor would be submitted to CMS and also may be shared with one or more other CMS contractors that support the implementation of the HOP QDRP and be publicly reported.

We are proposing to update and retain the following deadlines, which we established in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60643), for submitting the participation form:

Hospitals with Medicare acceptance dates on or after January 1, 2011: For the CY 2012 payment update, we are proposing that any hospital that has a Medicare acceptance date on or after January 1, 2011 (including a new hospital and hospitals that have merged) must submit a completed participation form no later than 180 days from the date identified as its Medicare acceptance date on the CMS Online System Certification and Reporting (OSCAR) system. Hospitals typically receive a package notifying them of their new CCN after they receive their Medicare acceptance date. The Medicare acceptance date is the earliest date that a hospital can receive Medicare payment for the services that it furnishes. Completing the participation form would include supplying the name and address of each hospital campus that shares the same CCN.

The use of the Medicare acceptance date as beginning the timeline for HOP QDRP participation allows CMS to monitor more effectively hospital compliance with the requirement to complete a participation form because a hospital's Medicare acceptance date is readily available to CMS through its data systems. In addition, providing an extended time period to register for the program would allow newly functioning hospitals sufficient time to get their operations fully functional before having to collect and submit quality data. We invite public comment on this proposed policy.

Hospitals with Medicare acceptance dates before January 1, 2011: For the CY 2012 payment update, we are proposing that any hospital that has a Medicare acceptance date on or before December 31, 2010 that is not currently participating in the HOP QDRP and wishes to participate in the CY 2012 HOP QDRP must submit a participation form by March 31, 2011. We are proposing a deadline of March 31, 2011, because we believe it would give hospitals sufficient time to decide whether they wish to participate in the HOP QDRP, as well as put into place the necessary staff and resources to timely report data for first quarter CY 2011 services. This requirement would apply to all hospitals whether or not the hospital billed for payment under the OPPS. We invite public comment on this proposed policy.

Under our current requirements, hospitals that want to withdraw from participation must follow the same deadlines as hospitals that want to participate. We are proposing to change this requirement. We are proposing to lengthen the time during which hospitals may withdraw from participation because we believe that hospitals should be allowed more time to consider this decision. In addition, this increased time to withdraw is comparable programmatically to our proposal under the RHQDAPU program (75 FR 23996). Specifically, for the CY 2012 payment update, we are proposing that any HOP QDRP participating hospital that wants to withdraw may do so at any time from January 1, 2011 to November 1, 2011. Hospitals that withdraw during this time period for the CY 2012 payment update would not be able to sign up to participate for the CY 2012 payment update, would have a 2.0 percentage point reduction in their CY 2012 payment update, and would be required to resubmit a participation form in order to participate for purposes of any future payment updates. We note that once a hospital has submitted a participation form, it is considered to be an active HOP QDRP participant until such time as the hospital submits a withdrawal form to CMS or the facility is designated as closed in the CMS OSCAR system. We invite public comment on this proposed policy.

2. Data Collection and Submission Requirements

a. General Data Collection and Submission Requirements

We are proposing that, to be eligible for the full CY 2012 OPPS payment update, hospitals would be required to:

- Submit data: Hospitals that would be participating in the HOP QDRP would be required to submit data for each applicable quarter by the deadline posted on the QualityNet Web site; there must be no lapse in data submission. For the CY 2012 annual payment update, the applicable quarters would be as follows: 3rd quarter CY 2010, 4th quarter CY 2010, 1st quarter CY 2011, and 2nd quarter CY 2011. Hospitals that did not participate in the CY 2011 HOP QDRP, but would like to participate in the CY 2012 HOP QDRP, and that have a Medicare acceptance date on the OSCAR system before January 1, 2011, would begin data submission for 1st quarter CY 2011 services using the CY 2012 measure set that would be finalized in the CY 2011 OPPS/ASC final rule with comment period. For those hospitals with Medicare acceptance dates on or after January 1, 2011, data submission must begin with the first full quarter following the submission of a completed online participation form. For the claims-based measures, we would calculate the measures using the hospital's Medicare claims data. For the CY 2012 payment update, we would utilize paid Medicare fee-for-service (FFS) claims submitted prior to January 1, 2011, to calculate these measures. For the structural measure to be used for the CY 2012 payment determination, hospitals would be required to submit data beginning with January 1, 2011 discharges using a Web-based tool

available on QualityNet beginning in 2011.

Sampling and Case Thresholds: It would not be necessary for a hospital to submit data for all eligible cases for some measures if sufficient eligible case thresholds are met. Instead, for those measures where a hospital has a sufficiently large number of cases, it would sample cases and submit data for these sampled cases rather than submitting data from all eligible cases. This sampling scheme, which includes the minimum number of cases based upon case volume, would be set out in the HOPD Specifications Manual at least three months in advance of the required data collection. We have proposed to change this notification timeframe for this sampling scheme to at least 3 months from at least 4 months to be consistent with the HOPD Specifications Manual release schedule. Hospitals would be required to meet the sampling requirements for required quality measures each reporting quarter.

In addition, in order to reduce the burden on hospitals that treat a low number of patients but otherwise meet the submission requirements for a particular quality measure, hospitals that have five or fewer claims (both Medicare and non-Medicare) for any measure included in a measure topic in a quarter would not be required to submit patient level data for the entire measure topic for that quarter. Even if hospitals would not be required to submit patient level data because they have five or fewer claims (both Medicare and non-Medicare) for any measure included in a measure topic in a quarter, we are proposing that they may voluntarily do so.

Hospitals would be required submit all required data according to the data submission schedule that will be available on the QualityNet Web site (*https://www.QualityNet.org*). This Web site meets or exceeds all current HIPAA requirements. Submission deadlines would, in general, be four months after the last day of each calendar quarter. Thus, for example, the submission deadline for data for services furnished during the first quarter of CY 2011 (January–March 2011) would be on or around August 1, 2011. The actual submission deadlines would be posted on the *http://www.QualityNet.org* Web site.

Hospitals would be required to submit data to the OPPS Clinical Warehouse using either the CMS Abstraction and Reporting Tool for Outpatient Department (CART–OPD) measures or the tool of a third-party vendor that meets the measure specification requirements for data transmission to QualityNet.

Hospitals would be required to submit quality data through My QualityNet, the secure portion of the QualityNet Web site, to the OPPS Clinical Warehouse. The OPPS Clinical Warehouse, which is maintained by a CMS-designated contractor, would submit the OPPS Clinical Warehouse data to CMS. OPPS Clinical Warehouse data are not currently considered to be Quality Improvement Organization (QIO) data; rather, we consider such data to be CMS data. However, it is possible that the information in the OPPS Clinical Warehouse may at some point become QIO information. If this occurs, these data would also become protected under the stringent QIO confidentiality regulations in 42 CFR Part 480.

Hospitals would be required to collect HOP QDRP data from outpatient episodes of care to which the required measures apply. For the purposes of the HOP QDRP, an outpatient "episode of care" is defined as care provided to a patient who has not been admitted as an inpatient, but who is registered on the hospital's medical records as an outpatient and receives services (rather than supplies alone) directly from the hospital. Every effort would be made to ensure that data elements common to both inpatient and outpatient settings are defined consistently for purposes of quality reporting (such as "time of arrival").

Hospitals would be required to submit quality data using the CCN under which the care was furnished.

To be accepted into the OPPS Clinical Warehouse, data submissions, at a minimum, would be required to be timely, complete, and accurate. Data submissions are considered to be "timely" when data are successfully accepted into the OPPS Clinical Warehouse on or before the reporting deadline. A "complete" submission would be determined based on whether the data satisfy the sampling criteria that are published and maintained in the HOPD Specifications Manual, and must correspond to both the aggregate number of cases submitted by a hospital and the number of Medicare claims the hospital submits for payment. We are aware of "data lags" that occur when hospitals submit claims, then cancel and correct those claims; efforts would be made to take such events into account that can change the aggregate Medicare case counts. To be considered "accurate," submissions would be required to pass validation, if applicable.

We strongly recommend that hospitals review OPPS Clinical Warehouse feedback reports and the HOP QDRP Provider Participation Reports that are accessible through their QualityNet accounts. These reports enable hospitals to verify whether the data they or their vendors submitted were accepted into the OPPS Clinical Warehouse and the date/time that such acceptance occurred. We also note that irrespective of whether a hospital submits data to the OPPS Clinical Warehouse itself or uses a vendor to complete the submissions, the hospital would be responsible for ensuring that HOP QDRP requirements are met.

Finally, during the past two years of the HOP QDRP, the submission of population and sampling data was not required, though, hospitals could submit, on a voluntary basis, the aggregate numbers of outpatient episodes of care which are eligible for submission under the HOP QDRP and sample size counts. These aggregated numbers of outpatient episodes represent the number of outpatient episodes of care in the universe of all possible cases eligible for data reporting under the HOP QDRP. For the CY 2012 payment update, we are proposing to require submission of this population and sample size data. Specifically, we are proposing that hospitals must submit on a quarterly basis, aggregate population and sample size counts for Medicare and non-Medicare encounters for the measure populations for which chart-abstracted data must be submitted. Under this proposal, hospitals would submit aggregate population and sample size counts for measure populations even if the hospital had not treated patients in a specific measure population; that is, if a hospital has not treated any patients in a specific HOP QDRP measure population, the hospital would still be required to submit a zero for its quarterly aggregate population and sample counts to meet the requirement.

We believe that hospitals have had sufficient time to become familiar with HOP QDRP data and to develop data systems necessary to support this requirement. We view it as vital for quality data reporting for hospitals to be able to determine accurately their aggregate population and appropriate sampling size data to assess their completeness of data reporting. We rely on hospitals to properly sample cases where sampling occurs so that representative data are submitted; for hospitals to correctly sample, it is necessary for them to be able to determine their aggregate population sizes. In addition, we believe it is highly beneficial for hospitals to develop systems that can determine whether or

not they have furnished services or billed for five or fewer cases for a particular measure topic on a quarterly basis.

We are proposing that the deadlines for the reporting of aggregate numbers of outpatient episodes of care and sample size counts would be the same as those for the reporting of data for the measures requiring chart abstraction, and these deadlines would be posted on the data submission schedule that would be available on the QualityNet Web site. Hospitals would be permitted to submit this information prior to the deadline; this would allow CMS to advise hospitals regarding their incomplete submission status as appropriate and give hospitals sufficient time to make appropriate revisions before the data submission deadline.

We plan to use the aggregate population and sample size data to assess data submission completeness and adherence to sampling requirements for Medicare and non-Medicare patients.

We invite public comment on these proposed requirements.

b. Extraordinary Circumstance Extension or Waiver for Reporting Quality Data

In our experience, there have been times when hospitals have been unable to submit required quality data due to extraordinary circumstances that are not within their control. It is our goal to not penalize hospitals for such circumstances and we do not want to unduly increase their burden during these times. Therefore, in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60046 through 600647), we adopted a process for hospitals to request and for CMS to grant extensions or waivers with respect to the reporting of required quality data when there are extraordinary circumstances beyond the control of the hospital. We are proposing to retain these procedures with some proposed modifications.

Under the process, in the event of extraordinary circumstances, such as natural disaster, not within the control of the hospital, for the hospital to receive consideration for an extension or waiver of the requirement to submit quality data for one or more quarters, a hospital would submit to CMS a request form that would be made available on the QualityNet Web site. The following information should be noted on the form:

- Hospital CCN;
- Hospital Name;
- CEO and any other designated personnel contact information, including name, e-mail address, telephone number, and mailing address (must include a physical address, a post office box address is not acceptable);
- Hospital's reason for requesting an extension or waiver;
- Evidence of the impact of the extraordinary circumstances, including but not limited to photographs, newspaper and other media articles; and
- A date when the hospital would again be able to submit HOP QDRP data, and a justification for the proposed date.

The request form would be signed by the hospital's CEO. A request form would be required to be submitted within 45 days of the date that the extraordinary circumstance occurred. We are proposing to remove the requirement found in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60646) that the hospital to include an identified reason for requesting an extension or waiver in addition to the hospital's reason for requesting an extension or waiver as a requirement. We believe that this requirement is redundant and removing it will reduce unnecessary hospital burden.

Following receipt of such a request, CMS would—

(1) Provide a written acknowledgement using the contact information provided in the request, to the CEO and any additional designated hospital personnel, notifying them that the hospital's request has been received;

(2) Provide a formal response to the CEO and any additional designated hospital personnel using the contact information provided in the request notifying them of our decision; and

(3) Complete any CY 2011 request for Extraordinary Circumstance Extension or Waiver for Reporting Quality Data requests reviews and communicate the results of these determinations within 90 days following our receipt of such a request. We are proposing to add a deadline for CMS response so that hospitals can have a designated timeline for when they should receive such a response.

This proposal would not preclude us from granting waivers or extensions to hospitals that have not requested them when we determine that an extraordinary circumstance, such as an act of nature (for example, hurricane) affects an entire region or locale. If we make the determination to grant a waiver or extension to hospitals in a region or locale, we would communicate this decision to hospitals and vendors through routine communication channels, including but not limited to e-mails and notices on the QualityNet Web site. We invite public comment on these proposals.

3. HOP QDRP Validation Requirements for Chart-Abstracted Data: Data Validation Approach for CY 2012 and Subsequent Years

a. Background

In the CY 2010 OPPS/ASC proposed rule, we solicited public comments on our proposed validation methodology (74 FR 35403 through 35404). We stated that we are considering building upon what we proposed as a validation approach for CY 2012 and subsequent years by, in addition to selecting a random sample of hospitals for validation purposes, selecting targeted hospitals based on criteria designed to measure whether the data they have reported raises a concern regarding data accuracy. These possible targeting criteria included identified abnormal data patterns, whether a hospital had previously failed validation, whether a hospital had not been previously selected for validation for 2 or more consecutive years, and some combination of some or all of the criteria.

We solicited public comments on whether such criteria, or another approach, should be applied in future years. We especially solicited suggestions for additional criteria that could be used to target hospitals for validation. We greatly appreciate all the public comments we received regarding the validation process proposed for CY 2012 and subsequent years. We responded to public comments on our proposed methodology for CY 2012 and subsequent years but did not finalize a validation process in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60650 through 60652). We noted that we would take all of the comments we received into account when we develop our validation proposals for CY 2012.

b. Proposed Data Validation Requirements for CY 2012

Similar to our proposal for the FY 2012 RHQDAPU program (75 FR 23991 through 23993), we are proposing to validate data from 800 randomly selected hospitals (approximately 20 percent of all participating HOP QDRP hospitals) each year, beginning with CY 2012 payment determination. We are proposing to sample 800 hospitals because we believe, based upon sampling simulation studies using HOP QDRP data, that sampling this number would provide a sufficient number for a representative sample of hospitals on various strata (for example, urban, rural, bed-size) while significantly reducing overall hospital burden. For CY 2012 payment determinations, we would

select only from hospitals participating for the CY 2012 payment update, so if a hospital submitted data for the CY 2011, but withdrew, this hospital would not be deemed as eligible for selection. We note that because 800 hospitals would be selected randomly, every HOP QDRP-participating hospital would be eligible each year for validation selection.

For each selected hospital, we are proposing to randomly select up to a total of 48 self-reported cases from the total number of cases (12 per quarter) that the hospital successfully submitted to the OPPS Clinical Warehouse. However, if a selected hospital has submitted less than 12 cases in any quarter, only those cases available would be validated. We believe that validating a larger number of cases per hospital, but only for 800 randomly selected hospitals, and validating these cases at the measure level (rather than the data element level) has several benefits. We are proposing up to a total of 48 cases per hospital because a sample size of about 50 is considered sufficient for detecting relationships and correlations, so a larger sample size is not deemed necessary (for reference, see Van Voohis, Wilson, Morgan, Carmen R. and Betsey L., (2007), *Understanding Power and Rules of Thumb for Determining Sample Sizes, Tutorials in Quantitative Methods for Psychology,* Volume 3(2), Pages 43–50). We believe that this approach is suitable for HOP QDRP data because it will: produce a more reliable estimate of whether a hospital's submitted data have been abstracted accurately; provide more statistically reliable estimates of the quality of care delivered in each selected hospital as well as at a national level; and reduce overall hospital burden because most hospitals will not be selected to undergo validation each year.

We would not be selecting cases stratified by measure or topic; our interest is whether the data submitted by hospitals accurately reflect the care delivered and documented in the medical record, not what the accuracy is by measure or whether there are differences by topic. Additionally, we note that, due to the distribution of HOP QDRP data submitted to date by hospital size, the data do not lend themselves to sampling by topic area. Specifically, small hospitals tend to have more AMI Cardiac Care cases and fewer Surgical Care cases, whereas, larger hospitals tend to have few if any AMI Cardiac Care cases and more Surgical Care cases.

Analysis of submitted HOP QDRP data indicate that this sampling design would provide sufficient case number of denominator cases per measure for determination of national and individual hospital measure estimates with acceptable levels of statistical certainty.

We are proposing to sample data for April 1, 2010 to March 31, 2011 services because this would provide a full year of the most recent data possible to use for the purpose of completing the validation in sufficient time for us to make the CY 2012 payment determinations.

A designated CMS contractor would, each quarter that applies to the validation, ask each of the 800 selected hospitals to submit medical documentation for up to 12 randomly selected cases submitted to and accepted by the HOP QDRP Clinical Warehouse. The CMS contractor would request paper copies of medical documentation corresponding to selected cases from each hospital via certified mail or other trackable method that requires a hospital representative to sign for the request letter; a trackable method would be utilized so that CMS would be assured that the hospital received the request. The hospital would have 45 calendar days from the date of the request as documented in the request letter to submit the requested documentation and have the documentation received by the CMS contractor. If the hospital does not comply within 30 calendar days of receipt of the initial medical documentation request, the CMS contractor would send a second letter by certified mail or other trackable method to the hospital, reminding the hospital that paper copies of the requested documentation must be submitted and received within 45 calendar days following the date of the initial CMS contractor request. If the hospital does not submit the requested documentation and the documentation is not received by the CMS contractor within the 45 calendar days, then the CMS contractor would assign a "zero" score to each data element for each selected case and the case would fail for all measures in the same topic (for example, OP–6 and OP–7 measures for a Surgical Care case).

We are proposing that the letter from the designated CMS contractor would be addressed to the hospital's medical record staff identified by the hospital for the submission of records under the RHQDAPU program (that is, the hospital's medical records staff identified by the hospital to their State QIO). If CMS has evidence that the hospital received both letters requesting medical records, the hospital would be deemed responsible for not returning the requested medical record documentation and the hospital would not be allowed to submit such medical documentation as part of its reconsideration request so that information not utilized in making a payment determination is not included in any reconsideration request.

Once the CMS contractor receives the requested medical documentation, the contractor would independently reabstract the same quality measure data elements that the hospital previously abstracted and submitted, and the contractor would then compare the two sets of data to determine whether the two sets of data match. Specifically, the contractor would conduct a measures level validation by calculating each measure within a submitted case using the independently reabstracted data and then comparing this to the measure reported by the hospital; a percent agreement would then be calculated. Specifically, the validation score for a hospital would equal the total number of measure matches divided by the total number of measures multiplied by 100 percent.

This method is the same as recommended in the CMS Hospital Value-Based Purchasing Report to Congress and is illustrated more fully on pages 83–84 of this report which can be found on our Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf.* We believe that this approach is appropriate and it was supported by many commenters when we requested comment on HOP QDRP validation requirements outlined in the CY 2010 OPPS/ASC proposed rule (74 FR 35402 through 35403; 74 FR 60647 through 60652).

To receive the full OPPS payment update, we are proposing that hospitals must attain at least a 75 percent validation score, based upon our validation process, for the designated time period. We have selected 75 percent as the threshold for the validation score because we believe this level is reasonable for hospitals to achieve while still ensuring accuracy of the data. Additionally, this level is consistent with what we proposed for the RHQDAPU program (75 FR 23993). Since we are not validating all hospital measures submitted, it is necessary to calculate a confidence interval that incorporates sampling error. We would use the upper bound of a one-tailed 95 percent confidence interval to estimate the validation score. We are proposing to use a one-tail confidence interval to calculate the validation score because it appropriately reflects our concern of whether the confidence interval for the calculated validation score includes or

is above the 75 percent validation threshold for a hospital to be considered as submitting accurate data. If the calculated upper limit is above the required 75 percent validation score threshold, we would consider a hospital's data to be "validated" for payment purposes. The use of a one-tailed confidence interval and the 75 percent and threshold level are the same as proposed for the RHQDAPU program for FY 2012 payment determinations (75 FR 23991 through 23993).

For derivation of the upper bound of a one-tailed 95 percent confidence interval we are proposing to use a binomial distribution approach as we are looking at the percentage of measures submitted by a hospital matching what is calculated from the reabstracted data. Since the measure match rate for each hospital is a proportion, a binomial approach is appropriate, see Pagano, Robert R., (1990), *Understanding Statistics in the Behavioral Sciences,* 3rd Edition, Pages 175–188.

Thus, we are proposing the following formula which includes a finite population correction factor and a continuity correction factor for calculating the upper bound of the one-tailed 95 percent confidence interval:

$$\textit{Upper Confidence Limit} = p + 1.645\left(\sqrt{\frac{p(1-p)}{n}}\right)\left(\sqrt{\frac{N-n}{N-1}}\right) + \frac{1}{2n}$$

In this formula, N represents the population for the reporting year, n represents the sample size for the reporting year, p (calculated as a percentage) represents the validation score for the reporting year (that is, the percentage of measures matching), and 1 − p represents the percentage of measures not matching. It should be noted that a confidence interval would not need to be calculated for hospitals that did not have enough cases to sample as the confidence interval is equal to zero (when the value of N is equal to n, N minus n equals zero and the upper confidence limit is equal to the validation score in the above formula). In addition, a confidence interval would not need to be calculated for those hospitals that have a validation score, p, that is greater than or equal to 75 percent because the hospital has attained the minimum threshold; the upper bound of any calculated confidence interval would be 75 percent or greater.

For further information on the proposed methodology for calculation of a 95 percent confidence interval for a binomial distribution utilizing a finite population correction, *see http://itl.nist.gov/div898/handbook/prc/section2/prc24.htm* and *http://courses.wcupa.edu/rbove/Berenson/10th%20ed%20CD-ROM%20topics/section7_3.pdf.*

We solicit public comments on this proposed validation methodology.

c. Additional Data Validation Conditions Under Consideration for CY 2013 and Subsequent Years

We are considering building upon what we are proposing as a validation approach for CY 2013 and subsequent years. We are considering, in addition to selecting a random sample of hospitals for validation purposes, selecting targeted hospitals based on criteria designed to measure whether the data they have reported raises a concern regarding data accuracy. Because hospitals have gained little experience with validation under the HOP QDRP, we are considering this approach for possible use beginning with the CY 2013 payment determination. Examples of targeting criteria could include:

- Abnormal data patterns identified such as consistently high HOP QDRP measure denominator exclusion rates resulting in unexpectedly low denominator counts;
- Whether a hospital had previously failed validation;
- Whether a hospital had not been previously selected for validation for 2 or more consecutive years;
- Whether a hospital had low submitted case numbers relative to population sizes; and/or
- Whether a hospital had any extreme outlier values for submitted data elements.

We invite comment on whether, in addition to random sampling for validation, we should use targeted validation and, if so, what criteria for targeting we should adopt.

E. Proposed HOP QDRP Reconsideration and Appeals Procedures

When the RHQDAPU program was initially implemented, it did not include a reconsideration process for hospitals. Subsequently, we received many requests for reconsideration of those payment decisions and, as a result, established a process by which participating hospitals would submit requests for reconsideration. We anticipated similar concerns with the HOP QDRP and, therefore, in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875), we stated our intent to implement for the HOP QDRP a reconsideration process modeled after the reconsideration process we implemented for the RHQDAPU program. In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68779), we adopted a mandatory reconsideration process that will apply to the CY 2010 payment decisions. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60654 through 60655), we continued this process for the CY 2011 payment update. We are proposing to continue this process for the CY 2012 payment update with some modification. Under this proposed process, the hospitals must—

- Submit to CMS, via QualityNet, a Reconsideration Request form that would be made available on the QualityNet Web site; this form would be submitted by February 3, 2012, and would contain the following information:
  - Hospital CCN.
  - Hospital Name.
  - CMS-identified reason for failure (as provided in any CMS notification of failure to the hospital).
  - Hospital basis for requesting reconsideration. This would identify the hospital's specific reason(s) for believing it met the HOP QDRP requirements and should receive a full annual payment update.
  - CEO and any additional designated hospital personnel contact information, including name, e-mail address, telephone number, and mailing address (must include physical address, not just a post office box).
  - A copy of all materials that the hospital submitted in order to receive the full payment update for CY 2012. Such material would include, but may not be limited to, the applicable Notice of Participation form or completed online registration form, and quality measure data that the hospital submitted via QualityNet.
- Submit paper copies of all the medical record documentation that it submitted for the initial validation. Hospitals would submit this

documentation to a designated CMS contractor which would have authority to review patient level information. We would post the address where hospitals are to ship this documentation on the QualityNet Web site. Final review of all mismatched data under a reconsideration request would be done by CMS.

• Provide a written justification for each appealed data element classified during the validation process as a mismatch. Only data elements that affect a hospital's validation score would be subject to reconsideration. We would review the data elements that were labeled as mismatched as well as the written justifications provided by the hospitals, and make a decision on the reconsideration request.

For CY 2011 reconsiderations, we required that a reconsideration request must be signed by the hospital CEO (74 FR 60654). However, we have found that this requirement increases the burden for hospitals as it hampers the electronic submission of the HOP QDRP reconsideration request form. Thus, we are proposing not to include this requirement; for CY 2012 reconsiderations, reconsideration request forms would not need to be signed by the hospital's CEO.

We invite public comment on these proposed requirements.

Following receipt of a request for reconsideration, CMS would—

• Provide an e-mail acknowledgement, using the contact information provided in the reconsideration request, to the CEO and any additional designated hospital personnel notifying them that the hospital's request has been received.

• Provide a formal response to the hospital CEO and any additional designated hospital personnel, using the contact information provided in the reconsideration request, notifying the hospital of the outcome of the reconsideration process.

We intend to complete any CY 2012 reconsideration reviews and communicate the results of these determinations within 90 days following the deadline for submitting requests for reconsideration. In the CY 2010 OPPS/ASC final rule with comment period 74 FR 60654 through 60655), in response to a comment, we indicated that we would "complete any reconsideration reviews and communicate the results of these determinations within 60 to 90 days following the date we receive the request for reconsideration." We are proposing to refine how we describe the time frame for CY 2011 from "60 to 90 days" to within "90 days" because designating a range of dates is unnecessary for this provision.

If a hospital is dissatisfied with the result of a HOP QDRP reconsideration decision, we are proposing that the hospital may file an appeal under 42 CFR Part 405, Subpart R (PRRB appeal).

Similar to our proposal for the RHQDAPU program (75 FR 23995 through 23996), the scope of our review when a hospital requests reconsideration because it failed our validation requirement would be as follows:

• Hospital requests reconsideration for CMS contractor-abstracted data elements classified as mismatches affecting validation scores. Hospitals would be required to have timely submitted requested medical record documentation to the CMS contractor during the quarterly validation process for the requested case to be eligible to be reconsidered on the basis of mismatched data elements.

• Hospital requests reconsideration for medical records submitted during the quarterly validation process and classified as invalid record selection. Invalid record selections would be defined as medical records submitted by hospitals during the quarterly validation process that do not match the patient's episode of care information as determined by the designated re-abstracting CMS contractor. In other words, the contractor determines that the hospital returned medical documentation that is different from that which was requested. If this designated contractor determines that the hospital submitted invalid or incorrect medical documentation, it would award a zero validation score for the case. During the reconsideration process, our review of invalid record selection would initially be limited to determining whether the medical documentation submitted initially to the designated CMS contractor was for the designated episode of care. If we determine during reconsideration that the hospital did submit medical documentation corresponding to the designated episode of care, then we would abstract data elements from the medical record documentation submitted by the hospital; otherwise, the case would not be abstracted.

• Hospital requests reconsideration for medical records not submitted to the CMS contractor within the 45 calendar day deadline. Our review would initially be limited to determining whether the CMS contractor received the requested medical record documentation within 45 calendar days, and whether the hospital received the initial medical record request and reminder notice. If we determine during reconsideration that the CMS contractor did receive the paper copy of the requested, supporting medical record documentation within 45 calendar days, then we would abstract data elements from the medical record documentation submitted by the hospital. If we determine that the hospital received two letters requesting medical documentation and still did not submit the requested documentation within the 45 calendar day period, CMS would not accept this documentation as part of the reconsideration and CMS would not abstract data from this documentation.

In sum, we are initially limiting the scope of our reconsideration reviews involving validation to information already submitted by the hospital during the quarterly validation process, and we would not abstract submitted medical record documentation that was not submitted to the CMS contractor during the quarterly validation process. We would expand the scope of our reconsideration reviews involving validation only if we find during the initial review that the hospital correctly and timely submitted the requested medical record documentation; only then would we abstract data elements from the medical record documentation submitted by the hospital as part of our reconsideration review.

If a hospital is dissatisfied with the result of a HOP QDRP reconsideration decision, the hospital would be able to file an appeal under 42 CFR part 405, Subpart R (PRRB appeal).

We invite public comment on these proposals.

F. Reporting of ASC Quality Data

As discussed above, section 109(b) of the MIEA–TRHCA amended section 1833(i) of the Act by redesignating clause (iv) as clause (v) and adding new clause (iv) to paragraph (2)(D) and by adding new paragraph (7). These amendments authorize the Secretary to require ASCs to submit data on quality measures and to reduce the annual payment update in a year by 2.0 percentage points for ASCs that fail to do so. However, these provisions permit, but do not require, the Secretary to take such action.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875), the CY 2009 OPPS/ASC final rule with comment period (73 FR 68780), and the CY 2010 OPPS/ASC final rule with comment period (74 FR 60656), we indicated that we intend to implement the provisions of section 109(b) of the MIEA–TRHCA in a future rulemaking. While promoting high quality care in the ASC setting through quality

reporting is highly desirable and fully in line with our efforts under other payment systems, the transition to the revised payment system in CY 2008 posed significant challenges to ASCs, and we determined that it would be most appropriate to allow time for ASCs to gain some experience with the revised payment system before introducing other new requirements. Further, by implementing quality reporting under the OPPS prior to establishing quality reporting for ASCs, CMS would gain experience with quality measurement in the ambulatory setting in order to identify the most appropriate measures for quality reporting in ASCs prior to the introduction of the requirement for ASCs. Finally, we are sensitive to the potential burden on ASCs associated with chart abstraction and believe that adopting such measures at this time is in contrast with our desire to minimize collection burden, particularly when measures may be reported via EHRs in the future.

We continue to believe that promoting high quality care in the ASC setting through quality reporting is highly desirable and fully in line with our efforts under other payment systems. However, we continue to have the concerns outlined above for CY 2011. We intend to implement the provisions of section 109(b) of the MIEA–TRHCA in a future rulemaking. We invite public comment on: (1) The deferral of quality data reporting for ASCs; (2) suggestions for quality measures geared toward the services provided by ASCs; and (3) potential reporting mechanisms for ASC quality data, including electronic submission of these data. In addition, we invite public comment on the following measures under future consideration for ASC quality data reporting:

- Patient Fall in the ASC;
- Patient Burn;
- Hospital Transfer/Admission;
- Wrong Site, Side, Patient, Procedure, Implant;
- Prophylactic IV Antibiotic Timing;
- Appropriate Surgical Site Hair Removal;
- Surgical site infection (SSI);
- Medication administration variance (MAV);
- Medication reconciliation; and
- VTE measures: outcome/assessment/prophylaxis.

We note that section 3006(f) of the Affordable Care Act, as added by section 10301(a) of the Affordable Care Act requires CMS to develop a plan to implement a value-based purchasing program for ASCs; this plan is due to Congress by January 1, 2011. We intend to align implementation of ASC quality reporting to be consistent with the value-based purchasing plan that will be developed. We intend to propose implementing the provisions of section 109(b) of the MIEA–TRHCA in CY 2012 rulemaking. We invite public comment on: (1) The timing of implementing quality data reporting for ASCs; (2) suggestions for quality measures for services provided by ASCs; and (3) potential reporting mechanisms for ASC quality data, including electronic submission of these data.

G. Electronic Health Records

As we stated in the CY 2010 OPPS/ASC final rule (74 FR 60656), we are actively seeking alternatives to manual chart abstraction for the collection of quality measures for its quality data reporting programs. Among these alternatives are claims-based measure calculations, collection of data from systematic registries widely used by hospitals, and electronic submission of quality measures using EHRs. In the CY 2009, we received suggestions during the public comment period that we adopt measures that can be collected via EHRs (73 FR 68769). We agree with the commenters about the importance of actively working to move to a system of data collection based on submission from EHRs. In section XVI.B.5.b. of this proposed rule, for the CY 2014 payment determination, we are proposing to adopt several chart-abstracted quality measures for diabetes mellitus, some of which have already been specified for EHR-based capture and submission, and others that are planned for EHR-based submission in the future. We have been engaged with health IT standard-setting organizations to promote the adoption of the necessary standards regarding data capture to facilitate data collection via EHRs, and have been collaborating with such organizations on standards for a number of quality measures. We encourage hospitals to take steps toward the adoption of EHRs that will allow for reporting of clinical quality data from the EHR directly to a CMS data repository. We also encourage hospitals that are implementing, upgrading, or developing EHR systems to ensure that such systems conform to standards adopted by HHS. We invite public comment on the future direction of EHR-based quality measurement submission.

XVII. Proposed Changes Relating to Payments to Hospitals for Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) Costs

A. Background

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) and implemented in regulations at 42 CFR 413.75 through 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved graduate medical education (GME) programs. Section 1886(h)(2) of the Act sets forth a methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable direct costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983, through September 30, 1984). The base year PRA is updated annually for inflation. In general, Medicare direct GME payments are calculated by multiplying the applicable PRA by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (and nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days.

Section 1886(d)(5)(B) of the Act provides for an additional payment amount under the IPPS for hospitals that have residents in an approved GME program in order to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at 42 CFR 412.105.

The Balanced Budget Act of 1997 (Pub. L. 105–33) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its FTE resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending during the 1996 calendar year. Under section 1886(d)(5)(B)(v) of the Act, a similar limit on the FTE resident count for IME purposes is effective for

discharges occurring on or after October 1, 1997.

The recently enacted Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) made a number of statutory changes relating to the determination of a hospital's FTE resident count for direct GME and IME payment purposes and the manner in which FTE resident limits are calculated and applied to hospitals under certain circumstances. (These two pieces of legislation are collectively referred to in this document as the "Affordable Care Act.") Below we set forth our proposals to implement the provisions of the Affordable Care Act relating to Medicare direct GME and IME payments.

B. Counting Resident Time in Nonprovider Settings (Section 5504 of the Affordable Care Act)

1. Background and Changes Made by the Affordable Care Act

Effective July 1, 1987, the Social Security Act was amended to allow hospitals to count the time residents spend training in sites that are not part of the hospital (referred to as "nonprovider" or "nonhospital sites") for purposes of direct GME payments under certain conditions. Specifically, section 1886(h)(4)(E) of the Act requires that the Secretary's rules concerning the computation of FTE residents for purposes of direct GME payments "provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting." (Section 1886(h)(4)(E) of the Act, as added by section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) (OBRA 86).) Regulations implementing this provision were published in the September 29, 1989 final rule (54 FR 40292) at 42 CFR 413.86(f)(3) (now § 413.78(c)), which stated that a hospital may count the time residents spend in nonprovider settings for purposes of direct GME payment if: (1) The residents spend their time in patient care activities; and (2) there is a written agreement between the hospital and the nonprovider entity stating that the hospital will incur all or substantially all of the costs of the program. The regulations at that time defined "all or substantially all" of the costs to include the residents' compensation for the time spent at the nonprovider setting. We also interpreted section 1886(h)(4)(E) of the Act to mean that only one single hospital was permitted to incur the costs of a particular training program and count the time residents spend training in a particular nonhospital setting.

Prior to October 1, 1997, for purposes of the IME payment adjustment, hospitals were not permitted to count the time residents spent training in nonhospital settings. However, section 4621(b)(2) of the Balanced Budget Act of 1997 revised section 1886(d)(5)(B) of the Act to allow providers to count time residents spend training in nonprovider sites for IME purposes, effective for discharges occurring on or after October 1, 1997. Specifically, section 1886(d)(5)(B)(iv) of the Act was amended to provide that "all the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting." In the July 31, 1998 final rule (63 FR 41005), at § 412.105(f)(1)(ii)(C) and § 413.86(f)(4), we specified the requirements that a hospital must meet in order to include the time spent by residents training in a nonhospital site in its FTE count for purposes of both direct GME and IME payments (we note that § 413.86(f)(4) is now redesignated as § 413.78(d)). In that final rule, we also redefined "all or substantially all of the costs for the training program in the nonhospital setting" as the residents' salaries and fringe benefits (including travel and lodging where applicable), *and* the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME.

In order to implement section 1886(h)(4)(E) (and later, section 1886(d)(5)(B)(iv)) of the Act, and to assist contractors in determining whether a hospital incurred "all or substantially all" of the costs of the program in the nonhospital setting, we required in § 413.86(f)(3) and (4) that there must be a written agreement between the hospital and the nonhospital site stating that the hospital will incur "all or substantially all" of the costs of training in the nonhospital setting (we note that § 413.86(f)(3) and (4) is now redesignated as § 413.78(c) and (d)). We later specified at § 413.78(d)(2) that the written agreement must indicate the amount of compensation provided by the hospital to the nonhospital site for supervisory teaching activities.

Section 713 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) imposed a 1-year moratorium relating to certain nonhospital site teaching physician costs for the period from January 1, 2004, through December 31, 2004. During this 1-year period, we were required to allow hospitals to count FTE allopathic or osteopathic family practice residents training in nonhospital settings for IME and direct GME payment purposes without regard to the financial arrangement between the hospital and the teaching physician practicing in the nonhospital setting to which the resident was assigned. We instructed our contractors (then referred to as only "fiscal intermediaries" or "FIs") regarding the effect of section 713 of the MMA in the One-Time Notification (OTN), "Changes to the FY 2004 Graduate Medical Education (GME) Payments as Required by the Medicare Modernization Act of 2003 (MMA)" (Change Request 3071, Transmittal 61, issued on March 12, 2004). Generally, we stated in the OTN that, when settling prior year cost reports during this 1-year period, or for family practice residents actually training in nonhospital settings during this 1-year period, contractors should allow hospitals to count allopathic and osteopathic family practice residents training in a nonhospital setting for direct GME and IME payment purposes without regard to the financial arrangement between the hospital and the nonhospital site pertaining to the teaching physicians' costs associated with the residency program. For further information on this provision and for a summary of comments and responses related to this provision, we refer readers to the FY 2005 IPPS final rule (69 FR 49176).

In an effort to respond to concerns expressed by hospitals about the administrative burden associated with meeting the written agreement requirements, in the FY 2005 IPPS final rule (69 FR 49179), at § 413.78(e), we revised our regulations to allow hospitals to choose to either enter into a written agreement with the nonhospital site before the hospital may begin to count residents training at the nonhospital site, or to pay concurrently for the cost of training at the nonhospital setting. That is, in the absence of a written agreement, hospitals are required to pay "all or substantially all" of the costs of the training program in the nonhospital setting by the end of the third month

following the month in which the training occurs.

On May 11, 2007, we published a final rule (72 FR 26949) that once again modified the definition of "all or substantially all of the costs for the training program in the nonhospital setting." That final rule further defined "all or substantially all" under § 413.75(b) to mean at least 90 percent of the total costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of the teaching physician's salaries attributable to direct GME. Although several public commenters had objected to our proposed redefinition of the "all or substantially all," we adopted the 90 percent rule because we believed it would substantially address concerns that had been voiced previously by the industry. With this modification, hospitals were no longer required to pay 100 percent of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the teaching physicians' costs attributable to direct GME at the nonhospital site. This change in policy also allowed providers to use an alternative, less burdensome method to calculate the GME teaching physician costs attributable to direct GME at nonhospital sites. In addition to the redefinition of "all or substantially all of the costs," the May 11, 2007 final rule also modified the regulation text at § 413.78(f)(3)(ii) to clarify that the required written agreement between a hospital and a nonhospital site must be in place before residents begin training at the nonhospital site. That final rule also specified the information that must be included in the written agreement, and stated that the amounts specified in the written agreement may be modified by June 30 of the applicable academic year.

Section 5504(a) of the Affordable Care Act made changes to section 1886(h)(4)(E) of the Act to significantly reduce the costs that hospitals must incur for residents training in nonhospital sites in order to count the FTE residents for purposes of Medicare direct GME payments. Specifically, section 5504(a) amended the statute to allow a hospital to count all the time that a resident trains in a nonhospital site so long as the hospital incurs the costs of the residents' salaries and fringe benefits for the time that the resident spends training in the nonhospital site. Section 5504(b) of the Affordable Care Act made similar changes to section 1886(d)(5)(iv) of the Act for IME payment purposes. For direct GME payments, the provision is effective for cost reporting periods beginning on or after July 1, 2010; for IME payments, the provision is effective for discharges occurring on or after July 1, 2010. The changes made by section 5504(a) and (b) also specify that if more than one hospital incurs the residency training costs in a nonhospital setting, those hospitals are to count a proportional share of the training time as determined by written agreement between the hospitals. In addition, section 5504(a) amended section 1886(h)(4)(E) of the Act to require hospitals to maintain documents indicating the amount of time their residents spend training in nonhospital sites relative to a base year, and to make those documents available to the Secretary.

Section 5504(c) of the Affordable Care Act specifies that the amendments made by the provisions of sections 5504(a) and (b) shall not be applied in a manner that would require the reopening of settled cost reports except where the provider has a jurisdictionally proper appeal pending on the issue of direct GME or IME payments as of March 23, 2010 (the date of the enactment of Pub. L. 111–148). We are proposing to interpret "pending, jurisdictionally proper appeal on direct GME or IME payments" to mean that in order for a hospital to request a change to its FTE count, direct GME or IME respectively, the "pending, jurisdictionally proper appeal" must be specific to direct GME or IME respectively. For example, in order for a hospital to increase its FTE count with regard to an ACA provision that is unique to IME (such as inclusion in the IME count of didactic time occurring in the hospital as specified by new section 1886(d)(5)(B)(x)(II)), the hospital's "pending, jurisdictionally proper appeal" must be on an IME issue; IME FTEs or the available bed count. However, if the hospital's "pending, jurisdictionally proper appeal" is on an issue that only affects direct GME payments, such as the initial residency period or the Medicare patient load, that appeal would not be sufficient in order for the hospital to increase its FTE count with regard to an ACA provision that is unique to IME, such as didactic time in the hospital setting.

2. Elimination of the "All or Substantially All of the Costs for the Training Program in the Nonhospital Setting" Requirement and New Cost Requirements for Hospitals

As stated earlier, in the May 11, 2007 final rule (72 FR 26949), we redefined the phrase "all or substantially all of the costs for the training program in the nonhospital setting" under § 413.75(b) of the regulations to mean at least 90 percent of the total costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of the teaching physicians' salaries attributable to nonpatient care direct GME. However, section 5504 of the Affordable Care Act revised the Act, effective on July 1, 2010, and eliminated the requirement that a hospital incur "all or substantially all of the costs for the training program in the nonhospital setting." Under the changes made by section 5504, hospitals are only required to incur the costs of the resident's salaries and fringe benefits during the time the resident spends in the nonhospital setting, and they no longer have to incur other training costs in the nonhospital site in order to count such time for direct GME and IME purposes.

We are proposing to revise our regulation at § 413.75(b) accordingly to conform to these new statutory requirements. Specifically, we are proposing to revise the existing definition of "all or substantially all of the costs for the training program in the nonhospital setting" to be effective for cost reporting periods beginning on or after July 1, 2007, and before July 1, 2010. We also are proposing to add a new § 413.78(g) that details how hospitals should count residents that train in nonhospital sites for cost reporting periods beginning on or after July 1, 2010. Specifically, we are proposing to require under § 413.78(g)(2) that a hospital or hospitals must incur the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting in order to count the time spent by those residents for direct GME payment purposes. § 412.105(f) has also been revised to reflect these changes for the purposes of IME payments.

3. Proposed Revision to Regulations To Allow More Than One Hospital To Incur the Costs of Training Programs at Nonhospital Settings, Either Directly or Through a Third Party

As indicated above, prior to the enactment of the Affordable Care Act, we had interpreted both section 1886(h)(4)(E) of the Act (regarding direct GME) and section 1886(d)(5)(B)(iv) of the Act (regarding IME) as allowing a hospital to count the time spent by residents training in a nonhospital site only when one single hospital incurred the costs of a particular training program in a particular nonhospital setting. We noted that both sections of the statute specified that a hospital could count the time spent by residents training in a nonhospital site "if *the*

hospital incurs all or substantially all of the costs for the training program in *that* setting" (emphasis added). While we understand that, in some cases, hospitals share the costs of training their respective residents in the same programs at the same nonhospital site, we have historically only allowed a hospital to count time spent by those residents if one single hospital met the requirement to incur "all or substantially all" of the training program costs at a nonhospital site. Accordingly, two or more hospitals could not count the time spent by their residents training in a nonhospital site if they shared the training costs at the site or if a third party incurred the costs of training at a nonhospital site on behalf of several hospitals. Examples of third parties that might incur nonhospital site training program costs are a medical or dental school, or a GME administrative entity that is established to operate the GME program.

Sections 5504(a) and (b) of the Affordable Care Act specifically address the situation in which more than one hospital incurs the costs of training programs at nonhospital settings, either directly or through a third party. Sections 5504(a) and (b) amend sections 1886(h)(4)(E) and 1886(d)(5)(B)(iv) of the Act, respectively, to provide that when more than one hospital incurs these costs, either directly or through a third party, those hospitals "shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting." Therefore, these statutory changes now allow hospitals to share the costs of resident training at nonhospital sites, so long as those hospitals divide the resident time proportionally pursuant to a written agreement, for the purposes of determining their respective direct GME and IME FTE resident counts at the nonhospital site. These provisions of the statute are effective for cost reporting periods beginning on or after July 1, 2010 for direct GME, and for discharges occurring on or after July 1, 2010 for IME. Accordingly, although hospitals that shared training costs at nonhospital sites could not count any of resident time spent training at those nonhospital sites prior to July 1, 2010, hospitals can count all of that training time beginning on or after July 1, 2010, as long as they divide the resident training time proportionally.

We are proposing to revise our regulations to reflect the statutory provision that allows hospitals to proportionally share the costs of resident training at nonhospital sites under a new paragraph (g)(2) of § 413.78 and to make a conforming cross-reference change under § 412.105(f)(1)(ii) of the IME regulations. While the statute allows hospitals to determine by an agreement the proportional share of time that residents spend training in the nonhospital site, we are proposing that hospitals must use some reasonable basis for establishing that proportion (proposed § 413.78(g)(2)(ii)). One such reasonable basis could be that each hospital counts the number of FTEs for which it incurs the salaries and fringe benefits. For example, if there are 10 FTEs training in a nonhospital setting in a particular program, and there are two hospitals that each incur the costs of the salaries and fringe benefits of 5 of those FTEs, each hospital could agree to count 50 percent of the FTEs (even if each hospital is not necessarily paying 50 percent of the cost, due to differences in resident salary amounts, this arrangement is acceptable, so long as 100 percent of the required cost is paid).

In addition to having a reasonable basis for establishing the proportion, hospitals also must be able to document the amount that they are paying collectively, and this amount must equate to at *least* the sum of all the salaries and fringe benefits of the residents for the amount of time that the residents are training in that site. The salaries and fringe benefits of the residents will vary depending upon the program year of the residents, and the specialty in which they are training. As we indicated in the May 11, 2007 final rule (72 FR 26961), hospitals must "take into account the actual salary and fringe benefits for each FTE resident that trains in the nonhospital site, which may vary by resident." Therefore, as also indicated in the May 11, 2007 final rule (72 FR 26970), global agreements that cover a variety of issues (GME and non-GME) between the hospital(s) and nonhospital site, and that only specify a lump sum payment amount with no break out of the residents' salaries and fringe benefits, do not provide sufficient information for the Medicare contractor to determine that "all or substantially all" of the costs (or, effective July 1, 2010, that all of the residents' salaries and fringe benefits) have been paid. Accordingly, we would expect that, regardless of whether there is one hospital paying the cost, or if more than one hospital is sharing the costs, hospitals would need to determine prior to the start of nonhospital rotations (with allowance for modification by June 30 of that academic year) the total cost of the salaries and fringe benefits of the residents that are training for the proportion of the year spent in each nonhospital site. Of course, in the instance where the residents remain on the payroll of one or more hospitals for the entire year, it would be easier to document that the hospital(s) continues to pay the residents' salaries and fringe benefits when the residents rotate to nonhospital sites. Similarly, where the residents are on the payroll of the medical or dental school, or of a third party GME administrative entity, and the hospitals reimburse the school or the third party for the *entire* salary and fringe benefit costs of the residents for both hospital and nonhospital training, the hospitals could easily document that they have incurred the requisite costs of training in nonhospital sites. In some circumstances, it may be more labor-intensive for a hospital or hospitals to document that they have incurred costs of training in the nonhospital site that equate to at least the sum of the salaries and fringe benefits of the FTE residents for the proportion of time spent in the nonhospital site. This is especially true in situations where funds are being transferred between one or more hospitals and a third party administrative entity not simply for Medicare GME purposes, but as part of global agreements that also address a variety of Medicare and non-Medicare issues. However, once the total costs for the residents' salaries and fringe benefits for time spent in the nonhospital site are determined and covered by the hospitals, the hospitals may decide among themselves the proportion of those costs each will incur, and may use a reasonable basis to allocate among themselves the proportion of FTE residents that each one will count, as discussed above.

As specified in section 5504, we are proposing further that the hospitals must record the proportion of the FTE resident time spent training in the nonhospital site that will be counted by each hospital for purposes of direct and indirect GME payment, as well as the reasonable basis for the proportion, in a written agreement between the hospitals. We are proposing to add this requirement in regulations at § 413.78(g)(2)(i). If hospitals have in place written agreements with the nonhospital site in accordance with our existing regulations at § 413.78(f)(3)(ii), we are proposing that the proportion of the FTE resident training time to be counted for IME and direct GME purposes by each hospital, and the basis for the proportion, may be recorded in that agreement (proposed § 413.78(g)(2)(iii)). We are proposing that if the hospitals choose to pay the

training program costs concurrently as described in § 413.78(g)(3)(i), that is, without a written agreement, the hospitals must still agree in writing to the proportion of costs and training time they plan to incur and count (proposed § 413.78(g)(2)(iv)) in addition to the basis for that proportion, as specified by the statute. That written agreement between the hospitals must be available for CMS review and for auditing purposes. In addition, we would expect that the hospitals' records of resident training time and training costs at nonhospital sites, as required by the Affordable Care Act and as discussed below, reflect the proportions of training time and costs as agreed upon and documented in whichever type of written agreement the hospitals used to record the proportional shares of resident training time that each will count for purposes of direct GME and IME payment.

4. Proposed Changes to Regulations Regarding Recordkeeping and Comparison to a Base Year

As stated above, section 5504(a) of the Affordable Care Act requires hospitals to maintain records of the amount of time that their residents spend in nonprovider settings, and to compare that time to the time spent by their residents in nonprovider sites in a base year as the Secretary may specify. This requirement is effective for cost reporting periods beginning on or after July 1, 2010. We are proposing to incorporate this statutory requirement for maintaining records under a new paragraph (g)(5) of § 413.78 of the regulations, and we anticipate amending the cost report for hospitals to include lines where hospitals can submit the required data, which is described below. These data will help CMS identify whether barriers to resident training in nonhospital sites exist. The original allowance of IME payments for training in nonhospital sights, as instituted by the BBA, was intended to act as an incentive to hospitals to increase such training. However, we have not seen a marked increase in the amount of training that occurs in nonhospital settings in the years since the implementation of the BBA. Advocates of expanding training in nonhospital sites have alleged that CMS' rules for counting residents in nonhospital sites regarding teaching physician salary costs were an obstacle to the expansion of training in nonhospital settings. The recordkeeping and reporting requirement added by section 5504(a) of the Affordable Care Act will provide the Secretary information to assess whether nonhospital site resident training increases as a result of the statutory revision of rules that were viewed as burdensome.

We understand that rotation schedules are a primary source of information that hospitals supply to Medicare contractors for determining where and for how much time each resident spends training in each hospital or nonhospital site. Therefore, we are proposing that rotation schedules be the source for establishing the amount of time that residents spend training in nonhospital sites, both in the base year and in subsequent years. The amendment to section 1886(h)(4)(E) of the Act by section 5504(a) of the Affordable Care Act states that the Secretary shall specify the aforementioned base year for the level of training at nonhospital sites. We are proposing that cost reporting periods beginning on or after July 1, 2009 and before June 30, 2010 be the base year against which we will compare subsequent years' data to determine if the amount of nonhospital training that occurs in subsequent years increases relative to that base year (proposed new § 413.78(g)(5)). We also are proposing that, to meet this documentation requirement, hospitals only need to maintain records of the total unweighted direct GME FTE count (before application of the direct GME FTE resident cap) of resident training time in nonhospital settings.

Section 5504(a) of the Affordable Care Act also made changes to require that these records be made available to the Secretary. In order for CMS to evaluate whether nonhospital site training has increased as a result of the changes made by section 5504 of the Affordable Care Act, we are proposing to include several additional cost report lines for hospitals to submit data for each of their primary care programs on a program-specific basis. With respect to hospitals' nonprimary care programs, hospitals would only need to supply that data on an overall hospital basis, and we are proposing to add one line on the cost report for hospitals to submit that data. We are only requiring program-specific data with respect to resident training time in nonhospital sites for primary care specialties because we believe that that is sufficient for the intent of this provision. The intent of this recordkeeping requirement is to see whether, as a result of the policy changes required under section 5504(a), there is an increase in the volume of residency training that takes place in nonhospital settings. Since residents at nonhospital sites typically train in primary care specialties, and in order to minimize the documentation burden on hospitals, we do not believe it is necessary to require program-specific data for other specialties that would provide only marginally useful information. For the purposes of this provision, we propose to use the definition of primary care resident in § 413.75(b) to identify those programs for which we are proposing to require program-specific data.

Once this information is made available to CMS, the data would be compared to the analogous data from the base year of cost reporting periods beginning on or after July 1, 2009 and before June 30, 2010, in order for CMS to determine whether the volume of nonhospital site training has increased. Specifically, we are proposing to use the total direct GME count of FTE training time in a primary care specialty in nonhospital sites (prior to application of direct GME FTE resident limits) as the gauge to determine if residency training time in nonhospital settings in that specialty has increased in an academic year relative to the base year. For example, if, in the base year, we find that 10.5 direct GME FTEs out of a total of 15 FTE family practice residents from a family practice residency program in a teaching hospital trained in nonhospital settings (that is, 70 percent of the FTE time of the residents in the family practice residency program was spent training in nonhospital sites), we would note the subsequent years' amount of direct GME FTE training time in nonhospital sites in that particular teaching program to see if that FTE proportion increased from 70 percent. This would help determine if more training time is spent by primary care residents in nonhospital sites. Or, for all of the nonprimary care teaching programs in a hospital, if 100 direct GME FTE residents out of 400 FTE residents spent time training in nonhospital settings (that is, 25 percent of the time spent by residents in the program is spent training in nonhospital sites), we would look to see if in subsequent years, more than 25 percent of the time spent by nonprimary care direct GME FTEs from that hospital is spent training in nonhospital sites.

C. Counting Resident Time for Didactic and Scholarly Activities and Other Activities (Section 5505 of the Affordable Care Act)

1. Background and Changes Made by the Affordable Care Act

Prior to the enactment of the Affordable Care Act, the time that residents spend training at a nonhospital setting in nonpatient care activities, as part of an approved

program, could not be included in a hospital's direct GME or IME FTE resident count. There were also differences in the rules for counting FTE resident time during the time that residents spend training in the hospital for direct GME and IME payments. For direct GME payment purposes, under 42 CFR 413.78(a), "residents in an approved program working in all areas of the hospital complex may be counted." As explained in the September 29, 1989 **Federal Register** (54 FR 40286), the hospital complex consists of the hospital and the hospital-based providers and subproviders. Therefore, the distinction between patient care activities and nonpatient care activities is not relevant to direct GME FTE count determinations when the residents are training in the hospital complex. However, for IME payment purposes, consistent with the regulations at 42 CFR 413.9 and 412.105(f)(1)(iii)(C), only time spent in patient care activities in the hospital is counted. It has been our longstanding policy that, regardless of the site of training, "we do not include residents in the IME count to the extent that the residents are not involved in furnishing patient care" (66 FR 39897, August 1, 2001).

Section 5505(a) of the Affordable Care Act added new subparagraph (J) to section 1886(h)(4) (as amended by section 5504) of the Act to allow hospitals to count certain nonpatient care activities that occur in certain nonprovider settings, including didactic conferences and seminars, in the hospital's direct GME FTE resident counts. The provision added by section 5505(a) allows a hospital to count the time that residents spend training in an approved program in a "nonprovider setting that is primarily engaged in furnishing patient care" for direct GME purposes, even if those residents are engaged in nonpatient care activities, such as didactic conferences and seminars (but not including research not associated with the treatment or diagnosis of a particular patient), during that training time at the nonhospital site. This statutory change is effective for cost reporting periods beginning on or after July 1, 2009. We are proposing to revise our regulations at § 413.78(f)(1) and (g)(1) to reflect the statutory provision.

Section 5505(b) of the Affordable Care Act addressed IME and added a new clause (x) to section 1886(d)(5)(B) of the Act which allows certain nonpatient care activities, including didactic conferences and seminars (but not including research not associated with the treatment or diagnosis of a particular patient), to be counted for IME purposes as well. However, for IME purposes, this change only applies to such activities during training that occurs in subsection (d) hospitals (which are IPPS hospitals), subsection (d) Puerto Rico hospitals (IPPS hospitals in Puerto Rico), hospitals that are reimbursed under a reimbursement system authorized under section 1814(b)(3) of the Act, or provider-based hospital outpatient departments. The IME provision is applicable to cost reporting periods beginning on or after January 1, 1983. We are proposing to revise our regulations at § 412.105(f)(1)(ii)(A) through (f)(1)(ii)(D) and (f)(1)(iii)(B) to reflect these statutory provisions.

As specified in section 1886(d)(5)(B)(x)(III) of the Act, as added by section 5505(b) of the Affordable Care Act, research activities that are not associated with the treatment or diagnosis of a particular patient are excluded from the allowable IME count of FTE residents, and this specific change applies to cost reporting periods beginning on or after October 1, 2001. We discuss this provision and our proposed implementation under section XVII.C.3. of this proposed rule.

Section 10501(j) of Public Law 111–152 amended section 5505 of Public Law 111–148 to clarify the application of the provisions of section 5505. The amendment prohibits the provisions of section 5505 from being applied in a manner that would require the reopening of settled cost reports except where the provider has a jurisdictionally proper appeal pending on the issue of direct GME or IME payments as of March 23, 2010 (the date of the enactment of Pub. L. 111–148). We are proposing to reflect this provision in the proposed revisions to our regulations under § 412.105(f)(1)(ii), § 412.105(f)(1)(iii)(C) and § 413.78(h). We are also proposing, as mentioned above with respect to Section 5504, to interpret "pending, jurisdictionally proper appeal on direct GME or IME payments" for this section to mean that in order for a hospital to request a change to its FTE count, direct GME or IME respectively, the "pending, jurisdictionally proper appeal" must be specific to direct GME or IME respectively. For example, in order for a hospital to increase its FTE count with regard to an ACA provision that is unique to IME (such as inclusion in the IME count of didactic time occurring in the hospital as specified by new section 1886(d)(5)(B)(x)(II)), the hospital's "pending, jurisdictionally proper appeal" must be on an IME issue; IME FTEs or the available bed count. However, if the hospital's "pending, jurisdictionally proper appeal" is on an issue that only affects direct GME payments, such as the initial residency period or the Medicare patient load, that appeal would not be sufficient in order for the hospital to increase its FTE count with regard to an Affordable Care Act provision that is unique to IME, such as didactic time in the hospital setting.

2. Definition of "Nonprovider Setting That Is Primarily Engaged in Furnishing Patient Care"

As stated above, section 5505(a) of the Affordable Care Act amended section 1886(h)(4) of the Act to allow hospitals to count the time that residents spend in certain nonpatient care activities in nonhospital sites towards the hospitals' direct GME resident count for cost reporting periods beginning on or after July 1, 2009. The amendments made by section 5505(a) to section 1886(h)(5) of the Act include a definition of the term "nonprovider setting that is primarily engaged in furnishing patient care" to mean "a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary." In past discussions regarding our policy to disallow time spent by residents in didactic nonpatient care activities, we have given extensive explanations of what we mean by the term "patient care activities." When section 1886(h)(4)(E) of the Act was first implemented, we specifically stated that "only time spent in activities relating to patient care may be counted [in nonhospital sites]" (54 FR 40292, September 29, 1989). In 1998, when we implemented the statute allowing FTE residents to be counted in nonhospital sites for IME, we reiterated that a hospital may only count resident training time "in nonhospital sites for indirect and direct GME, respectively, if the resident is involved in patient care" (63 FR 40986, July 31, 1998). In addition, we note that the scope of the term "patient care" had been well-established in the Medicare program even prior to issuance of the first rules on counting FTE residents for purposes of direct GME and IME payments. For example, prior to the IPPS, acute care hospitals were paid by Medicare for inpatient services based on their reasonable operating costs, or costs relating to the provision of reasonable and necessary "patient care." The longstanding regulation at 42 CFR 413.9 (Costs related to patient care) specifies that Medicare payment is limited to those services relating to "patient care," or to those relating to covered services for the care of beneficiaries. In the August 18, 2006 **Federal Register**, we defined the term "patient care activities"

at 42 CFR 413.75 in a way that was consistent with these previous, plain-language applications of the term (71 FR 48142). Therefore, we currently define "patient care" at § 413.75(b) as "the care and treatment of particular patients, including services for which a physician or other practitioner may bill, and orientation activities as defined in this section."

Section 5505(a) of the Affordable Care Act added a new subparagraph (K) to section 1886(h)(5) which defines the term "nonprovider setting that is primarily engaged in furnishing patient care" to mean "a nonprovider setting in which the primary activity is the care and treatment of particular patients, as defined by the Secretary." This definition uses the term "patient care" which we have defined previously, as discussed above. We are proposing to continue our current construction of the term "patient care" as described above and in current regulations and other guidance. Examples of nonprovider settings that would be "primarily engaged in furnishing patient care" are those settings in which the main mission is to provide patient care, such as doctors' offices and community health clinics. Nonprovider settings that *would* not meet these criteria include those with a main mission other than patient care. Examples of such settings are medical schools and dental schools, even if those schools are part of a larger system that includes institutions that are primarily engaged in patient care. Despite any affiliations with patient care settings, medical and dental schools are institutions that are primarily engaged in educational activities as opposed to patient care. Medical and dental schools retain their principal mission of education regardless of their participation in various systems and affiliations, parts of which may involve settings that are primarily engaged in furnishing patient care. Another example of a nonprovider setting that does not meet the "primarily engaged in furnishing patient care" criterion set forth in this section would be a hotel or convention center. While residents may attend didactic conferences and seminars in a hotel or convention center, that didactic time cannot be counted toward a hospital's direct GME FTE count because the main mission of a hotel or convention center is the provision of hospitality and meeting services. Thus, any such time spent in a hotel or convention center would not occur in a setting that is primarily engaged in furnishing patient care.

The exclusion of medical and dental schools from the definition of "nonprovider setting that is primarily engaged in furnishing patient care" is consistent with longstanding CMS policy, and we have addressed this policy several times in the past. We explained in response to comments in the aforementioned August 18, 2006 **Federal Register** that, "[W]e understand that it is quite common for hospitals, especially large academic medical centers, to be located on the same campus as a medical school, where the buildings are very closely situated or even connected, and the facilities are often shared. However * * * hospitals, nonhospital sites, and medical schools are structured separately for legal and financial purposes, and are recognized independently for state licensing and Medicare cost reporting purposes. As we stated in 2006, "to put it simply, a hospital is not a medical school, and a medical school is not a hospital" (71 FR 48093). In the August 22, 2007 **Federal Register**, we clarified that, "[T]he commenter is also correct that orientation activities in a related medical school cannot be counted * * * the nonhospital settings we were referring to in which orientation may be counted are those nonprovider settings such as physicians' offices or clinics, where patient care is routinely provided and a hospital is permitted to count the time spent by residents in accordance with our regulations at §§ 412.105(f)(1)(ii)(C) and 413.78(f), *not* other nonhospital settings where time spent by residents is not permitted to be counted for purposes of direct GME and IME" (72 FR 47382). Thus, while time spent by residents in certain nonpatient care activities may be counted for direct GME payment purposes in a nonhospital site primarily engaged in furnishing patient care, time spent by residents in nonpatient care activities at nonhospital sites that are *not* primarily engaged in patient care activities is not allowable for direct GME and IME payment purposes.

We are proposing to add, under § 413.75, the statutory definition of "nonprovider setting that is primarily engaged in furnishing patient care" to the definition of general terms used throughout the GME regulations.

3. Distinguishing Between Allowed "Nonpatient Care Activities" and Nonallowable Research Time

As discussed above, research time that is not associated with the treatment or diagnosis of a particular patient is specifically excluded from the "nonpatient care activities, such as didactic conferences and seminars" that are otherwise allowable under section 5505 of the Affordable Care Act for the purposes of direct GME in nonhospital sites for cost reporting periods beginning on or after July 1, 2009, and for purposes of IME in certain hospital settings for cost reporting periods beginning on or after January 1, 1983. There are several unique features of "research not associated with the treatment or diagnosis of a particular patient" that distinguish it from "nonpatient care activities, such as didactic conferences and seminars." "Research not associated with the treatment or diagnosis of a particular patient" usually comprises activities that are focused on developing new medical treatments, evaluating medical treatments for efficacy or safety, or elaborating upon knowledge that will contribute to the development and evaluation of new medical treatments in the future, rather than on establishing a diagnosis or furnishing therapeutic services for a particular patient.

Section 5505 further distinguishes "research not associated with the treatment or diagnosis of a particular patient" from "nonpatient care activities, such as didactic conferences and seminars," by specifying that nonpatient care activities include "didactic conferences and seminars." Conferences or seminars could include an administrative rotation, which would include resident training in the administrative aspects of medical care such as practice management.

4. Approved Leaves of Absence

In the FY 2008 IPPS proposed rule (72 FR 24814), we proposed to remove vacation, sick leave and other types of leave from the FTE calculation for IME and for direct GME purposes. We proposed this policy based on our belief that such leave time involved neither patient care nor nonpatient care activities. However, we did not finalize this proposed policy after many public commenters explained that the implementation of the policy would involve significant administrative burdens (FY 2008 IPPS final rule, 72 FR 47374). Thus, we did not revise our previously existing policy which allowed vacation and sick leave generally to be counted for direct GME and IME purposes. In the FY 2008 IPPS proposed rule, we also proposed to continue to count the time spent by residents in orientation activities in both the hospital and nonhospital settings. We proposed this policy because we recognized the distinct character of orientation activities as essential to the provision of patient care by residents. We did finalize our policy on orientation time, and in doing so, we specified that *patient care activities* means the care and treatment of

particular patients, including services for which a physician or other practitioner may bill, and orientation activities (§ 413.75(b)), effective for cost reporting periods beginning on or after October 1 2007.

Section 5505(a) of the Affordable Care Act added new subparagraph (K) to section 1886(h)(4) to clarify that hospitals may count residents' vacation, sick leave, and other approved leave time toward the hospitals' direct GME FTE resident count, so long as the leave does not prolong the total time the resident participates in his or her approved program. This direct GME provision regarding leave time is effective for cost reporting periods beginning on or after January 1, 1983. In addition, section 5505(b) of the Affordable Care Act allows hospitals to count residents' vacation, sick leave, and other approved leave time toward the hospitals' IME FTE resident count, as long as the leave does not prolong the total time the resident participates in his or her approved program. This IME provision regarding leave time is effective for cost reporting periods beginning on or after January 1, 1983.

We are proposing to revise our regulations to reflect these statutory changes regarding counting residents' vacation, sick leave, and other approved leave time toward the hospitals' direct FTE resident count under new § 413.78(h) for GME and under § 412.105(f)(1)(iii)(D) for IME. Please note that each hospital is to count the proportion of the leave of absence time as specified in 72 FR 47382. There, we explained that regardless of which hospital is paying the resident's salaries and fringe benefits, the hospital to which the resident is assigned during the time the vacation is taken is the hospital that counts that FTE time for direct GME and IME. If the rotation schedule does not clearly indicate where the resident is assigned during the time the vacation is taken, the hospitals to which the resident rotates over the course of the academic year would divide and count the resident's vacation time proportionately based on the amount of time spent in actual training at the respective hospitals. We are also proposing to specify that "other approved leave" includes those types of generally accepted leave of short duration (those that do not prolong the total time that the resident is participating in the approved training program) that have not been included in our resident leave time policies in the past. Examples of such "other approved leave" could include jury duty, other court leave, or voting leave.

D. Reductions and Increases to Hospitals' FTE Resident Caps for GME Payment Purposes (§§ 412.105(f)(1)(iv) and 413.79(m) and (o))

1. General Background on Methodology for Determining the FTE Resident Count

As we discuss in section XVII.A. of this proposed rule, Medicare makes both direct and indirect GME payments to hospitals that train residents in approved medical residency training programs. Direct GME payments are made in accordance with section 1886(h) of the Act, based generally on hospital-specific PRAs, the number of FTE residents, and the hospital's Medicare patient share. IME payments are made in accordance with section 1886(d)(5)(B) of the Act, based generally on the ratio of the hospital's FTE residents to the number of hospital beds. Accordingly, the calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count; generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. In an attempt to end the implicit incentive for hospitals to increase the number of FTE residents, Congress instituted a cap on the number of allopathic and osteopathic residents a hospital is allowed to count for direct GME and IME purposes under the provisions of section 1886(h)(4)(F) of the Act for direct GME and section 1886(d)(5)(B)(v) of the Act for IME. Dental and podiatric residents are not included in this statutorily mandated cap.

2. Reduction of Hospitals' FTE Resident Caps Under the Provisions of Section 5503 of the Affordable Care Act

Medicare makes direct GME and IME payments based on the number of FTE residents the hospital is permitted to count, as limited by the hospital's FTE resident caps. Some hospitals have trained a number of allopathic and osteopathic residents in excess of their FTE resident caps. Other hospitals have reduced their FTE resident counts to some level below their FTE resident caps. Section 5503 of the Affordable Care Act added a new section 1886(h)(8) to the Act to provide for reductions in the statutory FTE resident caps for direct GME under Medicare for certain hospitals, and authorizes a "redistribution" to other hospitals of the estimated number of FTE resident slots resulting from the reductions. Section 5503 also amended section 1886(d)(5)(B)(v) to require application of the provisions of 1886(h)(8) "in the same manner" to the FTE resident caps for IME. A previous redistribution of "unused" FTE resident slots was performed under section 422 of Public Law 108–173 (the Medicare Modernization Act of 2003). Section 422 provided for the redistribution of unused residency positions effective for portions of cost reporting periods beginning on or after July 1, 2005. While section 5503 of the Affordable Care Act is similar to section 422 of Public Law 108–173, there are substantive differences between the two provisions.

The new section 1886(h)(8)(A) of the Act provides that, effective July 1, 2011, a hospital's FTE resident cap will be reduced if its "reference resident level," is less than its "otherwise applicable resident limit," as these terms are described below. Rural hospitals with fewer than 250 acute care inpatient beds as well as those hospitals described in section XVII.D.5. of this proposed rule are exempt from a reduction. For other hospitals, any such reduction will be equal to 65 percent of the difference between the hospital's "otherwise applicable resident limit" and its "reference resident level."

Under the new section 1886(h)(8)(B) of the Act, the Secretary is authorized to increase the FTE resident caps for certain categories of hospitals for portions of cost reporting periods occurring on or after July 1, 2011, by an aggregate number that does not exceed the estimated overall reduction in FTE resident caps for all hospitals under section 1886(h)(8)(A) of the Act. A single hospital may receive an increase in its FTE resident cap of no more than 75 additional FTEs. That is, a hospital would be allowed to receive up to 75 additional slots for direct GME and up to 75 additional slots for IME. In determining which hospitals would receive an increase in their FTE resident caps, section 1886(h)(8)(B) of the Act directs us to—

- Take into account the demonstrated likelihood of the hospital filling the additional positions within the first three cost reporting periods beginning on or after July 1, 2011.
- Take into account whether the hospital has an accredited rural training track program.
- Distribute 70 percent of the resident slots to hospitals located in States with resident-to-population ratios in the lowest quartile.
- Distribute 30 percent of the resident slots to hospitals located in a State, a territory of the United States, or the District of Columbia that are among the top 10 States, territories, or Districts in terms of the ratio of the total population living in an area designated as a health

professional shortage area (HSPA), as of March 23, 2010, to the total population, and to hospitals located in rural areas.

In summary, section 5503 of the Affordable Care Act added a new section 1886(h)(8) of the Act that prescribes a methodology for determining reductions to certain hospitals' FTE resident caps based on unused FTE resident slots, provides for certain exceptions to the FTE resident cap reductions, and includes general criteria that CMS must consider in making a "redistribution" to other hospitals of the estimated number of FTE resident slots resulting from the reductions in the FTE resident caps. In this proposed rule, we are proposing procedures for determining whether, and by what amount, a hospital's FTE resident cap is subject to a reduction under section 1886(h)(8)(A) of the Act. We also are specifying an application process for hospitals that seek to receive increases in their FTE resident caps and the specific criteria that we will use to determine which hospitals will receive increases in their FTE resident caps under section 1886(h)(8)(B) of the Act.

3. Hospitals Subject to the FTE Resident Cap Reduction

As indicated earlier, section 1886(h)(8)(A) of the Act, as added by section 5503 of the Affordable Care Act, provides that if a hospital's "reference resident level" is less than its "otherwise applicable resident limit," its FTE resident cap(s) will be reduced by 65 percent of the difference between its "otherwise applicable resident limit" and its "reference resident level." Under section 1886(h)(8)(H)(i) (as added by section 5503 of the Affordable Care Act), the "reference resident level" refers to the number of unweighted allopathic and osteopathic FTE residents who are training at a hospital in a given cost reporting period. That is, the "reference resident level" refers to a hospital's allopathic and osteopathic FTE resident count for a specific period. Under section 1886(h)(8)(H)(ii) the "otherwise applicable resident limit" refers to a hospital's FTE resident cap established under sections 1886(h)(4)(F)(i) and (h)(4)(H) of the Act for direct GME payment purposes and a hospital's resident cap established under section 1886(d)(5)(B)(v) for IME payment purposes. For most hospitals, the permanent FTE cap under section 1886(h)(4)(F)(i) of the Act is based on: (1) For an urban hospital, the number of unweighted allopathic and osteopathic FTE residents in the hospital's most recent cost reporting period ending on or before December 31, 1996 (the "1996 cap"); (2) for a rural hospital, 130 percent of the 1996 cap, adjusted as specified under existing § 413.79(c)(2); and (3) any adjustments to the hospital's cap under paragraph (7), which specifies the previous "redistribution" of resident positions required by section 422 of Public Law 108–173. Section 1886(h)(4)(H) of the Act specifies that a hospital's FTE resident cap under subparagraph (F) may be adjusted for a new medical residency training program established on or after January 1, 1995, participation in a Medicare GME affiliated group, and establishment by an urban hospital of a separately accredited rural training track program. We are proposing that, in defining a hospital's "otherwise applicable resident limit" for purposes of section 1886(h)(8)(A) of the Act, we will look at the hospital's 1996 cap during its reference year, as adjusted for the following criteria: new programs as defined at § 413.79(e); participation in a Medicare GME affiliation agreement as defined at §§ 413.75(b) and 413.79(f); participation in an Emergency Medicare GME affiliation agreement as defined at § 413.79(f); participation in a hospital merger; and whether an urban hospital has a separately accredited rural training track program as defined at § 413.79(k). We discuss the applicability of Medicare GME affiliation agreements under section 1886(h)(8)(A) of the Act in more detail under section XVII.D.8.c. of this proposed rule and the treatment of hospital mergers under section XVII.D.8.d. of this proposed rule. Furthermore, section 1886(h)(8)(H)(iii) of the Act requires that, in determining a hospital's "otherwise applicable resident limit," section 1886(h)(7)(A) of the Act shall be taken into account. Section 1886(h)(7)(A) of the Act refers to the reduction to a hospital's cap(s) under section 422 of Public Law 108–173. The application of section 422 of Public Law 108–173 to the implementation of section 5503 of the Affordable Care Act is further discussed under section XVII.D.10. of this proposed rule.

In our discussion of the provisions of section 5503 of the Affordable Care Act under this section of this proposed rule, we generally refer to a hospital's number of unweighted allopathic and osteopathic FTE residents in a particular period as a hospital's "resident level." We also refer to a hospital's resident level in the applicable "reference period," as explained further below, as the hospital's "reference resident level." In addition, we refer to the "otherwise applicable resident limit" as the hospital's FTE resident cap that is applicable during the relevant cost reporting period. Thus, we are proposing, effective for portions of cost reporting periods beginning on or after July 1, 2011, we will permanently reduce the hospital's FTE resident cap by 65 percent of the difference between the reference resident level and the hospital's otherwise applicable resident limit for IME and direct GME respectively. For example, if a hospital's otherwise applicable resident limit for the reference period is 100, and its reference resident level is 80 FTEs, we will reduce the hospital's FTE resident cap by 13 FTEs [0.65 (100 − 80)] = 13. We are proposing to add new regulations at § 412.105(f)(1)(iv)(B)(2) for IME and at § 413.79(m) for direct GME to reflect our proposals regarding reductions to hospitals' FTE resident caps under section 5503.

4. Exemption From FTE Resident Cap Reduction for Certain Rural Hospitals

Section 1886(h)(8)(A)(ii)(I) of the Act, as added by section 5503 of the Affordable Care Act, specifically exempts rural hospitals (as defined in section 1886(d)(2)(D)(ii) of the Act) with fewer than 250 acute care inpatient beds from reductions to their FTE resident caps under section 1886(h)(8)(A). Section 1886(d)(2)(D)(ii) of the Act defines a rural area as any area outside a Metropolitan Statistical Area (MSA). Under the existing regulations at § 412.62(f)(ii), an "urban area" means: (1) An MSA or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or (2) the following New England counties: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Under existing § 412.62(f)(iii), a "rural area" means any area outside an urban area. We note that we no longer use the term MSA, and instead use the term Core-Based Statistical Area (CBSA) for locality and wage index purposes. A hospital's bed size is based on its number of available beds, as determined for IME payment purposes under § 412.105(b) of the regulations. For purposes of determining whether a rural hospital has fewer than 250 beds, we are proposing to use data from the rural hospital's most recent cost reporting period ending on or before March 23, 2010. (This information may be found on Worksheet S–3, Part I of the Medicare cost report, CMS–2552–96, the sum of lines 1 and 6 through 10 in column 2, minus line 26 in column 6, divided by the number of days in the cost reporting period.) We are proposing that if a rural hospital has fewer than

250 beds in its most recent cost reporting period ending on or before March 23, 2010, the hospital would not be subject to a possible reduction to its FTE resident cap(s) under section 1886(h)(8)(A) of the Act. However, if a rural hospital has at least 250 beds in its most recent cost reporting period ending on or before March 23, 2010, we are proposing that the rural hospital would be subject to a reduction to its FTE resident cap(s).

5. Application of Section 5503 to Hospitals That Participate in Demonstration Projects or Voluntary Residency Reduction Programs and Certain Other Hospitals

In addition to certain rural hospitals as noted above, section 1886(h)(8)(A)(ii) of the Act also exempts certain other hospitals from a cap reduction.

Section 1886(h)(8)(A)(ii)(II) of the Act, as amended by section 5503 of the Affordable Care Act, specifically exempts "a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90–248, if the hospital demonstrates to the Secretary that it has a specific plan in place for filling the unused positions by not later than 2 years after the date of enactment of this paragraph." This language is referring to the National Voluntary Residency Reduction Plan (VRRP), the New York Medicare GME Demonstration (New York Demonstration), and the Utah Medicare GME Demonstration (Utah Demonstration).

In July 1997, 42 New York teaching hospitals participated in the New York Demonstration. An additional seven hospitals joined the New York Demonstration in July 1998. The purpose of the New York Demonstration was to test reimbursement changes associated with residency training to determine whether hospitals could use time-limited transition funding to replace and reengineer the services provided by a portion of their residency trainees. In exchange for reducing its count of residents by 20 to 25 percent over a 5-year period, while maintaining or increasing its primary care-to-specialty ratio of residents, a participating hospital (or consortium of hospitals) participating in the New York Demonstration would receive "hold harmless payments" for 6 years.

Since 2003, nine Utah teaching hospitals have participated in the Utah Demonstration to allocate Medicare GME funding to Utah hospitals based on health professions workforce planning. Under the Utah Demonstration, Medicare contractors redirect Medicare direct GME funds from each of the teaching hospitals in Utah and pay those amounts to the Utah Medical Education Council, an agency of the State government.

Under the VRRP approved under section 1886(h)(6)(B) of the Act, hospitals could use time-limited transition funding to replace the services provided by a portion of their residents. In exchange for reducing its count of residents by 20 to 25 percent over a 5-year period, while maintaining or increasing its primary care-to-specialty ratio of residents, a VRRP participating hospital would receive "hold harmless payments" for 5 years.

Based on the language of section 1886(h)(8)(A)(ii)(II) of the Act, we are proposing that hospitals that participated in the New York Demonstration, the Utah Demonstration, or a VRRP could be exempt from a cap reduction under section 1886(h)(8)(A) of the Act. We are proposing to not differentiate between those hospitals that withdrew from either demonstration prior to its completion and those hospitals that completed either demonstration. That is, we are proposing that any hospital that, at some point, participated in the New York Demonstration, the Utah Demonstration, or the VRRP could be exempt from a cap reduction. Specifically, consistent with the statutory language at section 1886(h)(8) of the Act, even though only seven hospitals actually completed the New York Demonstration, any hospital that participated in the New York Demonstration could be exempt from a cap reduction. As required under section 1886(h)(8)(A)(ii)(II) of the Act, to be exempt from the cap reduction, hospitals that had a VRRP approved under section 1886(h)(6)(B) of the Act or hospitals that participated in a demonstration project approved under section 402 of Pub. L. 90–248 must demonstrate to the Secretary that they have a plan in place for filling their unused slots within 2 years after the date of enactment of Pub. L. 111–148 (that is, by March 23, 2012). We are proposing that these hospitals must submit their plans specifying how they would fill their unused slots to CMS by December 1, 2010, in order to be exempt from a cap reduction.

In addition to the hospitals described under 1886(h)(8)(A)(ii)(II) of the Act, section 1886(h)(8)(A)(ii)(III) of the Act exempts a hospital described under section 1886(h)(4)(H)(v) of the Act from a cap reduction. Therefore, we are proposing that such hospital described under section 1886(h)(4)(H)(v) of the Act be exempt from a cap reduction.

Finally, section 1886(h)(8)(H)(i) of the Act provides that the hospital's reference resident level is the resident level for the one cost reporting period out of the three most recent cost reporting periods ending before March 23, 2010, with the highest resident level. Under section 1886(h)(8)(A)(i), that reference resident level is used to make the determination of whether a hospital's FTE resident cap(s) should be reduced. Therefore, we are proposing that if a hospital trains at or above its otherwise applicable resident level in *all* of its three most recent cost reporting periods ending before March 23, 2010, the hospital would be exempt from a cap reduction. A separate determination would be made regarding any reduction to the hospital's direct GME cap and its IME cap.

6. Determining the Estimated Number of FTE Resident Slots Available for Redistribution

In accordance with section 1886(h)(8)(A) of the Act, as added by section 5503 of the Affordable Care Act, we will determine the number of resident positions available for redistribution by estimating the expected reductions to hospitals' FTE resident caps. We believe that section 1886(h)(8)(A) of the Act allows us to distinguish between the FTE counts that are used to determine the number of FTE resident slots that are available for redistribution (that is, the "redistribution pool") and the actual number of FTE residents by which hospitals' FTE resident caps are ultimately reduced. We are proposing to estimate the reduction to a hospital's FTE cap under section 1886(h)(8)(A) of the Act for purposes of determining the number of FTEs that a hospital might contribute to the redistribution pool. We are proposing to estimate the redistribution pool for redistribution in accordance with section 1886(h)(8)(B)(i) of the Act, as added by section 5503(a)(4), which states: "The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (*as estimated by the Secretary*)" (emphasis added). Therefore, we are proposing to estimate and redistribute the number of resident slots in the redistribution pool, and to ensure that the aggregate number of FTE residents by which we increase the FTE resident caps of qualifying hospitals under section 1886(h)(8)(B) of the Act is not more than CMS' estimate of the redistribution pool. We note if we

were subsequently to perform an audit, as described further in section XVII.D.7. of this proposed rule, in order to make a final determination regarding any reductions to a hospital's FTE resident cap, and find that the aggregate number of FTE resident reductions differed from the number CMS had initially estimated for the redistribution pool, the number of slots that can be redistributed from the redistribution pool to qualifying hospitals would not be affected.

To ensure that we will begin making payments for most hospitals based on the revised FTE resident caps by July 1, 2011, we are proposing to set a date by which we will have determined a hospital's reference resident level and compared it to the hospital's otherwise applicable FTE resident cap(s) to estimate whether, and by how much, the hospital's FTE cap(s) would be reduced. We are proposing that this date be May 1, 2011, and that date would apply for all hospitals for purposes of determining an estimate of whether and by how much their FTE resident caps should be reduced. In the event that the Medicare contractors have not completed an audit (explained further under section XVII.D.7. of this proposed rule) by May 1, 2011, we are proposing to estimate by May 1, 2011, the number of FTE residents by which a hospital's FTE resident cap is expected to be reduced. For example, a Medicare contractor may estimate by May 1, 2011, that Hospital A's FTE resident cap should be reduced by 10 FTEs. Thus, we would place 10 FTEs into the redistribution pool. It is possible that even after May 1, 2011, the contractor may continue to audit Hospital A's relevant cost reports to determine if, in fact, 10 FTEs is the appropriate number by which to reduce Hospital A's FTE resident cap, and could ultimately conclude that Hospital A's FTE resident cap should only be reduced by 8 FTEs. If the Medicare contractor does not make this revised determination based on the audit by May 1, 2011, we would reduce Hospital A's FTE resident cap by 8 FTEs effective July 1, 2011, but the number of FTE residents in the redistribution pool attributable to Hospital A would remain at 10 FTEs (the estimated number as of May 1, 2011). Similarly, if the Medicare contractor ultimately concluded that Hospital A's FTE resident cap should be reduced by 12 FTEs, but this final determination is not made by May 1, 2011, Hospital A's FTE resident cap would be reduced by 12 FTEs effective July 1, 2011, but the number of FTE residents in the redistribution pool attributable to Hospital A would remain at 10 FTEs. Therefore, because we believe that section 1886(h)(8)(B)(i) of the Act allows us to distinguish between the FTE counts that are used to determine the size of the redistribution pool, and the actual aggregate number of FTE residents by which hospitals' FTE resident caps are ultimately reduced, we are proposing to use estimated information to determine possible reductions to hospitals' FTE resident caps to estimate the number of FTE resident slots to be distributed under section 1886(h)(8)(B). In addition, we note that, as was done when we implemented section 422 of Pub. L. 108–173, Medicare contractors will provide hospitals with a time-limited opportunity to review cap reduction determinations for possible technical errors before they are finalized.

7. Reference Cost Reports That Are Under Appeal

We understand that there may be instances where a hospital's otherwise applicable resident limit or a hospital's FTE resident count for a reference cost reporting period might be under appeal. When implementing section 422 of Public Law 108–173, we stated in the August 11, 2004 **Federal Register** (69 FR 49118) that we believe that it is in the best interest of the Medicare program, CMS, the contractors, and the hospitals to adopt an approach that allows for finality as early as possible during the process of implementing this provision. We stated that we believed Congress gave some consideration to the challenges we would encounter in implementing a provision as complex as section 422 in such a short timeframe by providing the Secretary with the discretion to distinguish between the FTE counts that are used to estimate the number of FTE resident slots that are available for redistribution (that is, the "redistribution pool"), and the actual number of FTE residents by which hospitals' FTE resident caps are ultimately reduced.

Furthermore, as we stated in the August 11, 2004 **Federal Register** (69 FR 49118), the fact that the Congress took the unusual step of including the language at section 1886(h)(7)(D) of the Act which provides that, "There shall be no administrative or judicial review . . . with respect to determinations made under this paragraph," supports the position advocating for finality. If we had delayed determinations concerning hospital-specific FTE cap determinations until all affected cost reports are settled, audited, and appealed through the various channels normally available to providers, the language, and in particular the specified timeframe, under section 1886(h)(7)(D) of the Act would have been rendered meaningless. Therefore, despite the complexity of section 422 and the potential for profound and long-term GME payment ramifications, we believed that the Congress did not expect the implementation of section 422 provision to linger indefinitely. Rather, by limiting appeal rights and requiring an effective date of July 1, 2005, for reductions in FTE resident caps (which required implementation in a relatively short timeframe), the Congress expected section 1886(h)(7) of the Act, as added by section 422 of Public Law 108–173, to be implemented with expediency and finality.

Similarly, in implementing section 5503 of the Affordable Care Act, we note that determinations under section 1886(h)(8)(A)(i) of the Act are required to be made effective July 1, 2011, and, for the same reasons cited when we implemented section 422, we believe these determinations should be final on, or as quickly as possible after, that date. We note that section 5503(a)(3) of the Affordable Care Act modified section 1886(h)(7)(E) of the Act by inserting "or paragraph (8)" to specify that there shall be no administrative or judicial review with respect to determinations made under section 5503 as well. Therefore, as was our final policy when implementing section 422, we are proposing to not wait for appeals of reference period cost reports to be resolved before making a final determination as to whether and by how much a hospital's FTE resident cap will be reduced. However, we do perceive the need in certain instances to continue audit work for a limited time period past July 1, 2011, to promote the accuracy of FTE resident cap determinations. As under section 422, we are proposing to adopt a policy that would require the Medicare contractors to use the latest available cost report or audit data at the time they make their determinations. If, as of the time the Medicare contractor makes the determination as to whether and by how much a hospital's FTE resident cap should be reduced, there is a pending appeal of the hospital's otherwise applicable resident limit for the reference cost reporting period (that is, a final decision has not been rendered), the Medicare contractor would not wait until a decision is rendered, but would use the FTE resident cap from the initially settled (as indicated in the Notice of Program Reimbursement (NPR)) reference period cost report. Alternatively, if the appeal regarding the otherwise applicable resident limit has

been resolved as of the time that the Medicare contractor makes the determination as to whether and by how much a hospital's FTE resident cap should be reduced, the Medicare contractor would use the FTE resident level that will be used in issuing the subsequent NPR, as established through the appeal. If a reference period cost report has been submitted but not settled at the time the Medicare contractor is making the determination as to whether and by how much a hospital's FTE resident cap should be reduced, the reference resident level is subject to audit by the Medicare contractor, and the final determination regarding any possible reduction to the hospital's FTE resident cap is not subject to appeal. Although we would make every effort to provide contractors with the resources they need to complete as many audits as possible in time to notify each hospital by July 1, 2011, of their FTE cap determinations under section 1886(h)(8)(A) of the Act, there may be instances where the audits of the reference resident levels may not be completed by July 1, 2011. We anticipate that within the scope of their normal audit work, the Medicare contractors will complete as many of these audits as possible, and some of the audits may not be completed until December 31, 2011. We are proposing that, in accordance with section 1886(h)(8)(A) all cap determinations made after July 1, 2011 and through December 2011 will be effective retroactively to July 1, 2011.

8. Determining the Possible Reduction to a Hospital's FTE Resident Cap

a. Reference Resident Level—General

In order to determine if a hospital's reference resident level is less than the hospital's otherwise applicable FTE resident cap, section 1886(h)(8)(H) of the Act, as added by section 5503 of the Affordable Care Act, directs the Secretary to use one of three reference cost reporting periods. Section 1886(h)(8)(H) of the Act directs the Secretary to use a hospital's most recent cost reporting period ending before the date of enactment, which is March 23, 2010, with the highest resident level "for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary," as the reference period. Generally, if the hospital's resident level for either direct GME or IME is less than the hospital's otherwise applicable resident limit for direct GME or IME, respectively, in the reference period, the hospital's FTE resident cap for direct GME and/or IME will be reduced by 65 percent of the difference between the resident level and the otherwise applicable resident limit. We note that, for purposes of determining a reduction to a hospital's direct GME cap, the unweighted direct GME cap will be compared to the direct GME FTE resident count. The following explanation is an example of how a hospital's cap(s) would be reduced under section 1886(h)(8)(A) of the Act. For purposes of this example, Hospital A's three most recent cost reporting periods ending before March 23, 2010, which have been submitted to the Medicare contractor are as follows: July 1, 2006–June 30, 2007; July 1, 2007–June 30, 2008; and July 1, 2008–June 30, 2009. Hospital A's FTE resident count and FTE resident caps (as adjusted for those items discussed in section XVII.D.3. of this proposed rule) are as noted in the table.

Cost Reporting Period	IME Unweighted FTE Count	Direct GME Unweighted FTE Count	IME FTE Cap	Direct GME Cap
July 1, 2006 – June 30, 2007	17	20	18	20
July 1, 2007 – June 30, 2008	16	21	20	20
July 1, 2008 – June 30, 20099	14	20	20	20

As noted earlier in this preamble, a separate determination regarding whether and by how much to reduce a hospital's cap will be made for its direct GME cap and for its IME cap. In order to determine whether Hospital A would be subject to a cap reduction, we must first determine whether Hospital A was training at or above its cap in all three most recent (settled or submitted) cost reporting periods ending before March 23, 2010. For purposes of a reduction to Hospital A's IME cap, we note from the chart above that in all three cost reporting periods, Hospital A is training below its otherwise applicable resident limit for IME. Therefore, we know that Hospital A would be subject to an IME cap reduction. In order to determine which cost reporting period should be used as the reference period to determine the FTE cap reduction, we would use the cost reporting period with the highest FTE resident count for IME, which would be July 1, 2006–June 30, 2007. Therefore, we calculate the difference between the otherwise applicable resident limit for IME for the reference period (July 1, 2006–June 30, 2007) and the reference resident level for IME, and determine the IME cap reduction based on 65 percent of the difference. For purposes of Hospital A's IME cap reduction, we would determine the difference between 18 (the otherwise applicable resident limit) and 17 (the reference resident level) and multiply that difference by 65 percent [(18 − 17) × .65] = 0.65. Therefore, the IME FTE cap for Hospital A would be reduced by 0.65 of an FTE. For purposes of a reduction to Hospital A's direct GME cap, we note from the chart above that Hospital A was training at or above its otherwise applicable resident limits for direct GME in all three cost reporting periods. Because a hospital that is training at or above its cap in *all* three cost reporting periods is exempt from a cap reduction, we would conclude that Hospital A's direct GME cap would not be reduced for direct GME payment purposes. We note that, in general, if a hospital was not participating in a Medicare GME affiliated group during any of its three most recent cost reporting periods ending before March 23, 2010, its reference cost reporting period will be the cost reporting period with the least amount of difference between the reference resident level and the otherwise applicable resident limit. In addition, we are proposing, that if a hospital has the same resident level for two or more cost reporting periods and that resident level is the "highest" resident level, we will use the cost reporting period of those "highest" cost reporting periods in which there is the least amount of difference between the resident level and the otherwise applicable resident limit to determine a cap reduction.

b. Audits of the Reference Cost Reporting Periods

As mentioned under XVII.D.8.a. of this proposed rule, to determine a possible reduction to a hospital's FTE resident cap, section 1886(h)(8)(H)(i) of the Act, as added by section 5503(a) of

Affordable Care Act, directs the Secretary to use, as the reference cost report, the one cost report out of the hospital's three most recent cost reporting periods ending before March 23, 2010, with the highest resident count "for which a cost report has been *settled* (or, *if not, submitted (subject to audit*), as determined by the Secretary" (emphasis added). We are proposing that if a hospital's cost report for the reference cost reporting period has been settled, the hospital's settled cost report, without further audit, would be used to determine possible reductions to the FTE resident caps. We note that the "settled" cost report does not necessarily mean the initial cost report settlement. The Medicare contractor may have previously settled the cost report, reopened it to audit it, and then settled the cost report again, issuing a revised NPR. Thus, we would refer to the more recently issued NPR for that cost reporting period. For those cost reporting periods that would be used as the reference cost reporting period, which have been submitted to the Medicare contractor but not settled, Medicare contractors may perform desk or onsite audits related to section 5503. In addition, if the reference period cost report is for a period other than 12 months, we are proposing that for direct GME, the Medicare contractor would prorate the FTE resident caps and unweighted FTE resident count to equal 12-month counts.

c. Medicare GME Affiliation Agreements

As described above, some hospitals that have resident levels below their FTE resident caps may have entered into Medicare GME affiliation agreements (as permitted under § 413.79(f) of our regulations) with other hospitals that would otherwise exceed their FTE resident caps. Thus, while some hospitals in the Medicare GME affiliated group were training a number of residents below their FTE resident caps prior to entering into a Medicare GME affiliation agreement, upon affiliating, their FTE resident caps were temporarily reduced because some or all of their excess FTE slots were temporarily added to the FTE resident caps of other hospitals as part of the affiliation agreement. Under section 422 of Pub. L. 108–173, the statute directed us to apply the provisions to hospitals that were members of the same affiliated group as of July 1, 2003. In implementing section 422, we based the FTE resident cap reductions for hospitals that were participating in a Medicare GME affiliated group on the aggregate cap and count data from all hospitals participating in the same Medicare GME affiliated group(s). If a hospital was training a number of residents below its FTE resident cap for the reference cost reporting period but the hospital was part of a Medicare GME affiliated group for some or all of that reference cost reporting period, the Medicare contractor determined if the *aggregate* affiliated count for all hospitals in the affiliated group was greater than the aggregate affiliated cap. If the aggregate affiliated count was greater than the aggregate cap, then there was no reduction made to the FTE caps of any hospital in the affiliated group (even for a hospital that was part of the affiliated group, but was training below its cap). However, we note that, in contrast to section 422 of Pub. L. 108–173, section 5503 of the Affordable Care Act does not include language specific to affiliated groups. Rather, section 1886(h)(8)(H) of the Act, as added by section 5503 of the Affordable Care Act, defines the reference resident level and the otherwise applicable resident limit with respect to "a hospital." Similarly, section 1886(h)(8)(A) refers only to "a hospital's" reference resident level. Thus in contrast to section 422 of Public Law 108–173, section 5503 is not amenable to determinations based on the aggregate experience of a Medicare GME affiliated group. Therefore, we are proposing that Medicare contractors would make determinations regarding FTE cap reductions under section 1886(h)(8)(A)(i) by considering the relationship of the individual hospital's otherwise applicable resident limit for the reference period (which is the FTE resident cap for a period as adjusted by any affiliation agreement(s)) to the individual hospital's reference resident level. That is, we are proposing that in a hospital's reference year, if that hospital is participating in a Medicare GME affiliated group and is training a number of residents below its FTE caps as adjusted pursuant to any affiliation agreements which can be found on Worksheet E, Part A, line 3.06 for IME, and Worksheet E–3 Part IV, line 3.03 for direct GME, the hospital's FTE resident caps would be subject to a reduction under section 1886(h)(8)(A)(i) even if the Medicare GME affiliated group as a whole may be training a number of residents above the group's aggregate FTE resident cap.

d. Treatment of Hospitals That Have Merged

We note that there may be instances where two hospitals merge on or after March 23, 2010, but were not merged in any or all of their three most recent cost reporting periods ending before March 23, 2010. For these hospitals, we are proposing that the Medicare contractors identify the hospitals' three most recent cost reporting periods ending before March 23, 2010, and treat the hospitals for purposes of section 1886(h)(8)(A)(i) as if they were merged during those periods in determining whether there should be a reduction to the merged facility's FTE resident cap(s). That is, we are proposing that for each of the 3 years, we would combine the FTE resident counts and caps of the formerly separate facilities in order to identify the reference period, and to calculate the reference resident level and the otherwise applicable resident limit for the merged facility (for IME and direct GME respectively), even if the two facilities have different fiscal year ends. In addition, if any of the cost reporting periods are less than 12 months or greater than 13 months, the Medicare contractor would prorate the FTE resident counts and FTE caps for direct GME to equal a 12-month cost reporting period.

9. Application of Section 5503 to Hospitals That File Low Utilization Medicare Cost Reports

In general, section 5503 of the Affordable Care Act applies to Medicare-participating hospitals that train residents in approved residency training programs. However, some Medicare-participating hospitals may choose to submit low utilization cost reports. These low utilization cost reports may not contain the cost report worksheet that is used to calculate payments for direct GME, Worksheet E–3 Part IV. That is, these cost reports may not contain FTE resident count and cap information. For example, because Medicare-participating children's hospitals primarily serve a non-Medicare population and, therefore, receive minimal Medicare payments, some teaching children's hospitals submit low utilization cost reports. If a children's hospital files a low utilization cost report in a given cost reporting period, and does not file the Worksheet E–3 Part IV, that hospital is not considered by Medicare to be a teaching hospital for that cost reporting period. In addition, although children's hospitals may have an FTE resident "cap" that is applicable for purposes of the Children's Hospital Graduate Medical Education (CHGME) Payment Program, administered by HRSA, this cap is not necessarily used for Medicare payment purposes. Therefore, we are proposing that if a low utilization hospital does not have a cap for Medicare payment purposes, it would not be subject to a negative cap

reduction under section 5503. In addition, we are proposing that if a low utilization hospital does have a cap for Medicare payment purposes (for example, it had filed a regular cost report in 1996) but did *not* file Worksheet E–3 Part IV as part of its cost report in *all* three most recent cost reporting periods ending before March 23, 2010, it will be exempt from cap reduction. In addition, we are proposing that if a low utilization hospital has a cap for Medicare payment purposes and filed Worksheet E–3 Part IV in at least one of its three most recent cost reports ending before March 23, 2010, the Medicare contractor would determine, based on the data of the available cost reports with Worksheet E–3 Part IV, whether a cap reduction is necessary under section 1886(h)(8)(A)(i).

For those low utilization hospitals that have an FTE cap for Medicare payment purposes and have filed Worksheet E–3 Part IV in any of the three most recent cost reporting periods ending before March 23, 2010, we are proposing that determinations as to whether, and by how much, that low utilization hospital's cap may be reduced using the same methodology that we are proposing to use for other Medicare-participating teaching hospitals. In addition, for purposes of section 1886(h)(8)(B) of the Act, we are proposing that, a low utilization hospital would be eligible to apply for an increase in its FTE resident cap under section 1886(h)(8)(B) of the Act, subject to the same demonstrated likelihood and evaluation criteria proposed in this proposed rule for all other hospitals. However, as explained further below in this preamble, section 1886(h)(8)(B)(ii) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, specifies certain requirements and thresholds that a hospital that receives additional slots must meet in order to retain those slots. One requirement is that the hospital must ensure for a 5-year period that its number of FTE primary care residents is not less than the average number of FTE primary care residents during the 3 most recent cost reporting periods ending prior to March 23, 2010. Accordingly, we are proposing that an applying children's hospital must meet the same documentation requirements to establish this primary care average as other applying hospitals, which would mean that the children's hospital must have submitted a Worksheet E–3, Part IV with its Medicare cost report for those 3 most recent cost reporting periods ending prior to March 23, 2010. Furthermore, we are proposing that, in order to receive an increase in its FTE resident cap under section 1886(h)(8)(B) of the Act effective July 1, 2011, in addition to complying with the proposed application requirements as described in this preamble, the hospital would be required to file Worksheet E–3, Part IV, with its Medicare cost report for its cost reporting period that includes July 1, 2011 through and including its cost reporting period that includes June 30, 2016 (that is, the 5-year period). We are proposing that the low utilization hospital must meet this requirement because section 1886(h)(8)(B) is intended to allow a hospital to increase its FTE counts for purposes of Medicare GME payments. We do not believe it would be appropriate to grant an increase in a hospital's FTE resident cap under section 1886(h)(8)(B) of the Act if the hospital does not use the slots for Medicare purposes (but only, for example, for purposes of the CHGME Payment Program) as would be evidenced by not filing a Worksheet E–3, Part IV. Moreover, as explained further below, we are required under section 1886(h)(8)(B)(ii) and (iii) to ensure certain levels of primary care or general surgery training, and the information in Worksheet E–3 Part IV, would be necessary for that purpose.

10. Treatment of Hospitals With Caps That Have Been Reduced or Increased Under Section 422 of Pub. L. 108–173

For purposes of implementation of section 5503(a) of the Affordable Care Act, section 1886(h)(8)(H)(iii) of the Act states that the term "otherwise applicable resident limit," means, "with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A)." As noted earlier in this preamble, section 1886(h)(7)(A) of the Act, as added by section 422 of Pub. L. 108–173, provided for reductions to hospitals' caps if the hospitals were training a number of residents below their FTE resident caps during the relevant reference period, and for a "redistribution" that increased the FTE resident caps for certain hospitals. Although sections 1886(h)(4)(F)(i) and (H) refer to paragraph (7), which includes both cap reductions and increases made pursuant to section 422 of Pub. L. 108–173, we believe that specific mention of only paragraph (7)(A), which refers to cap reductions made under section 422, gives the Secretary the authority to only take into account the reductions made to hospitals' caps under section 1886(h)(7)(A), for purposes of implementing section 1886(h)(8)(A)(i) of the Act. That is, we believe specific mention of paragraph (7)(A) is meant to provide that in determining a hospital's otherwise applicable resident limit, the Secretary should take into account any reductions to its reference resident level made under section 1886(h)(7)(A) to determine whether a cap reduction under section 1886(h)(8)(A)(i) is necessary. Furthermore, section 1886(h)(8)(H)(i) requires that for purposes of determining the reference resident level, the Secretary is required to consider the hospital's three most recent cost reporting periods ending prior to March 23, 2010 that have been settled (or, if not, submitted (subject to audit)), as determined by the Secretary. In addition, we note that increases made under section 1886(h)(7)(B) were effective for portions of cost reporting periods beginning on or after July 1, 2005, and that some hospitals may still be filling their residency training programs with FTE resident slots gained under section 1886(h)(7)(B), during what may be their reference cost reporting period for purposes of section 1886(h)(8)(A)(i). Therefore, we believe that it would be inappropriate to include increases made under section 1886(h)(7)(B) in determining the hospital's reference resident level for purposes of cap reductions under section 1886(h)(8)(A)(i). Hospitals that received increases to their caps under section 1886(h)(7)(B) may still be "building" their residency programs using the additional FTE resident slots they received under section 1886(h)(7)(B). Therefore, it would be premature to remove any of those FTE resident slots. Accordingly, we are proposing that, in determining whether a cap reduction is necessary under section 1886(h)(8)(A)(i) we would compare the hospital's FTE resident count for its reference period to its FTE resident cap, as adjusted under section 1886(h)(7)(A). We are proposing that we would *not* consider any increases to its resident cap a hospital may have received under section 1886(h)(7).

11. Criteria for Determining Hospitals That Will Receive Increases in Their FTE Resident Caps

Generally, under section 1886(h)(8)(A) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, the Secretary is to reduce the FTE resident caps for hospitals that were training a number of residents below their otherwise applicable resident limit in the reference period by 65 percent of the "excess" resident slots. Under section 1886(h)(8)(B), the Secretary is to

"redistribute" the estimated number of FTE reductions under section 1886(h)(8)(A) to increase the FTE resident caps for use by other hospitals. Under section 1886(h)(8)(B)(i) of the Act, the Secretary is authorized to increase the otherwise applicable FTE resident cap for each qualifying hospital that submits a timely application by a number that the Secretary may approve, for portions of cost reporting periods occurring on or after July 1, 2011. In implementing section 1886(h)(8)(B) of the Act, we note the difficulty in deciding which teaching hospitals are more "deserving" than others to receive the redistributed unused resident slots. Therefore, in addition to some considerations and priorities in redistribution that are specified in section 5503, we are proposing certain additional criteria that we believe will allow for an objective decision-making process.

Section 1886(h)(8)(B) of the Act, as added by section 5503 of the Affordable Care Act, establishes certain parameters in the statutory language for hospitals to meet to qualify to receive increases in their FTE resident caps. First, section 1886(h)(8)(B)(i) of the Act states that the aggregate number of increases in the otherwise applicable resident limits (caps) shall be equal to the aggregate reduction in the resident limits determined under section 1886(h)(8)(A) of the Act as estimated by the Secretary(as discussed in section XVII.D of this proposed rule). Section 1886(h)(8)(F) of the Act states that in no case will any hospital receive an FTE cap increase of more than 75 FTE positions as a result of the redistribution. In addition, section 1886(h)(8)(C) of the Act specifies that, in determining which hospitals will receive the increases to their FTE resident caps, the Secretary is required to take into account the demonstrated likelihood that the hospital would be able to fill the position(s) within the first three cost reporting periods beginning on or after July 1, 2011, and whether the hospital has an accredited rural training track program.

In setting up an application process for hospitals to apply for FTE resident cap increases from the redistribution pool (discussed in section XVII.D.8. of this proposed rule), we are proposing to consider the "demonstrated likelihood" criterion under section 1886(h)(8)(C)(i) as an eligibility criterion that a hospital must meet in order for CMS to further consider the hospital's application for an increase in its FTE resident cap. We are proposing that a hospital would meet the "demonstrated likelihood" criterion by demonstrating that it is either already training a number of FTE residents at or in excess of its current FTE caps (IME and direct GME FTE caps, respectively, *including any applicable section 422 cap add-on*), or that it does not have sufficient room under its current FTE caps to accommodate a planned new program or expansion of an existing program. We believe it is appropriate to consider a hospital's "demonstrated likelihood" as a requirement because we believe such hospitals will be best positioned to make immediate and efficient use of any FTE cap increase, and thereby, to use any resulting increase in Medicare GME payments to train the physician workforce that will provide care to Medicare beneficiaries. Thus, we are proposing that, in order to be eligible for consideration for an increase under section 1886(h)(8)(B) of the Act, a hospital must first demonstrate the likelihood that it will able to fill the slots within the first three cost reporting periods beginning on or after July 1, 2011, by meeting *at least one* of the following three criteria and by providing documentation that it meets the criterion in its application for an increase to its FTE resident cap:

• *Demonstrated Likelihood Criterion 1.* The hospital does not have sufficient room under its current FTE cap for a new residency program that it intends to establish on or after July 1, 2011 (that is, a newly approved program that begins training residents at any point within the hospital's first three cost reporting periods beginning on or after July 1, 2011). Under this criterion, the hospital would select one of the following:

(1) Hospital will establish a newly approved residency program. (Under this selection, the hospital would be required to check at least one of the following, if applicable):

• Application for approval of the new residency program has been submitted to the ACGME, AOA, or the ABMS by December 1, 2010. (The hospital would be required to attach a copy.)

• The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program by December 1, 2010. (The hospital would be required to attach a copy.)

• The hospital has received written correspondence from the ACGME, AOA, or ABMS acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). (The hospital would be required to attach a copy.)

(2) Hospital will likely fill the slots requested. (The hospital would be required to select at least one of the following, if applicable.)

• The hospital does not have sufficient room under its FTE cap, and the hospital's existing residency programs had a combined resident fill rate of at least 85 percent in each of program years 2007 through 2009. (The hospital would be required to attach documentation.)

• The hospital does not have sufficient room under its FTE cap, and the specialty program for which the hospital is applying has a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. (The hospital would be required to attach documentation.)

• *Demonstrated Likelihood Criterion 2.* The hospital does not have sufficient room under its FTE cap, and the hospital intends to use the additional FTEs to expand an existing residency training program within the hospital's first three cost reporting periods beginning on or after July 1, 2011.

(1) Hospital intends to expand an existing program. Under this selection, the hospital would be required to check at least one of the following, if applicable:

• The appropriate accrediting body (the ACGME, AOA, or ABMS) has approved the hospital's expansion of the number of FTE residents in the program. (The hospital would be required to attach documentation.)

• The American Osteopathic Association Residency Match Program has accepted or will be accepting the hospital's participation in the match for the existing program that will include additional resident slots in that residency training program. (The hospital would be required to attach documentation.)

• The hospital has submitted an institutional review document or program information form for the expansion of the existing residency training program by December 1, 2010. (The hospital would be required to attach documentation.)

(2) Hospital will likely fill the slots of the expanded existing residency program. Under this selection, the hospital would be required to check at least one of the following, if applicable:

• The hospital does not have sufficient room under its FTE cap, and the hospital has other previously established residency programs, with a resident fill rate of at least 85 percent in each of program years 2007 through 2009. (The hospital would be required to attach documentation.)

• The hospital does not have sufficient room under its FTE cap, and the hospital is expanding an existing program in a particular specialty with a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. (The hospital would be required to attach documentation.)

• *Demonstrated Likelihood Criterion 3.* Hospital is applying for an increase in its FTE resident cap because the hospital is already training residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both. The hospital would be required to attach copies of *each* of the following:

—Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor by July 1, 2010 documenting on Worksheet E, Part A, Worksheet E–3, Part VI, and Worksheet E–3, Part VI, the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

—Copies of the 2010 residency match information concerning the number of residents at the hospital in its existing programs (that is, all programs, not only the ones for which the hospital may be requesting more slots).

—Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for direct GME and IME.

We are proposing that *each* hospital applying for an increase under section 1886(h)(8)(B)(i) would be required to meet at least one of the above criteria in order to demonstrate the likelihood that it will be able to fill the additional slots associated with any increase in the hospital's FTE resident cap within the first three cost reporting periods beginning on or after July 1, 2012. In other words, each hospital that wishes to apply for an increase in its FTE resident cap, as a preliminary matter, would be required to meet the "demonstrated likelihood" criterion in order for CMS to further consider the hospital's application for an increase in its FTE resident cap.

Although a hospital might be applying for additional slots for more than one specialty program, each application by a hospital must be program-specific. That is, the hospital would be required to complete a separate CMS evaluation form for each program and to demonstrate the likelihood of filling the slots in each program. However, in accordance with our general policy with respect to FTE resident caps, increases in the hospital's FTE resident caps under section 1886(h)(8)(B)(i) for direct GME and IME, once granted to a hospital, would no longer be program-specific. Rather, the hospital's adjusted FTE resident caps would be applied to the hospital's FTE resident counts, including any residents the hospital trains. We note, however, that for FTE residents counted as a result of an increase in the FTE resident caps under section 422 of Pub. L. 108–173, payment is calculated separately for direct GME purposes using the national average PRA and, for IME purposes using a multiplier of 0.66. If a hospital receives an increase to its FTE resident cap(s) under section 5503, and also received a cap increase under section 422, we are proposing that the hospital would first assess whether it is training a number of residents in excess of its combined 1996 FTE and section 5503 caps and, only if its number of FTE residents still exceeds this combined cap would the separate 422 payment rates be applied to the excess FTEs for IME and direct GME, respectively.

For purposes of the application for the increase to the FTE caps under section 1886(h)(8)(B)(i) of the Act, we are proposing to define "national fill rate" for each academic year, as we did when implementing section 422 of Public Law 108–173. That is, we defined "national fill rate" as the number of residents training in a program nationally as compared to the number of accredited slots in that program as of June 30 of that year. This information is available from the ACGME and the AOA. Furthermore, we are proposing to require that, for the purposes of an application for an increase to a hospital's FTE resident cap under section 1886(h)(8)(B) of the Act, a hospital must use the "fill rate" for the most recent academic year for which data are available.

We understand that hospitals may train fewer residents than the number of available accredited slots in their approved programs due to reasons other than an inability to fill those slots. Furthermore, because we understand that a national fill rate is not necessarily the only indicator of the ability of hospitals to fill residency positions in its CBSA or State, and there may be characteristics particular to a region, such as population density, variety of practice settings, or access to technology or procedures that may allow a specified area to have a fill rate in a specific program that exceeds the program's national fill rate, we are proposing several options for a hospital to satisfy the "fill rate'" criterion. In part, as when implementing section 422 of Public Law 108–173, we specified that the fill rate "threshold" is 85 percent. We believe that this rate will reasonably identify those programs that are likely to fill FTE resident positions in newly approved or expanded programs (while providing some latitude to account for other factors that affect the national fill rate), and to fully utilize an increase in FTE resident cap slots that may be available under section 1886(h)(8)(B) of the Act as added by section 5503. We are proposing that a hospital may demonstrate the likelihood of filling FTE resident positions associated with a possible increase in its FTE resident cap under section 5503 by documenting that any of the following applies to the new program or to an expansion of an existing program:

• The specialty program has a resident fill rate nationally, across all hospitals, of at least 85 percent.

• The specialty program has a resident fill rate within the State in which the hospital is located of at least 85 percent.

• If the hospital is located within an urban CBSA, the specialty program has a resident fill rate within the CBSA of at least 85 percent.

For the purposes of demonstrating the likelihood of filling FTE resident positions under section 1886(h)(8)(C)(i) of the Act, as added by section 5503, we are proposing that "national fill rate" means, for the most recent academic year for which data is available, the number of residents training in a program nationally (combined allopathic and osteopathic residents) compared to the number of accredited slots in that program nationally as of June 30 of that year. The proposed Demonstrated Likelihood Criterion 1 and Demonstrated Likelihood Criterion 2 also allow a hospital to demonstrate the likelihood of filling the requested slots by demonstrating that the hospital's existing residency programs had a "resident fill rate" of at least 85 percent in each program year from 2007 through 2009. For the purpose of fulfilling these demonstrated likelihood criteria, we are proposing to define "resident fill rate" to mean, for the most recent academic year for which data is available, the number of residents training in each program in total at a particular hospital as compared to the number of accredited slots in each program in total at that hospital as of June 30 of that year.

We also understand that, for certain programs, because of the length of the accreditation process and a relatively long match period, a hospital may be unable to accept its first class of PGY–1 residents until July 1, 2012. We are proposing that the hospital may still

apply to receive a full complement of residents for the 3 years beginning July 1, 2012, assuming the applicant hospital can demonstrate the likelihood that it will fill the slots relating to a possible increase in its FTE resident caps under section 1886(h)(8)(B)(i). However, if the applicant hospital does not demonstrate the likelihood that it will fill *any* FTE slots for programs described by the hospital on the CMS evaluation form(s) at *any* point within the hospital's first three cost reporting periods beginning on or after July 1, 2011, the hospital would not be eligible for further consideration by CMS of an increase to the hospital's FTE caps under section 1886(h)(8)(B)(i). Accordingly, our proposed Demonstrated Likelihood Criterion 1 would reflect that the hospital does not have sufficient room under its FTE cap to train residents in a newly approved residency program that it demonstrates it will establish within the hospital's first three cost reporting periods beginning on or after July 1, 2011 (that is, a newly approved program that begins training residents *at any point within the hospital's first three cost reporting periods beginning on or after July 1, 2011*) (emphasis added).

Under Demonstrated Likelihood Criterion 3, we are proposing to allow a hospital that is already training a number of FTE residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both, to meet the demonstrated likelihood requirement. In order to document that it meets this criterion, a hospital would be required to submit copies of the 2010 "residency match" information concerning the number of residents the hospital has in an existing program. We believe the most recent match information could indicate that the hospital is expected to take in more residents than the number of cap slots it has available. For purposes of the application of this demonstrated likelihood criterion, we are defining "residency match" as a national process administered by the National Residency Matching Program (NRMP), including the NRMP's Specialties Matching Service, the San Francisco Matching Program, the American Osteopathic Association Residency Match Program, or the Urology Matching Program, by which applicants to approved medical residency programs are paired with programs on the basis of preferences expressed by both the applicants and the program directors.

We also note that under Demonstrated Likelihood Criteria 2 and 3, the hospital would be applying for an increase in its FTE cap because it is expanding an *existing* residency program, or it is already training residents in an *existing* residency training program(s) in excess of its FTE caps, respectively. By existing program, we are proposing that, as of July 1, 2010, the hospital is either already training residents in this program or programs, or the program exists at another hospital prior to July 1, 2011, but the residents begin to rotate at the applying hospital on or after July 1, 2011. We are providing several proposed methods for hospitals to be able to demonstrate to CMS under the proposed Demonstrated Likelihood Criterion 1 that they can fill the slots by showing to CMS that they are establishing a *new* residency program on or after July 1, 2011. We believe hospitals that establish new residency programs *before* July 1, 2011, could possibly also meet Demonstrated Likelihood Criterion 2, relating to a hospital that is expanding an existing residency program on or after July 1, 2011. From the perspective of applying for the cap increase under section 1886(h)(8)(B)(i), the new program that starts training residents in 2010 is an "existing residency program" because it began before July 1, 2011, and it is "expanding" if that program is increasing in the number of FTE residents in the first three cost reporting periods beginning on or after July 1, 2011.

We note that the listing of programs participating in the AOA Match Program will be available on the National Matching Services Web site as of November 1, 2010. Therefore, we are proposing that programs utilizing the AOA Match Program may, in addition to the two options listed above, demonstrate the intent to expand an existing program by documenting that the AOA has accepted the hospital's participation in the match program by the December 1, 2010 application deadline. Therefore, we are proposing that this method of demonstrating the hospital's intent to expand an existing program will be applicable for programs participating in the AOA Match Program.

12. Application Process for the Increases in Hospitals' FTE Resident Caps

In order for hospitals to be considered for increases to their FTE resident caps under section 1886(h)(8)(B)(i) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, we are proposing to require that each qualifying hospital submit a timely application by December 1, 2010. As part of the requirements that a hospital must fulfill in order to complete an application for an increase to its FTE resident caps, we are proposing to require that the applicant hospital must include the total number of requested FTE resident slots (for all residency programs) for direct GME or IME, or both (not to exceed 75 FTEs for each, as specified under section 1886(h)(8)(F) of the Act). Thus, we would require that the hospital's total requests for increases in the IME and the direct GME caps (that is, the total number of requested FTE resident slots increases (for all residency programs at the hospitals)) would be required to be indicated on the same application for an increase under section 1886(h)(8)(B)(i). We are proposing that each hospital must submit the following information on its application for an increase in its FTE resident cap:

- The name and Medicare provider number of the hospital, and the name of the Medicare contractor to which the hospital submits its cost report.
- The total number of requested FTE resident slots (for all residency programs at the hospital) for direct GME or IME, or both (not to exceed 75 FTEs each).
- A completed copy of the CMS evaluation form (as described below) for each residency program for which the applicant hospital intends to use the requested increase in the number of FTE residents and source documentation to support the assertions made by the hospital on the evaluation form. (For example, if the hospital checks off on the evaluation form that the hospital is starting a new geriatrics program, the hospital would include documentation to support that assertion.)
- FTE resident counts for direct GME and IME and FTE resident caps for direct GME and IME reported by the hospital in the most recent as-filed cost report. (The hospital would be required to include copies of Worksheets E, Part A, E–3, Part IV, *and if a hospital received an increase to its FTE cap(s) under section 422 of Pub. L. 108–173,* a copy of E–3, Part VI.)
- An attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, of the following information in the hospital's application for an increase in its FTE resident cap:

"I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under federal law. Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil, and administrative

action, fines and/or imprisonment may result. I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the books and records of the hospital in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents."

We are proposing that any hospital that wishes to apply for an increase in its FTE resident cap(s) under section 1886(h)(8)(B)(i) must submit a copy of its completed application (as described above) to the CMS Central Office and to the CMS Regional Office for the region in which the applicant hospital is located, and that the application must be received by CMS on or before December 1, 2010. (The mailing addresses for the CMS offices are indicated at the end of this section of the preamble.) We note that some hospitals' FTE counts will be subject to audit for purposes of possible cap reductions under section 1886(h)(8)(A)(i), and those audits may not be completed by December 1, 2010. Because the results of such an audit may be a factor in a hospital's decision whether to request an increase in its FTE resident cap under section 1886(h)(8)(B)(i) of the Act, we are proposing to allow a later date for those hospitals to apply for increases in their FTE resident caps. Therefore, if a hospital's resident level is audited for purposes of section 1886(h)(8)(A) of the Act, whether or not the hospital's FTE resident caps are reduced under section 1886(h)(8)(A) of the Act, if that hospital wishes to apply for an increase in its FTE resident cap(s) available under section 1886(h)(8)(B)(i) of the Act, we are proposing that the hospital must submit a completed application to CMS and that the application must be received on or before March 1, 2011.

We note that, although a hospital might be applying for an increase to its FTE caps either to start a new program or expand a particular program, the FTE caps are not program-specific; but rather, they are hospital-specific. A hospital, and not a particular residency training program, would be applying for an increase to its FTE caps. We are proposing that all completed applications that are timely received according to the above deadlines would be evaluated by CMS according to the criteria described under section XVII.D. of this proposed rule for determining the priority distribution of FTE resident slots. Hospitals that satisfy at least one of the "demonstrated likelihood" criteria would be further evaluated by the evaluation criteria described below.

13. CMS Evaluation of Applications for Increases in FTE Resident Caps

We are proposing to require hospitals to submit, with their applications for increases in their FTE resident caps, a completed copy of the CMS Evaluation Form. The CMS Evaluation Form will ask the hospital to check off which of the "demonstrated likelihood" criteria (described above in section XVII.D.11. of this proposed rule) the hospital meets. We also are proposing to require that the hospital provide the documentation that supports the "demonstrated likelihood" criteria it has checked off on the Evaluation Form.

Assuming that the applicant hospital meets the "demonstrated likelihood" requirement, we are proposing that the applicant hospital would indicate on the CMS Evaluation Form the category(ies) for which it believes it will qualify. We would use this indication to prioritize the applications. This prioritization is derived from section 1886(h)(8)(C) and (D) of the Act, as added by section 5503 of the Affordable Care Act. That section established considerations in redistribution and a priority order that must be applied in determining the hospitals that will receive increases in their FTE caps. As discussed above, the first consideration in redistribution is that the applicant hospital must demonstrate the likelihood of filling the slots requested within the first three cost reporting periods beginning on or after July 1, 2011. Another consideration is "whether the hospital has an accredited rural training track" (as described in section 1886(h)(4)(H)(iv) of the Act). Accordingly, we are proposing that, in distinguishing between hospitals within a priority category, and determining which hospitals will receive FTE cap increases, we would give preference to a hospital that has an accredited rural training track over a hospital that does not have such a program. Under section 1886(h)(4)(H)(iv) of the Act, as implemented in the regulations at § 413.79(k), an urban hospital that operates a rural training track (often known as separately accredited 1–2 tracks in family medicine) wherein residents rotate at the urban hospital for less than one-half of the duration of the program, and to a rural area for the remainder of the program, the urban hospital may include in its FTE count the FTE resident time spent training in the rural track, even if that time would be in excess of the hospital's FTE cap. We note that if an urban hospital is interested in starting a new rural training track, it need not apply for additional slots under section 1886(h)(8)(B)(i). Rather, under the existing regulations at § 413.79(k), the urban hospital may receive an increase to its FTE cap to reflect FTE residents training in the rural track. (For more details on rural training tracks, and the direct GME and IME payment rules associated with them, we refer readers to 66 FR 39902, August 1, 2001, and 68 FR 45454, August 1, 2003). However, because section 1886(h)(8)(C) of the Act states that the Secretary shall take into account "whether the hospital *has* an accredited rural training track" (emphasis added), we are proposing that an applying urban hospital that either *has* a separately accredited rural training track, or can document that it *will have* a separately accredited rural training track as of July 1, 2011, may receive preference over a hospital that, all other things being equal, does not and will not have a rural training track by that date. We note that section 1886(h)(8)(C) of the Act does not specify that a hospital must be applying for additional slots in order to expand its existing rural training track in order to qualify to receive additional slots. Rather, section 1886(h)(8)(C) of the Act merely states that "the Secretary *shall take into account* * * * whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv))" (emphasis added). That is, the fact that an urban hospital *already has* (or, under this proposed rule, would have as of July 1, 2011) a separately accredited rural training track is sufficient to give preference in redistribution to such a hospital.

Section 1886(h)(8)(D) of the Act instructs the Secretary to "distribute the increase to hospitals based on the following factors":

- *Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary) (section 1886(h)(8)(D)(i) of the Act).* In order to determine which States are in the lowest quartile for resident-to-population ratios, we are proposing to use three sources of data, and the latest data available for each of those three sources. First, we are proposing to determine the number of allopathic residents in each state by using data from the ACGME's Data Resource Book for the Academic Year 2008–2009. As of publication of this proposed rule, this is the most recent data available from the ACGME. In this book, which is available free of charge on the ACGME's Web site, is a table titled "Number of Residents in Core and Subspecialty Programs, by State" (*www.acgme.org/acWebsite/dataBook/2008-2009_ACGME_Data_Resource_Book.pdf*). This table lists

each State (including Puerto Rico), and includes a column called "Number of Residents." We are proposing to use the data from this column called "Number of Residents" as part of the numerator to determine the resident-to-population ratio in each state. However, because these data only include residents enrolled in ACGME-accredited programs, we also are proposing to add to these numbers the number of residents enrolled in AOA-accredited programs. We are proposing to access data on the number of osteopathic residents in each State from the AOA, which was provided to CMS upon special request. These data are what is generally published in the AOA's *Journal of the American Osteopathic Association (JAOA).* As of the issuance of this proposed rule, the most recent data published in JAOA was that for the 2007–2008 academic year. However, because we have data from the ACGME for the 2008–2009 academic year, we requested and received data from the AOA for the 2008–2009 academic year as well. Although these data will not be published in the JAOA for some months, we have received permission from the AOA to publish it in this proposed rule (as indicated at the end of the GME discussion). These data are also presented in the form of a table listing each State (there are no osteopathic programs in Puerto Rico), and a column for the total number of residents in each State. Therefore, we are proposing that the numerator for the ratio for each State would be the sum of the residents from the 2008–2009 ACGME's table for that State, and the residents from the 2008–2009 AOA table for that State.

We understand that, although graduates of allopathic medical schools are precluded from training in AOA-accredited programs, there is no similar prohibition on osteopathic residents training in allopathic programs. Because there are osteopathic residents who enroll and participate in allopathic ACGME-accredited programs, we want to ensure that there is no double counting of residents in the numerator. We have learned from the ACGME that their data in the ACGME Data Resource Book include osteopaths, but only those training in ACGME-accredited programs. The AOA data do not include osteopathic residents who are training in ACGME-accredited programs; AOA data only include osteopathic residents enrolled and training in AOA-accredited programs. Therefore, we do not believe there is a concern about double counting with respect to osteopathic residents training in allopathic programs. However, we also are aware that there are some programs that are dually accredited by the ACMGE, and the AOA, and residents completing these programs are able to sit for both the ABMS and the AOA board examination in that specialty. We understand that the ACGME will include a resident in its resident count as long as that resident is training in an ACGME-accredited program, even if that program is dually accredited. The AOA has the same practice of including in its total count of residents those who are in AOA-accredited programs, even if it is a dual eligible program. Therefore, there is some degree of unavoidable double counting of residents in the total count. However, we understand that the number of residents in dually-accredited programs is less than 500, and because 500 is only 0.44 percent of the combined ACGME and AOA 2008–2009 resident count of 114, 416, we believe the effect of counting these residents by both the ACGME and AOA is negligible and would not harm the integrity of the data.

We are proposing to define "resident" in "resident-to-population" ratio as actual individual residents, as opposed to the FTE resident figures that are used for Medicare payment purposes. We believe it is appropriate to define "residents" as actual individual residents in this instance because the intent behind this criterion is to identify those States that have low numbers of physicians-in-training in relation to the general population for which those physicians-in-training are providing health care services. An "FTE" measure, which is the measure used for most Medicare payment purposes, does not accurately reflect the number of individual physicians-in-training providing services in a State.

With regard to State population data to be used in the denominator of each State's resident-to-population ratio, we again are proposing to use the latest available data on State populations. We are proposing to use data from the Census Bureau that is from the 2000 Census, but that have been updated with the most recent data available as of July 1, 2009. We accessed these data from the following Web site: *http://www.census.gov/popest/datasets.html.* On this Web page, the following data can be found: State population datasets—Population, population change and estimated components of population change: April 1, 2000 to July 1, 2009 (NST–EST2009–alldata). We are proposing to use the CSV file at this link. Specifically, we are proposing to use the data for State population from the column called POPESTIMATE2009 (column Q of the CSV spreadsheet). Therefore, we are proposing to determine each State's resident-to-population ratio, and specifically those States that fall within the lowest quartile by using the sum of the 2008–2009 ACGME and AOA resident data for each State, as described above, in the numerator for each State, and by using the population data updated as of July 1, 2009 in the denominator for each State from the column called POPESTIMATE2009 in column Q of the CSV spreadsheet. The following table lists each State, and is sorted by resident-to-population ratio from lowest to highest. The first 13 shaded states are the states in the lowest quartile.

BILLING CODE 4120–01–P

State Name	Census data as of July 1, 2009	ACGME resident data 2008-2009	AOA resident data 2008-2009	Total resident data	Resident to population ratio
Montana	974,989	20	0	20	0.0021%
Idaho	1,545,801	50	0	50	0.0032%
Alaska	698,473	35	3	38	0.0054%
Wyoming	544,270	40	4	44	0.0081%
Nevada	2,643,085	242	48	290	0.0110%
South Dakota	812,383	97	0	97	0.0119%
North Dakota	646,844	107	0	107	0.0165%
Mississippi	2,951,996	495	0	495	0.0168%
Florida	18,537,969	3,331	293	3,624	0.0195%
Puerto Rico Commonwealth	3,967,288	801	0	801	0.0202%
Indiana	6,423,113	1,278	20	1,298	0.0202%
Arizona	6,595,778	1,296	45	1,341	0.0203%
Georgia	9,829,211	2,044	8	2,052	0.0209%
Oregon	3,825,657	805	0	805	0.0210%
Colorado	5,024,748	1,135	0	1,135	0.0226%
Arkansas	2,889,450	703	3	706	0.0244%
South Carolina	4,561,242	1,115	8	1,123	0.0246%
Utah	2,784,572	687	0	687	0.0247%
Washington	6,664,195	1,652	0	1,652	0.0248%
Kansas	2,818,747	694	6	700	0.0248%
Oklahoma	3,687,050	735	189	924	0.0251%
Alabama	4,708,708	1,201	0	1,201	0.0255%
California	36,961,664	9,658	176	9,834	0.0266%
Maine	1,318,301	295	56	351	0.0266%
Kentucky	4,314,113	1,119	31	1,150	0.0267%
New Mexico	2,009,671	534	5	539	0.0268%
New Hampshire	1,324,575	368	4	372	0.0281%
Iowa	3,007,856	816	29	845	0.0281%
Texas	24,782,302	6,993	101	7,094	0.0286%
Virginia	7,882,590	2,229	46	2,275	0.0289%
Wisconsin	5,654,774	1,660	21	1,681	0.0297%
North Carolina	9,380,884	2,817	14	2,831	0.0302%
Hawaii	1,295,178	415	0	415	0.0320%
Tennessee	6,296,254	2,089	2	2,091	0.0332%

State Name	Census data as of July 1, 2009	ACGME resident data 2008-2009	AOA resident data 2008-2009	Total resident data	Resident to population ratio
New Jersey	8,707,739	2,731	319	3,050	0.0350%
Nebraska	1,796,619	641	0	641	0.0357%
Delaware	885,122	306	18	324	0.0366%
Louisiana	4,492,076	1,666	0	1,666	0.0371%
West Virginia	1,819,777	620	96	716	0.0393%
Minnesota	5,266,214	2,144	0	2,144	0.0407%
Vermont	621,760	259	0	259	0.0417%
Missouri	5,987,580	2,514	114	2,628	0.0439%
Maryland	5,699,478	2,632	0	2,632	0.0462%
Illinois	12,910,409	5,728	261	5,989	0.0464%
Ohio	11,542,645	5,293	565	5,858	0.0508%
Connecticut	3,518,288	2,010	13	2,023	0.0575%
Michigan	9,969,727	4,574	1,196	5,770	0.0579%
Pennsylvania	12,604,767	7,236	737	7,973	0.0633%
Rhode Island	1,053,209	725	0	725	0.0688%
Massachusetts	6,593,587	5,195	14	5,209	0.0790%
New York	19,541,453	15,821	489	16,310	0.0835%
District of Columbia	599,657	1,831	0	1,831	0.3053%

BILLING CODE 4120–01–C

Based on the foregoing proposed data, the following States fall within the lowest quartile for resident-to-population ratios: Montana, Idaho, Alaska, Wyoming, Nevada, South Dakota, North Dakota, Mississippi, Florida, Puerto Rico, Indiana, Arizona, and Georgia. Accordingly, we are proposing that, consistent with section 1886(h)(8)(D)(i) of the Act, a hospital located in any one of these States that applies for an increase to its FTE cap under section 1886(h)(8)(B) of the Act would receive preference over a hospital that is applying for an increase to its cap that is not located in one of these States.

• *Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of (1) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to (2) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).*

In order to determine which applying hospitals fall within this priority category, we need to determine the total population living in a HPSA in each State, territory, or District computed "as of the date of enactment," and we need to determine the total population of each State, territory, or District "(as determined by the Secretary based on the most recent available population data published by the Bureau of the Census)." "Territory" is referring to Puerto Rico, which currently has teaching hospitals, and "District of Columbia" refers to Washington D.C. For ease of reference, and consistent with the definition of "State" at section 210 of the Act, we are proposing to refer to "State, territory, or District" simply as "State." We have received data on the population of each HPSA from the Health Resources and Services Administration's (HRSA) Geospatial Warehouse. HRSA's Shortage Designation Branch develops shortage designation criteria and uses them to decide whether or not a geographic area, or population group, is a HPSA. HRSA updates HPSA statistics on its Web site on a daily basis, and we have requested and received the data reflective of the "date of enactment"; that is, March 23, 2010. Because HRSA updates the data on its Web site daily, the data as of March 23, 2010 are no longer available on its Web site. (General information on HPSAs and current data can be found on HRSA's Web site at: *http://bhpr.hrsa.gov/shortage/*).

HRSA designates three different kinds of HPSAs: Primary Care HPSAs, Dental HPSAs, and Mental Health HPSAs. While many areas may only be designated as one of these kinds of HPSAs, some areas may be designated as two or three of these kinds of areas. Thus, if we were to add the population in each State that is in a Primary Care HPSA, a Dental HPSA, and a Mental Health HPSA, we would be duplicating the HPSA populations in each State. Therefore, we are proposing to use *only* the population in each State that is in a Primary Care HPSA. We believe that it is appropriate to choose to recognize only the Primary Care HPSAs in each State for the purpose of implementing section 5503 because section 5503 is intended to encourage an increase in the number of primary care residents that are currently being trained in hospitals, as is evidenced by the "Requirements" in section 1886(h)(8)(B)(ii) of the Act, as added by section 5503(a)(4), which requires hospitals that receive additional slots under this section to maintain a certain average number of primary care resident positions, and that not less than 75 percent of the redistributed positions must be awarded for slots used in a primary care or a general surgery residency.

With respect to data on each State's total population "as determined by the Secretary based on the most recent available population data published by the Bureau of the Census," we are proposing to use the same data that we are using under the first priority

category with regard to determining resident-to-population ratios, as explained above. These data, which are the most recent available, were last updated on July 1, 2009. As explained above, we accessed these data from the following Web site: *http://www.census.gov/popest/datasets.html.* On this Web page, the following data can be found: State population datasets—population change and estimated components of population change: April 1, 2000 to July 1, 2009 (NST–EST2009–alldata). We are proposing to use the CSV file at this link. Specifically, we are proposing to use the data for State population from the column called POPESTIMATE2009 (column Q of the CSV spreadsheet).

The following table lists each State, its Primary Care HPSA population-to-State population ratio from highest to lowest, and whether that State falls within the top 10 States for such Primary Care HPSA population-to-State population ratios:

BILLING CODE 4120–01–P

State Name	Census data as of July 1, 2009	Primary Care HPSA	Primary Care HPSA to Population Ratio
Louisiana	4,492,076	3,119,598	69.4467%
Mississippi	2,951,996	1,781,774	60.3583%
Puerto Rico Commonwealth	3,967,288	2,282,408	57.5307%
New Mexico	2,009,671	1,036,774	51.5892%
South Dakota	812,383	351,926	43.3202%
District of Columbia	599,657	257,377	42.9207%
Montana	974,989	384,030	39.3881%
North Dakota	646,844	239,550	37.0337%
Wyoming	544,270	199,656	36.6833%
Alabama	4,708,708	1,725,293	36.6405%
Arizona	6,595,778	1,981,387	30.0402%
Illinois	12,910,409	3,858,062	29.8833%
Missouri	5,987,580	1,780,841	29.7422%
Idaho	1,545,801	453,347	29.3276%
Kentucky	4,314,113	1,155,928	26.7941%
South Carolina	4,561,242	1,159,709	25.4253%
Texas	24,782,302	6,040,714	24.3751%
Delaware	885,122	215,060	24.2972%
New York	19,541,453	4,691,714	24.0090%
Oklahoma	3,687,050	866,358	23.4973%
Georgia	9,829,211	2,276,546	23.1610%
Florida	18,537,969	4,287,169	23.1264%
Tennessee	6,296,254	1,455,365	23.1148%
Alaska	698,473	153,999	22.0480%
Kansas	2,818,747	570,639	20.2444%
Colorado	5,024,748	970,145	19.3073%
Michigan	9,969,727	1,916,653	19.2247%
Nevada	2,643,085	504,174	19.0752%
North Carolina	9,380,884	1,673,482	17.8393%
Iowa	3,007,856	536,519	17.8373%
Wisconsin	5,654,774	998,920	17.6651%
West Virginia	1,819,777	318,133	17.4820%
Arkansas	2,889,450	501,208	17.3461%
Utah	2,784,572	477,193	17.1370%
Washington	6,664,195	1,140,882	17.1196%
California	36,961,664	6,014,851	16.2732%
Virginia	7,882,590	1,222,771	15.5123%
Oregon	3,825,657	579,368	15.1443%
Rhode Island	1,053,209	156,064	14.8180%
Connecticut	3,518,288	477,837	13.5815%
Massachusetts	6,593,587	893,375	13.5492%
Indiana	6,423,113	816,234	12.7078%
Maine	1,318,301	156,116	11.8422%
Ohio	11,542,645	1,326,610	11.4931%
Pennsylvania	12,604,767	1,431,314	11.3553%
Minnesota	5,266,214	493,764	9.3761%
Maryland	5,699,478	523,260	9.1808%
Nebraska	1,796,619	146,196	8.1373%
Hawaii	1,295,178	93,107	7.1887%
Vermont	621,760	40,313	6.4837%
New Hampshire	1,324,575	84,038	6.3445%
New Jersey	8,707,739	376,405	4.3226%

BILLING CODE 4120–01–C

• *Whether the hospital is located in a rural area (as defined in section 1886(d)(2)(D)(ii) of the Act).* Section 1886(d)(2)(D)(ii) of the Act defines a rural area as any area outside a MSA. Under the existing regulations at § 412.62(f)(ii), an "urban area" means (1) a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA); or (2) the following New England counties: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Under existing § 412.62(f)(iii), a "rural area" means any area outside an urban area. Thus, for purposes of the amendments made by section 5503, we are proposing that any hospital located in an area that is not in a MSA is a rural hospital, regardless of any reclassification under § 412.102 or § 412.103. We also point out that, since FY 2005, we no longer use the term MSA, but instead use CBSA, or Core-Based Statistical Area. There are urban CBSAs, and rural CBSAs are areas outside of an urban CBSA. We note that this definition of "rural" is consistent with our policy concerning designation of wage index areas.

We also are proposing that, in determining which applicant hospitals receive priority within the priority category of hospitals located in a State in the lowest quartile for resident-to-population ratios that hospitals in a State that is ranked *lower* in the quartile (with number one being the lowest) would receive preference over hospitals in states that are still within the quartile, but ranked higher. For example, all other things being equal, a hospital located in Montana would receive preference over a hospital located in Idaho, while this hospital would receive preference over a hospital located in Alaska, and so on. Similarly, we are proposing that, in determining which applicant hospitals receive priority within the priority category of hospitals located in a State that is among the top 10 of these areas in terms of the ratio of Primary Care HPSA population to total population, hospitals in an area that is ranked *higher* in the top 10 (with number 1 being highest and number 10 being lowest) would receive preference over hospitals in an area that are still within the top 10, but ranked lower. For example, all other things being equal, a hospital located in Louisiana would receive preference over a hospital located in Mississippi, while a hospital in Mississippi would receive preference over a hospital located in Puerto Rico, and so on.

As we described above, we are proposing that an applicant hospital indicate on the CMS Evaluation Form the category(ies) for which it believes it will qualify, and we will use this indication to prioritize the applications. Each of the categories (described below) is derived from the priorities established by section 1886(h)(8)(D) of the Act, as added by section 5503 of the Affordable Care Act. We are proposing to use the following categories to determine the order in which hospitals would be eligible to receive increases in their FTE resident caps:

• *First Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND the hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND the hospital is located in a rural area.

• *Second Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND is *either* in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* it is located in a rural area, *or* is an urban hospital and has or will have as of July 1, 2010, a rural training track.

• *Third Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile.

• *Fourth Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND either the hospital is located in a rural area *or* the hospital is an urban hospital and has, or will have as of July 1, 2010, a rural training track.

• *Fifth Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* the hospital is located in a rural area.

We believe it is appropriate to establish priority level categories based on the fact that some hospitals that apply for the additional resident slots may fit into more than one of the three statutory priority categories listed in section 1886(h)(8)(D) of the Act. Therefore, we are proposing to give consideration first to those hospitals that meet more than one of the statutory priority categories over those hospitals that meet only one of the statutory priorities. We are further proposing that a hospital that is in a State whose resident-to-population ratio is within the lowest quartile would receive priority over a hospital that is not located in one of these States. We believe this is consistent with the direction established at section 1886(h)(8)(E)(i) of the Act which specifies that the Secretary shall reserve 70 percent of all positions available for distribution for hospitals in a State whose resident-to-population ratio is within the lowest quartile. Only 30 percent of the positions are to be distributed to hospitals in States whose Primary Care HPSA to population ratio is in the top 10 States, and hospitals located in rural areas. In addition, as discussed above, the first consideration in redistribution under section 1886(h)(8)(C) of the Act is that the applicant hospital must demonstrate the likelihood of filling the slots requested within the first three cost reporting periods beginning on or after July 1, 2011. The second consideration is "whether the hospital has an accredited rural training track" (as described in section 1886(h)(4)(H)(iv) of the Act). Accordingly, we are proposing that, in distinguishing between hospitals within priority categories, and in determining which hospitals qualify to receive additional slots, we would give preference to a hospital that has an accredited rural training track as compared to a hospital that does not have such a program.

Because section 1886(h)(8)(E) of the Act specifies that 70 percent of the slots are to be reserved for hospitals that are in a State whose resident-to-population ratio is within the lowest quartile, and 30 percent of the positions are to be reserved for hospitals in States whose Primary Care HPSA to population ratio is in the top 10 States, and hospitals located in rural areas, we are proposing that no slots would be given to hospitals that do not fit within either of these categories.

14. CMS Evaluation of Application for Increases in FTE Resident Caps—Evaluation Criteria

We anticipate that there will be a limited number of slots available for distribution from the redistribution pool, while there will be a great demand for those limited slots. Therefore, as we did when implementing section 422 of Public Law 108–173, we are proposing to use additional criteria (some of which are the same as those used to implement section 422) for evaluating the applications for increases in hospitals' FTE resident caps within each of the seven level priority categories described above under section 5503. In addition, in implementing section 5503, we are proposing to assign a certain number of points to each evaluation criterion, such that some will be worth more points than others. We note that the criteria are not mutually exclusive. Hospitals may qualify for a number of different criteria and their "score" is the total point value for all criteria met by the hospital for

each program. Because we anticipate that the redistribution pool under section 5503 will be smaller than that under section 422, we believe a more rigorous and competitive ranking system is appropriate under section 5503. Thus, we are assigning a different amount of points to each Evaluation Criterion, rather than just assigning one point to each.

Evaluation Criterion One. The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report. (5 Points) We have selected 60 percent utilization because we believe that level would identify hospitals where Medicare beneficiaries will benefit the most from the presence of a residency program, and it is consistent with the utilization percentage required for Medicare-dependent, small rural hospitals (MDHs) as specified in § 412.108. In addition, it identifies a type of hospital that warrants atypical treatment by the Medicare program because it is so reliant on Medicare funding.

Evaluation Criterion Two. The hospital will use the additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program. (5 Points) Section 5503 places a particular emphasis on increasing the number of residency positions in primary care specialties, as evidenced by the requirement at section 1886(h)(8)(B)(ii) of the Act that a hospital that receives slots must maintain at least the same number of primary care residents as it had during the three most recent cost reporting periods prior to enactment, and that not less than 75 percent of additional positions received must be in a primary care or a general surgery residency. Geriatrics is included in the definition of "primary care resident" at section 1886(h)(5)(H) of the Act. We believe that, of all the medical specialties, geriatrics is the one specialty that is devoted primarily to the care of the elderly, including Medicare beneficiaries. As such, we are proposing to give special consideration to geriatric programs to meet the "fill rate" criterion for demonstrating the likelihood of filling FTE resident slots under section 5503. Geriatrics is not a separately approved training program; rather, it is a subspecialty of another specialty program. For example, there is a geriatrics subspecialty of family practice or internal medicine. We are proposing that, for the purposes of meeting the 85 percent fill rate criterion, we would allow hospitals that are starting a new geriatrics program or expanding an existing geriatric program to use the fill rate associated with the overall specialty program (rather than the fill rate for the geriatric subspecialty) to meet this demonstrated likelihood criterion.

Evaluation Criterion Three. The hospital will use additional slots to establish a new or expand an existing primary care program with a demonstrated focus on training residents to pursue careers in primary care, rather than in nonprimary subspecialties of those primary care programs (for example, the hospital has an internal medicine program with a designated primary care track). (3 Points) As stated previously, section 5503 places a particular emphasis on encouraging the growth in the number of primary care residents, and specifically, physicians who practice in primary care, rather than only completing a primary care residency as a prerequisite for further subspecialty training. Although this proposed Evaluation Criterion applies to any primary care specialty, according to the 2010–2011 ACGME Green Book, 30.1 percent of accredited internal medicine programs offer a primary care track. However, the ACGME does not have separate standards for or does not separately accredit primary care tracks from categorical primary care programs. We understand that, particularly for internal medicine residents, these tracks are a way for graduating medical students who are interested in primary care to declare that interest early on, and in many cases, actually match into an internal medicine program with a primary care track through the National Residency Match Program. These residents may pursue their interest in primary care by choosing to do more electives in ambulatory and community-based settings throughout the 3 years of primary care training than residents with an interest in specialization might do. We believe that encouraging growth of these programs will increase the number of primary care practitioners. Therefore, we are proposing to give special consideration to hospitals that are applying for additional slots to start or expand a program(s) that particularly focuses on residents who wish to pursue careers in primary care, and we would prioritize among hospitals that are applying for slots in a primary care program(s) accordingly. One example of a hospital that demonstrates a focus on training residents to pursue careers in primary care is a hospital that has a primary care track in internal medicine. We are proposing that one way hospitals may qualify for a point under this evaluation criterion is by documenting that they are advertising that they have an internal medicine program with a primary care track in the March 2011 National Residency Match Program.

Evaluation Criterion Four. The hospital will use all the additional slots to establish a new or expand an existing primary care residency program or general surgery program. (5 Points) "Primary care resident" is defined at section 1886(h)(5)(H) of the Act as a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. Section 1886(h)(8)(B)(ii)(II) of the Act states that not less than 75 percent of additional positions received must be in a primary care or a general surgery residency. Therefore, we are proposing to award 5 points to a hospital that goes beyond this minimum requirement, and documents that it will use *all* of the slots received for either primary care or general surgery programs.

Evaluation Criterion Five. The hospital is located in a Primary Care HPSA.—2 Points. We believe this evaluation criterion is consistent with the goal of reducing the shortage of primary care physicians, and increasing access to care in underserved areas.

Evaluation Criterion Six. The hospital is in a rural area (as defined under section 1886(d)(2)(D)(ii) of the Act) and is or will be on or after July 1, 2011, a training site for a rural track residency program (as specified under § 413.79(k)), but is unable to count all of the FTE residents training in the rural track because the rural hospital's FTE cap is lower than its unweighted count of allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011. (1 Point). We understand that there are some rural hospitals that serve as training sites for an urban hospital's rural training track. The residents in the rural track are counted in the urban hospital's FTE count, but because the rural training tracks are not necessarily considered "new" medical residency programs according to the regulations at § 413.79(l), the rural hospital cannot receive an increase to its FTE caps under § 413.79(e)(3) and, therefore, cannot receive direct GME and IME payments for training all or some of those residents. The rural hospital may be training residents in excess of its FTE resident cap prior to July 1, 2011 and, therefore, cannot receive IME or direct GME payment for some or all of the FTEs in the rural training track, or it

wishes to expand its rural training track above its FTE resident cap on or after July 1, 2011. We are proposing this evaluation criterion as a remedy to these scenarios to allow the rural hospital the possibility of receiving payment for FTEs in its rural training track.

We are proposing to use these criteria to evaluate the applications by hospitals for increases in their FTE resident caps that fall within each of the seven level priority categories. We are proposing to place each application in the appropriate priority level category based on a review of the information a hospital checks off on the proposed CMS Evaluation Form for each allopathic and osteopathic specialty program requested by the applicant hospital, and the corresponding requested FTE cap increase (the proposed form appears below). We propose to place all of these evaluation criteria on the Evaluation Form and to ask the hospital to check off which criteria on the form apply for each specialty program for which an FTE cap increase is requested. Based on the evaluation criteria checked off on the form, we are proposing to score each CMS Evaluation Form. The higher-scoring CMS Evaluation Form(s) for each applicant hospital within each level priority category would be awarded the FTE resident cap increases first. It is possible that a hospital may qualify for multiple points for the same program. For example, if a hospital would be applying for slots to start a primary care track within an internal medicine program, and also would be using *all* of the slots it receives in that internal medicine program, the hospital may receive points both for Evaluation Criterion Three and Evaluation Criterion Four. Similarly, if a hospital would be applying for slots to start or expand a geriatrics program, and the additional slots would all be used for the geriatrics program, then the hospital may receive points for both Evaluation Criterion Two and Evaluation Criterion Four. Further, as specified by section 1886(h)(8)(E) of the Act, 70 percent of all positions are reserved to be distributed to qualifying hospitals that are in States with resident-to-population ratios in the lowest quartile, and 30 percent of the positions are reserved to go to hospitals that are located in States with HPSA population to State population ratios within the top 10 and to rural hospitals. As we described above, we are proposing to award the cap increases in the order of the seven specified level priority categories because, as a general rule, we believe hospitals that meet more than one of the statutory priorities should be awarded the increases in their FTE resident caps first before other hospitals. We also believe that hospitals that meet a higher statutory priority category should receive first consideration over hospitals that meet lower statutory priorities. That is the reason, for instance, we are proposing that the first, second, and third level categories give preference to hospitals located in States with resident-to-population ratios in the lowest quartile before considering hospitals that are only located in States with high Primary Care HPSA population to State population ratios or to hospitals that are only rural. Furthermore, in the case where, for example, Hospital A's application for a program falls within the Level Priority Category One, but scores no points on the evaluation criteria on the CMS Evaluation Form for that program, and Hospital B's application for a program falls within the Level Priority Category Two, and scored 5 points on the evaluation criteria on the CMS Evaluation Form for the program, Hospital A would receive the section 5503 cap increase *before* Hospital B, because Hospital A qualified to be in the higher level priority category.

Thus, first level priority category hospitals that score highest on the evaluation criteria on the CMS Evaluation Form for a particular specialty program would receive the increases in their FTE resident caps first. For example, if Hospital D is a rural hospital that is located in Mississippi, thereby falling within the first level priority category, and Hospital D checks off on the CMS Evaluation Form that it has a Medicare utilization of 60 percent (5 points), is using all the slots to expand a primary care residency program (5 points), and is located in a Primary Care HPSA (2 points), Hospital D would receive a score of 12 points on the completed CMS Evaluation Form. We are proposing that we would first award FTE cap increases to hospitals whose CMS Evaluation Forms for a particular program receive the most points (if there are any), and then to those with successively fewer points within the level priority category. Hospital D would receive the increase in its FTE resident cap(s) requested on its application only after all the hospitals in the first level priority category whose applications receive 13 or more points are awarded their requests first. We are proposing to proceed through each level priority category accordingly, and only move on to distribute slots to hospitals in the next priority level category once all the qualifying applicants in the previous priority level category have received slots. Once we have distributed 70 percent of the slots to hospitals within States with resident-to-population ratios in the lowest quartile in accordance with the Priority Level Categories One through Three (or awarded increases to all qualified applicant hospitals located in States with resident to population ratios in the lowest quartile), we are proposing to then distribute the remaining slots to hospitals in the fourth and fifth level categories. Because of this requirement that 70 percent of the slots be reserved for distribution to hospitals within States with resident-to-population ratios in the lowest quartile, it is possible that after first distributing slots to hospitals with the highest scores on their CMS Evaluation Form, if there are requests for slots by those hospitals which in the aggregate exceed the 70 percent of slots available, there may be some remaining qualifying hospitals within the same priority level category that receive the same score on the CMS Evaluation Form. Thus, we would have no way of distinguishing among these hospitals of equal rank. If this situation occurs, we are proposing to prorate the remaining amount of slots in the "70 percent" pool, and distribute an equal share of slots to these hospitals of equal rank. If a similar situation occurs within the "30 percent" pool, we also are proposing to prorate the remaining amount of slots in the "30 percent" pool, and distribute an equal share of slots to hospitals of equal rank.

For example, assume all applicant hospitals in the first and second level priority categories receive the requested increases in their FTE resident caps, and that we have awarded cap increases for all the third level priority category hospitals that scored 5 or above on their CMS Evaluation Forms for each residency program. We next evaluate hospital applications and accompanying CMS Evaluation Forms in the third Level Priority Category (The hospital is in a State whose resident-to-population ratio is within the lowest quartile) with fewer than 5 points and we find that there is only a sufficient number of resident slots remaining in the estimated "70 percent" pool to grant half of the requests for slots from hospitals that scored 4 points. We are proposing to prorate all of the remaining FTEs among the 4-point CMS Evaluation Forms and accompanying applications in the third level priority category. Thus, after awarding slots to hospitals in the third level priority with at least 5 points, and to hospitals in the first two level priority categories, if we could have awarded a total of 200 FTE slots

for direct GME and 185 FTE slots for IME to only 50 percent of the 4-point CMS Evaluation Forms in the third level priority category (at the point that the estimated "70 percent" pool of FTE slots is spent), we are proposing to divide all of the 200 FTE slots remaining in the 70 percent pool for direct GME and 185 FTE slots for IME among *all* of the 4-point CMS Evaluation Forms and accompanying applications in that third priority category, no matter what level of FTE resident cap increase was requested on the individual hospital's application, but not to exceed the number of slots a hospital requested for IME and direct GME respectively.

We are also considering another possible scenario that could occur with respect to hospitals that fall into the Second Level Priority Category: The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND is *either* in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* it is located in a rural area, *or* is an urban hospital and has or will have as of July 1, 2010, a rural training track. Because a hospital in this second level priority category is located both in a State whose resident-to-population ratio is within the lowest quartile, AND is *either* in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* it is located in a rural area, we believe that its request for additional slots must first be fulfilled from the "70 percent pool." However, if there are insufficient slots in the "70 percent pool" to satisfy the requests of all otherwise qualified applicants in the second level priority category, then, rather than immediately prorating the remaining slots in the "70 percent pool" among the applicable hospitals in the second level priority category, we are proposing to draw from the "30 percent pool" to grant the full FTE cap increases (as applicable) to qualifying hospitals in the second level priority category.

Alternatively, although unlikely, we recognize that the reverse situation may occur, where there may not be a sufficient number of qualified applicants or requests for FTEs in order to distribute at least 70 percent of the slots hospitals located in the 13 States whose resident-to-population ratios are in the lowest quartile (priority level categories one through three). Should this occur, we are proposing to begin evaluating applications from the next category of qualifying hospitals (that is, those located in States that are among the top 10 States for Primary Care HPSA to population ratios, and rural hospitals—priority level categories four and five), and potentially distribute more than 30 percent of the slots to hospitals in those latter categories.

We recognize the complexity of the proposed evaluation process for the award of increases in hospital's FTE resident caps under section 1886(h)(8)(B) of the Act. Therefore, we have included the following examples depicting the proposed procedures:

Example 1

Hospital H is an urban hospital located in a State that is in the lowest quartile for resident-to-population ratios. Hospital H can demonstrate the likelihood that it will fill the requested five FTEs resident slots for direct GME and IME for expanding a geriatric program because it is currently training a number of FTE residents that exceeds both of its FTE caps, and has attached to its application for the increase a copy of Hospital H's past three Medicare cost reports (as filed or audited, whichever is most recent and available), which documents on Worksheet E, Part A, Worksheet E–3, Part IV, and Worksheet E–3, Part VI that, according to the resident counts and the FTE resident caps, Hospital H is training residents in excess of its caps. Hospital H is also located in a Primary Care HPSA (but is not located in a State that is among the top 10 States in terms of its Primary Care HPSA population to State population ratio).

We would evaluate Hospital H's application as follows: Hospital H is in the third Level Priority Category (The hospital is in a State whose resident-to-population ratio is within the lowest quartile), and receives a score of 12 (expanding a geriatrics program-Evaluation Criterion Two-5 points, using all slots for a primary care residency program-Evaluation Criterion Four-5 points, and is located in a Primary Care HPSA-Evaluation Criterion Five-2 points).

Example 2

Hospital J is a rural hospital located in Montana. Hospital J is a rotation site for an urban hospital's family practice rural track program, but is unable to count all of the FTE residents training in the rural track because the rural hospital's FTE cap is lower than its unweighted count of allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011. The rural hospital wishes to expand the number of FTE residents training in the family practice rural track. The rural hospital also wishes to serve as a training site for one pediatrics resident in a pediatrics program that already exists at the urban hospital (that is, it is not a new pediatrics program).

Hospital J would need to submit two CMS Evaluation Forms; one for family practice and another for pediatrics, and we would evaluate each accordingly. Both requests would put the hospital in the second level priority category (The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND is *either* in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* it is located in a rural area, *or* is an urban hospital and has or will have as of July 1, 2010, a rural training track), and it can demonstrate the likelihood of filling the slots (because it is already over its FTE caps based on the family medicine residents it is training in the rural track, and together with the urban hospital, it has requested from the ACGME accreditation to expand the number of family practice residents training in the rural track and to receive a pediatrics resident). For the family practice request, Hospital J would receive 5 points under Evaluation Criterion Four because *all* the slots it is requesting (that is, family practice *and* pediatrics) are for primary care programs, and it would receive 1 point under Evaluation Criterion Six because it is requesting the family practice slots for its rural training track, for a total of 6 points for the family practice request. For the pediatrics request, Hospital J would be placed in the second Priority Level Category, and receives 5 points under Evaluation Criterion Four because *all* the slots it is requesting (that is, family practice *and* pediatrics) are for primary care programs.

15. Exception If Positions Are Not Redistributed by July 1, 2011

Section 1886(h)(8)(E)(iii) of the Act states that in the case where, by July 1, 2011, the Secretary "does not distribute positions to hospitals," the Secretary shall distribute such positions to other hospitals in accordance with the considerations in redistribution specified at section 1886(h)(8)(C) of the Act (that is, the demonstrated likelihood of filling the slots and whether the hospital has a rural training track), and the priority for certain areas specified at section 1886(h)(8)(D) of the Act (that is, whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile, whether the hospital is located in a State that is in top 10 States in terms of Primary Care HPSA population to State population, and whether the hospital is rural). We believe that the phrase "does not distribute positions to hospitals" contemplates the scenario where there would be more slots available than the amount that qualifying hospitals

requested, and therefore, CMS would be left with slots in the distribution pool as of July 1, 2011. The Secretary is directed to initiate another round of applications after July 1, 2011, in which hospitals that could demonstrate that they could use the slots would apply and possibly receive a portion of the remaining slots, until all the slots in the pool are redistributed. Should the situation arise where there are unused slots available as of July 1, 2011, we would propose a process for redistributing those slots "in accordance with the considerations in redistribution specified at section 1886(h)(8)(C)." We would then alert the public through another round of notice and comment rulemaking to establish the application timeframe, criteria, process and other relevant information at that time.

16. Application of Direct GME PRAs for Primary Care and Nonprimary Care Residents and Conforming Changes for the IME Multiplier

Section 1886(h)(8)(G) of the Act states that, "With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital." Hospitals that receive increases in their FTE resident caps under section 1886(h)(8)(B)(i) will receive direct GME payments associated with those FTE residents in the same manner as they receive direct GME payments for their other (non-section 422) FTE residents, that is, using the primary care PRA that is reported on Worksheet E–3, Part IV, line 3.23, and the nonprimary care PRA reported on line 3.17 of the same worksheet. This provision in section 5503 differs from section 422 in that hospitals that received additional slots under section 422 receive direct GME payment for FTE residents attributable to those slots using a single locality-adjusted national average PRA (42 CFR 413.77(g)), and the payment determination is made on Worksheet E–3, Part VI. Thus, if a hospital received additional slots under section 422, and they train a number of residents that is sufficient to require them to count FTE residents under those slots, the hospital will continue to receive direct GME payment for those slots using the locality-adjusted national average PRA. However, we are proposing that a hospital that receives additional slots under section 5503 would be paid for FTE residents counted under those slots using the same primary care and nonprimary PRAs for which payment is made for FTE residents subject to the 1996 FTE cap. We are expecting to revise Worksheet E–3, Part IV to add a line on which hospitals would report the number of FTEs by which the hospital's FTE caps were increased for direct GME slots received under section 5503. To create a hospital's total adjusted direct GME FTE cap, the increase granted under section 1886(h)(8)(B)(i) would be added to the 1996 direct GME FTE cap and would include any applicable new program adjustment received under § 413.79(e), and any applicable adjustments for the cost reporting period due to a Medicare GME affiliation agreement. In a given cost reporting year, we are proposing that a hospital would only count FTE residents under its direct GME section 422 cap slots on Worksheet E–3, Part VI if the number of unweighted allopathic and osteopathic residents it is training exceeds the total adjusted direct GME cap (including the section 5503 slots) on Worksheet E–3, Part IV.

In addition, with respect to the IME adjustment, we are proposing that a hospital that receives an increase in its FTE cap under section 1886(h)(8)(B)(i) will count FTE residents under those slots, and payment will be made with respect to residents counted under those slots, using the same IME multiplier for which payment is made for FTE residents subject to the 1996 FTE cap (that is, currently a multiplier of 1.35). This is because section 1886(d)(5)(B)(x) of the Act, as added by section 5503(b)(2), states, "For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions." This provision in section 5503 differs from section 422 in that hospitals that received additional slots under section 422 receive IME payment for FTE residents counted under those slots using a special multiplier of 0.66 (42 CFR 412.105(e)(2)), and the payment determination is made on Worksheet E–3, Part VI. We also are expecting to revise Worksheet E, Part A to add a line in which applicable hospitals would report the amount of additional IME slots received under section 5503. To create a hospital's total adjusted IME FTE cap, this additional amount would be added to the 1996 IME FTE cap, any applicable new program adjustment received under § 413.79(e), and any applicable adjustments for the period due to a Medicare GME affiliation agreement. In a given cost reporting year, we are proposing that a hospital would only use its IME section 422 cap slots on Worksheet E–3, Part VI if the number of unweighted allopathic and osteopathic residents it is training exceeds the total adjusted IME cap (including the section 5503 slots) on Worksheet E, Part A. Finally, under section 422 of Pub. L. 108–173, hospitals that were members of the same Medicare GME affiliated group on or after July 1, 2005, and that received additional FTE cap slots under section 422 are precluded from including those additional section 422 slots in the aggregate affiliated cap. This is in part because section 422 specified that a hospital would receive direct GME and IME payments for additional slots awarded under section 422 with rates that were different from the non-section 422 cap slots, and tracking the different direct GME and IME payment rates associated with FTE residents that are counted as a result of the section 422 cap increases and those that were not would be extremely difficult for the Medicare contractors. In addition, in order to qualify for additional slots under section 422, the hospitals had to document a need for those slots. Similarly, under section 5503, we are proposing that hospitals that receive additional slots under section 5503 *cannot* use these slots as part of the aggregate cap in a Medicare GME affiliation agreement. This is because we believe that once a hospital has demonstrated that it truly needs the additional slots, has made the effort to carefully document that it will fill those slots within three years, and once we have determined that the characteristics of the hospital and its training program warrant an increase in the hospital's FTE resident caps under section 1886(h)(8)(B)(i), we do not believe it would be appropriate for the hospital to transfer those positions to another hospital, albeit temporarily, under the terms of a Medicare GME affiliation agreement. To do so would be to undermine the goals and specifications for the redistribution of residency positions as set forth under section 5503.

We note that section 1886(h)(8)(B) of the Act, which addresses the increases in hospitals' FTE resident caps, makes no reference to section 1886(h)(4)(G) or 1886(d)(5)(B)(vi)(II) of the Act, which are the provisions concerning the rolling average count of FTE residents. Furthermore, there is no mention of

section 1886(d)(5)(B)(vi)(I) of the Act, the provision regarding the cap on the IME resident-to-bed ratio, in section 1886(h)(8)(B) of the Act either. That is, the statute does not provide for an exclusion from application of the rolling average for residents counted as a result of FTE cap increases under section 1886(h)(8)(B)(i) of the Act, nor does the statute exempt the residents counted pursuant to FTE cap increases under section 1886(h)(8)(B)(i) from the application of the cap on the IME resident-to-bed ratio. In light of the absence of a specific directive in section 1886(h)(8)(B)(i) of the Act exempting those residents from application of the rolling average for direct GME and IME, and the cap on the IME resident-to-bed ratio, and with no apparent reason to treat residents counted as a result of the FTE cap increases under section 1886(h)(8)(B) of the Act differently, we are proposing to require that if a hospital increases its direct GME or IME FTE count of residents under an increase in the hospital's FTE resident cap under section 1886(h)(8)(B)(i) of the Act, those FTE residents would be immediately subject to the rolling average calculation and the cap on the IME resident-to-bed ratio. Furthermore, we believe that, given potentially significant shifts of FTE resident positions among hospitals as a result of section 1886(h)(8) of the Act, the inclusion of FTE residents counted as a result of FTE cap increases under section 1886(h)(8)(B)(i) of the Act in the rolling average would introduce a measure of stability and predictability, and mitigate radical shifts in GME payments from period to period.

17. Other Issues Related to a Request for Increase in the FTE Caps Under Section 5503

• Rural Hospitals or Urban Nonteaching Hospitals

Rural hospitals may receive an adjustment to their FTE caps for establishing a new residency program under § 413.79(e)(1)(iii) of the existing regulations at any time. Therefore, if a rural hospital is interested in starting a new program, or interested in participating in training residents in a new program on or after July 1, 2011, it need not apply for slots under section 5503 for that new program. If a rural hospital seeks to expand an existing program, and does not have sufficient space under its existing FTE caps to cover those additional residents, the rural hospital may apply for an increase to its FTE caps under section 5503. Similarly, an urban hospital may request additional slots under section 5503 for the purpose of expanding an existing program. A hospital, rural or urban, that is not yet a teaching hospital and does not have a cap established, may *not* apply for a permanent adjustment to their FTE caps under section 5503 since a non-teaching hospital may apply for a permanent cap adjustment under current Medicare regulations at § 413.79(e). Also, if an urban non-teaching hospital becomes a teaching hospital because it begins to serve as a rotating site for another hospital's existing program, it may apply for additional slots under section 5503, which would not preempt the hospital from later getting a new cap adjustment under § 413.79(e) for starting a new program.

• Closed Teaching Hospitals

We note that under section 5506 of Public Law 111–148, as explained further in section XVII.E. of this proposed rule, the FTE resident caps of teaching hospitals that close on or after March 23, 2008 are to be redistributed to other qualifying hospitals according to specific criteria. Assuming a teaching hospital closed recently, it is possible that based on the closed teaching hospital's three most recent cost reporting periods ending prior to March 23, 2010, its FTE resident caps could be subject to reduction under section 5503. However, so as to avoid duplication of FTE resident slots in the redistribution processes under sections 5503 and 5506, we are proposing that if a hospital closes on or after March 23, 2008, then its FTE resident cap slots would not be redistributed under section 5503, but would be reserved for redistribution under section 5506.

• Requirements for Hospitals That Receive Additional Slots Under Section 5503

Section 1886(h)(8)(B)(ii) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, specifies requirements and thresholds that a hospital that applies for and receives additional slots effective July 1, 2011 must meet in order to retain those slots. Under section 422 of Public Law 108–173, hospitals that received additional slots were not held accountable for meeting any requirements once those slots were received effective July 1, 2005, nor did section 422 require that CMS conduct any subsequent reviews of the hospitals that received the slots in order to determine that the hospitals were meeting certain thresholds. However, section 1886(h)(8)(B)(i) of the Act, as added by section 5503 of the Affordable Care Act specifies requirements that a hospital that receives an increase in its FTE resident caps under section 1886(h)(8)(B)(i) must meet, at least for a 5-year period beginning on and after July 1, 2011, and section 1886(h)(8)(B)(iii) directs the Secretary to reduce the FTE caps of the hospital by the same number of FTE residents by which the hospital's FTE caps were increased if the hospital fails to meet these requirements. Specifically, section 1886(h)(8)(B)(ii) of the Act states, "a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

(I) The number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (as determined by the Secretary), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph; and

(II) Not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period."

Section 1886(h)(5)(H) of the Act defines "primary care resident" as a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. We are proposing that a hospital that is applying to receive additional slots would have to submit data from the 3 most recent cost reporting periods ending before March 23, 2010 (the date of enactment) on the number of unweighted FTE residents in these primary care programs. We note that this primary care average is based on the hospital's total FTE count that would otherwise be allowable in absence of the FTE cap; if a hospital is training FTE residents in excess of its FTE caps, it would still determine the 3-year average based on the total number of unweighted primary care FTE residents. A total primary care FTE count, one for IME and one for direct GME, is sufficient for the hospital for each of these 3 cost reporting periods; a hospital need not report these data by specialty.

However, we note that, currently, the Medicare cost report does not track a hospital's number of primary care residents. For direct GME, on Worksheet E–3, Part IV, line 3.19, the hospital's number of weighted primary care and OB/GYN residents is reported. Thus, if a hospital trains OB/GYN residents in addition to primary care residents, we are proposing that the OB/GYN count must be subtracted from the number reported on line 3.19 of Worksheet E–3, Part IV for the hospital's 3 most recent cost reporting periods ending before March 23, 2010. This would produce a weighted FTE count for direct GME. In any case, the source documentation for these data is the rotation schedules for the applicable years. For IME, on Worksheet E, Part A, there is no line that currently records the number of primary care residents, as the distinction between primary care and non-primary care residents is only necessary in the direct GME payment formula (due to the use of a primary care and OB/GYN PRA and a nonprimary care PRA for certain years).

Therefore, we are proposing that the applicant hospital must develop from its rotation schedules three IME FTE primary care counts to correspond to its three most recent cost reporting periods ending before March 23, 2010. As part of its application, we are proposing that the hospital must include the documentation that it used to arrive at its direct GME and IME primary care FTE counts, including a copy of Worksheet E–3, Part IV for direct GME, and if the hospital has an OB/GYN program, the rotation schedules corresponding to the three most recent cost reporting periods ending prior to March 23, 2010 for OB/GYN, and the rotation schedules for all primary care residency programs used to establish the IME primary care FTE count corresponding to the three most recent cost reporting periods ending prior to March 23, 2010. Although we have considered proposing that a hospital may demonstrate that it is complying with the requirement to maintain the primary care average with only a single unweighted FTE count, rather than one FTE count for direct GME and one FTE count for IME, we believe that we need to propose to require documentation from both a direct GME and an IME FTE count because section 5503 of the Affordable Care Act amended section 1886(d)(5)(B)(v) of the Act to make the entire section 1886(h)(8), of which maintenance of this primary care average is a part, applicable for purposes of IME. Thus, both section 1886(h) of the Act for direct GME and section 1886(d)(5)(B) of the Act for IME are equally impacted by section 5503. Furthermore, we are proposing that the FTE counts for IME and direct GME used to derive these primary care averages are subject to audit by the Medicare contractors, and that, as part of reviews or audits performed by the Medicare contractors in accordance with their normal audit plans, the Medicare contractors would check whether a hospital is maintaining its primary care average in each of the cost reports in the 5-year period as early as tentative settlement of those five respective cost reports, and may take prompt action accordingly to adjust a hospital's FTE caps and direct GME and IME interim payments.

In addition to maintaining this average number of primary care residents, section 1886(h)(8)(B)(ii)(II) of the Act also requires that a hospital that receives an increase to its FTE resident caps under section 1886(h)(8)(B)(i) must ensure that 75 percent of those slots are used to train primary care or general surgery residents. A hospital that applies for additional slots may or may not already train at least 75 percent or more of its residents in primary care or general surgery programs. At a minimum, the applicant hospital is required to maintain the average number of FTE primary care residents that it trained during the three most recent cost reporting periods ending prior to March 23, 2010. Further, we are proposing that in addition to the primary care residents used to maintain the primary care average, the applicant hospital must separately ensure that at least 75 percent of the increased FTE cap slots it receives are used to count FTE residents in primary care or general surgery. We are proposing that the hospital must be able to document that, during each of the five years in the five-year period of July 1, 2011 to June 30, 2016, for IME and direct GME respectively, and for *each* cost report during those five years, that not only is it maintaining its primary care average, but that 75 percent of the increased FTE cap slots that it received are being used to count residents training in primary care or general surgery programs. For example, Hospital A has a June 30 fiscal year end, an FTE cap of 100 FTEs, and a total FTE count of 110. In its three most recent cost reports ending prior to March 23, 2010 (fiscal year end June 30, 2009, June 30, 2008, and June 30, 2007), Hospital A was training 60 primary care FTE residents, 50 primary care FTE residents, and 40 primary care FTE residents respectively. The average number of primary care FTE residents during those three years is 50. Hospital A applied for and received 10 additional FTE cap slots under section 5503. Beginning July 1, 2011, for each cost report ending June 30, 2012, June 30, 2013, June 30, 2014, June 30, 2015, and June 30, 2016, Hospital A must ensure that it does not train less than 50 primary care FTE residents, and it must ensure that it trains an *additional* 7.5 FTEs of the 10 slots it receives in either primary care or general surgery. In another example, Hospital B has a December 31 fiscal year end, an FTE cap of 10 FTEs, and a total FTE count of 12. In its 3 most recent cost reports ending prior to March 23, 2010 (fiscal year end December 31, 2009, December 31, 2008 and December 31, 2007), Hospital A was training 12 primary care FTE residents in each of the 3 years. The average number of primary care FTE residents is 12. Hospital B applied for and received 4 additional FTE cap slots under section 5503. Beginning July 1, 2011 and ending June 30, 2016, Hospital B must ensure that it does not train less than 12 primary care FTE residents, and it must ensure that it trains an *additional* 3 FTEs of the 4 slots it receives in either primary care or general surgery. We are proposing that the Medicare contractors would check whether a hospital is maintaining this 75-percent threshold as part of reviews or audits performed by the Medicare contractors in accordance with their normal audit plans in the 5-year period as early as tentative settlement of those five respective cost reports, and may take action accordingly to adjust a hospital's FTE resident caps and direct GME and IME interim payments.

It is possible that there are hospitals that are not currently training, nor have they trained in any of their three cost reporting periods ending prior to March 23, 2010, any primary care residents at all, but that such hospitals are applying for an increase to their FTE caps for a new primary care or general surgery program that they would like to start. Such hospitals would have a primary care average of zero. Because the intent of section 5503 is to try to increase the number of primary care (or general surgery) residents in training, we are proposing that such hospitals would be able to apply for additional slots under section 5503. Should such a hospital receive an FTE cap increase, we are proposing that 75 percent of the increased FTE cap slots must be used to count FTE residents in either primary care or general surgery. We are proposing that a hospital is required to document in *each* of the 5 years that it has maintained the primary care average

and that at least 75 percent of the slots it receives is used for training either primary care and/or general surgery residents rather than only once at the end of the 5-year period. As explained more fully below, if a hospital has not met these requirements, we believe it would be less disruptive financially and administratively to a hospital if we make the adjustment to the hospital's FTE resident caps under section 1886(h)(8)(B)(iii)(I) and recover any overpayment after 1 year rather than after the conclusion of the full 5 year monitoring period under section 1886(h)(8)(B)(ii).

Section 1886(h)(8)(B)(ii) of the Act also states that "The Secretary may determine whether a hospital has met the requirements under this clause *during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period*" (emphasis added). We are proposing that the "5-year period beginning on the date of such increase" is July 1, 2011 through June 30, 2016, because the effective date of section 5503 is for portions of cost reporting periods beginning on or after July 1, 2011. Thus, it is during this 5-year period that an "average number of full-time equivalent primary care residents" must be maintained, and that 75 percent of the additional slots must be trained in primary care or general surgery, for IME and direct GME respectively. However, the Secretary is given some discretion as to how and when she determines whether a hospital is meeting or has met the requirements "during such 5-year period." Although we believe that the 5-year period must be within July 1, 2011 through June 30, 2016, we believe we have flexibility to determine which cost reporting periods within that 5-year period we may use to assess whether the hospital is consistently meeting the required criteria. For the sake of administrative simplicity, on behalf of hospitals and the Medicare contractors, we are proposing that the Medicare contractors, in accordance with their normal audit plans, would make assessments based on a hospital's fiscal year when possible, such that the Medicare contractors could make a first assessment for an initial "short" period, then annually as each of the hospital's fiscal year ends until there is another final "short" assessment period that starts after the provider's last fiscal year end within the 5-year window and runs through June 30, 2016. If a hospital has a June 30 fiscal year end, we are proposing that the Medicare contractor could assess whether the hospital is meeting the required criteria five times, starting with its cost reporting period beginning on July 1, 2011, and ending with its fifth cost reporting period that starts on July 1, 2015 (and ending June 30, 2016). However, for hospitals that have a fiscal year end of other than June 30, we are proposing that the Medicare contractors could assess whether the hospital met the requirements for the portion of its cost reporting period that occurs after July 1, 2011, its subsequent full cost reporting periods, and then ending with the portion of the cost reporting period prior to June 30, 2016. In other words, we are proposing that the hospital would be considered to meet the required criteria in "Year 1" if it meets the requirements based on an annualized FTE count from July 1, 2011 through the end of its cost reporting period; in each of years 2 through 4, it must meet the requirements based on its next 3 cost reporting periods; and in year 5, it must meet the requirements based on an annualized FTE count from the first day of its cost reporting period through June 30, 2016 (which is the last day on which a hospital has any obligation to meet these requirements). For example, assume Hospital C has a September 30 fiscal year end, and receives 16 additional slots under section 5503, and has a primary care average of 30 FTE residents. We are proposing that during the period of July 1, 2011 through June 30, 2016, Hospital C must demonstrate that it is training at least 75 percent of its 16 slots in primary care or general surgery (that is, 12 slots), and that it maintains a primary care FTE count of 30, as follows:

Year 1—July 1, 2011 to September 30, 2011, with an annualized count of 3 (that is, 12 divided by 4) additional FTEs in primary care/general surgery, and an annualized count of 7.5 (that is, 30 divided by 4) FTEs training in primary care residency programs.

Year 2—October 1, 2011 to September 30, 2012, with 12 FTEs in primary care/general surgery, and 30 FTEs in primary care programs.

Year 3—October 1, 2012 to September 30, 2013, with 12 FTEs in primary care/general surgery, and 30 FTEs in primary care programs.

Year 4—October 1, 2012 to September 30, 2014, with 12 FTEs in primary care/general surgery, and 30 FTEs in primary care programs.

Year 5—October 1, 2014 to September 30, 2015, with 12 FTEs in primary care/general surgery, and 30 FTEs in primary care programs.

Year 6—October 1, 2015 to June 30, 2016, with an annualized count of 9 additional FTEs in primary care/general surgery, and an annualized count of 22.5 FTEs training in primary care residency programs.

We are proposing to reserve the right to assess as many times as necessary in the 5-year period that a hospital is meeting the required criteria. Furthermore, if a Medicare contractor determines during an audit that a hospital did not meet the requirements during, for example, the second year, the contractor could go back and audit the first year (full, or short period), and make a retroactive adjustment. We also understand that we should consider that hospitals might not immediately fill all the slots they receive, particularly because they are only required to demonstrate the likelihood of filling the slots within the first three cost reporting periods beginning on or after July 1, 2011. Accordingly, in the preceding example in which Hospital C was awarded 16 slots and has a September 30 fiscal year end, assume it only added 2 actual residents immediately on July 1, 2011. Two residents equate to 0.5 FTE for the 3-month period of July 1, 2011 to September 30, 2011. Seventy five percent of 0.5 FTE equals 0.375. We are proposing that at least 0.375 of the new FTEs added for the period of July 1, 2011 to September 30, 2011 must be in primary care or general surgery in order to meet the requirement in "Year 1."

In a case where the Medicare contractor determines that a hospital did not meet the requirements in a cost reporting year within the 5-year time period, section 1886(h)(8)(B)(iii) of the Act states that "the Secretary shall—

(I) Reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

(II) Provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph." Hospitals have different fiscal year ends and are subject to different audit schedules, which may occur several years after a hospital's cost report is submitted. Therefore, even though we are proposing that the Medicare contractors may make adjustments to a hospital's direct GME and IME payments as early as tentative settlement, it may be several years after June 30, 2016 before CMS determines the exact number of reductions, if any, that are applied to the FTE caps of hospitals that received additional slots, but that failed to meet the requirements under section 1886(h)(8)(B)(ii) of the Act, discussed above. However, once we have determined the number of slots available for a second redistribution, we would distribute them "in accordance with the requirements of this

paragraph." That is, we would distribute the slots to hospitals that applied under this first redistribution and that qualified to receive the slots they requested, but for whom we did not have sufficient slots in the "pool" to grant them the full number of FTE slots that they requested. As discussed above in section XVII.D. of this proposed rule, because of the requirement that 70 percent of the slots be redistributed to hospitals within States with resident-to-population ratios in the lowest quartile, it is possible that, after first distributing slots to hospitals with the highest scores on their CMS Evaluation Form, there may be some remaining qualifying hospitals within the same priority level category that receive the same score on the CMS Evaluation Form. Thus, we would have no way of distinguishing among these hospitals of equal rank. If this situation occurs, we are proposing to prorate the remaining amount of slots in the "70 percent" pool, and distribute an equal share of slots to these hospitals of equal rank. If a similar situation occurs within the "30 percent" pool, we also are proposing to prorate the remaining amount of slots in the "30 percent" pool and distribute an equal share of slots to hospitals of equal rank. Accordingly, in the event that there is a second redistribution process pursuant to section 1886(h)(8)(B)(iii)(II), we are proposing to distribute the slots in the "pool" (created by the failure of one or more hospitals to meet the criteria specified under section 1886(h)(8)(B)(ii)) to those hospitals that did not receive all of the slots for which they technically qualified, and for which we had to prorate under the first redistribution. If we have sufficient slots to fully satisfy the original requests of those qualifying hospitals, we would assign them the difference between the prorated amount awarded under the first redistribution and the amount of slots they requested on their original application (assuming they actually otherwise qualified for all the slots they requested). In other words, we would go back to the original applications and continue to assign slots to those hospitals that originally qualified to receive slots under section 5503, but for which we did not have sufficient slots to satisfy their requests. We are proposing to assign the additional slots in the same priority order as under the first redistribution process under section 5503, resuming where we left off, until all the slots have been distributed. After such point, there would be no further harvesting of slots or redistribution under section 5503.

We are proposing to add new regulations at § 412.105(f)(1)(iv)(C)(2) for IME and at § 413.79(n) for direct GME to reflect our proposals regarding hospitals receiving increases to their FTE resident caps under section 5503, and the requirements that hospitals must meet in order to keep those FTE slots, and not be subject to a removal of those FTE slots during the 5-year period of July 1, 2011 through June 30, 2016.

- No Administrative or Judicial Review

Section 5503(a)(3) of the Affordable Care Act amended section 1886(h)(7)(E) of the Act by adding "or paragraph (8)" such that section 1886(h)(7)(E) of the Act now specifies that "There shall be no administrative or judicial review under section 1869, 1878, or otherwise, with respect to determinations made under this paragraph or paragraph (8)." As stated in the preceding section regarding reference cost reports that are under appeal, we believe the fact that Congress included this language clearly means that the Congress intended for our determination with regard to FTE resident cap reductions under section 1886(h)(8)(A) to be final, and not subject to appeal. Because of this statutory language, together with the requirement that all reductions and increases in FTE resident caps be made effective July 1, 2011, we do not believe it would be appropriate to allow hospitals (or CMS) to appeal determinations concerning the FTE cap reductions or the FTE cap increases) under section 1886(h)(8) of the Act. In addition, as indicated previously, we believe that Congress intended this provision to be implemented fairly, but efficiently, avoiding the delays and uncertainty that would be produced by an appeals process. Furthermore, we note that, as explained previously in this preamble, as was done under section 422 of Public Law 108–173, Medicare contractors will provide hospitals with a time-limited opportunity to review cap reduction determinations for possible technical errors before they are finalized.

BILLING CODE 4120–01–P

ADDENDUM

Trainees in Osteopathic Programs as Reported - By State 2008-2009

State	Interns		Residents		Total	
	Programs	Trainees	Programs	Trainees	Programs	Trainees
Alaska	1	3	0	0	1	3
Arizona	3	15	7	30	10	45
Arkansas	1	0	1	3	2	3
California	6	64	23	112	29	176
Colorado	1	0	0	0	1	0
Connecticut	1	10	1	3	2	13
Delaware	1	12	1	6	2	18
Florida	13	111	38	182	51	293
Georgia	3	5	3	3	6	8
Illinois	15	77	36	184	51	261
Indiana	3	8	3	12	6	20
Iowa	2	8	3	21	5	29
Kansas	1	3	1	3	2	6
Kentucky	6	16	7	15	13	31
Maine	4	14	9	42	13	56
Massachusetts	3	11	2	3	5	14
Michigan	24	338	174	858	198	1196
Minnesota	1	0	1	0	2	0
Mississippi	0	0	1	0	1	0
Missouri	5	24	21	90	26	114
Nevada	1	25	4	23	5	48
New Hampshire	1	4	0	0	1	4
New Jersey	9	83	48	236	57	319
New Mexico	1	1	1	4	2	5
New York	21	191	52	298	73	489
North Carolina	2	7	2	7	4	14
North Dakota	1	0	0	0	1	0
Ohio	17	168	97	397	114	565
Oklahoma	4	54	25	135	29	189
Oregon	1	0	6	0	7	0
Pennsylvania	43	282	97	455	140	737
Rhode Island	0	0	2	0	2	0
South Carolina	1	5	1	3	2	8
Tennessee	2	2	0	0	2	2
Texas	9	39	20	62	29	101
Virginia	5	16	9	30	14	46
Washington	0	0	1	0	1	0
West Virginia	8	43	18	53	26	96
Wisconsin	2	5	2	16	4	21
Wyoming	1	1	1	3	2	4
Total	**223**	**1,645**	**718**	**3,289**	**941**	**4,934**

Source: The American Osteopathic Association

Draft CMS Evaluation Form

As Part of the Application for the Increase in a Hospital's FTE Cap(s) under Section 5503 of the Affordable Care Act

Directions: Please fill out the information below for each residency program for which the applicant hospital intends to use the increase in its FTE cap(s). The applicant hospital is responsible for complying with the other requirements listed in the CY 2011 Hospital Outpatient Prospective Payment System Final Rule with Comment Period in order to complete its application for the increase in its FTE cap(s) under section 5503 of The Affordable Care Act, Pub. L. 111-148.

NAME OF HOSPITAL: _____

MEDICARE PROVIDER NUMBER: _____

NAME OF MEDICARE CONTRACTOR: _____

NAME OF SPECIALTY TRAINING PROGRAM: _____

(Check one): ☐ Allopathic Program ☐ Osteopathic Program

NUMBER OF FTE SLOTS REQUESTED FOR PROGRAM:

Direct GME: _____ **IME:** _____

Section A: Demonstrated Likelihood of Filling the FTE Slots

(Place an "X" in the box for the applicable criterion and subcriteria.)

A1: Demonstrated Likelihood Criterion 1. The hospital does not have sufficient room under its FTE cap for a new residency program that it intends to establish on or after July 1, 2011 (that is, a newly approved program that begins training residents at any point within the hospital's first three cost reporting periods beginning on or after July 1, 2011).

(1) Hospital will establish this newly approved residency program. **(The hospital must check at least one of the following, if applicable.)**

☐ Application for approval of the new residency program has been submitted to the ACGME, AOA or the ABMS by December 1, 2010. **(The hospital must attach a copy.)**

☐ The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program by December 1, 2010. **(The hospital must attach a copy.)**

☐ The hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). **(The hospital must attach a copy.)**

(2) Hospital will likely fill the slots requested. **(The hospital must check at least one of the following, if applicable.)**

☐ The hospital does not have sufficient room under its FTE cap, and the hospital's existing residency programs had a resident fill rate of at least 85 percent in each of program years 2007 through 2009. **(The hospital must attach documentation.)**

☐ The hospital does not have sufficient room under its FTE cap, and the specialty program for which the hospital is applying has a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. **(The hospital must attach documentation.)**

☐ A2: Demonstrated Likelihood Criterion 2. The hospital does not have sufficient room under its FTE cap, and the hospital intends to use the additional FTEs to expand an existing residency training program within the hospital's first three cost reporting periods beginning on or after July 1, 2011.

☐ (1) Hospital intends to expand an existing program. **(The hospital must check at least one of the following, if applicable.)**

☐ The appropriate accrediting body (the ACGME, AOA or ABMS) has approved the hospital's expansion of the number of FTE residents in the program. **(The hospital must attach documentation.)**

☐ The American Osteopathic Association Residency Match Program has accepted or will be accepting the hospital's participation in the match for the existing program that will include additional resident slots in that residency training program. **(The hospital must attach documentation.)**

☐ The hospital has submitted an institutional review document or program information form for the expansion of the existing residency training program by December 1, 2010. **(The hospital must attach documentation).**

☐ (2) Hospital will likely fill the slots of the expanded residency program. **(Check at least one of the following, if applicable.)**

☐ The hospital does not have sufficient room under its FTE cap, and the hospital has other previously established residency programs, with a resident fill rate of at least 85 percent in each of program years 2007 through 2009.) **(The hospital must attach documentation.)**

☐ The hospital does not have sufficient room under its FTE cap, and the hospital is expanding an existing program in a particular specialty with a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. **(The hospital must attach documentation.)**

☐ A3: Demonstrated Likelihood Criterion 3. Hospital is applying for an increase in its FTE resident cap because the hospital is already training residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both. **(Copies of EACH of the following must be attached.)**

- Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor by July 1, 2010 documenting on Worksheet E, Part A, Worksheet E-3, Part VI, and Worksheet E-3, Part VI the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

- Copies of the 2010 residency match information concerning the number of residents at the hospital in its existing programs.

- Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for direct GME and IME.

Section B. Level Priority Category

(Place an "X" in the appropriate box that is applicable to the level priority category that describes the applicant hospital.)

☐ First Level Priority Category: The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND the hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND the hospital is located in a rural area.

☐ Second Level Priority Category: The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND is either in a State whose Primary Care HPSA to population ratio is in the top 10 States, or it is located in a rural area, or is an urban hospital and has or will have as of July 1, 2010, a rural training track.

☐ Third Level Priority Category: The hospital is in a State whose resident-to-population ratio is within the lowest quartile.

Fourth Level Priority Category: The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND either the hospital is located in a rural area or the hospital is an urban hospital and has, or will have as of July 1, 2010, a rural training track.

☐ Fifth Level Priority Category: The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, or the hospital is located in a rural area.

Section C. Evaluation Criteria

(Place an "X" in the box for each criterion that is appropriate for the applicant hospital and for the program for which the increase in the FTE cap is requested.)

☐ Evaluation Criterion One. *The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report.* 5 POINTS.

☐ Evaluation Criterion Two. *The hospital will use the additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program.* 5 POINTS.

☐ Evaluation Criterion Three. *The hospital will use additional slots to establish a new or expand an existing primary care program with a demonstrated focus on training residents to pursue careers in primary care, rather than in non-primary subspecialties of those primary care programs (for example, the hospital has an internal medicine program with a designated primary care track).* 3 POINTS.

☐ Evaluation Criterion Four. *The hospital will use all the additional slots to establish a new or expand an existing primary care residency program or general surgery program.* – 5 POINTS.

☐ Evaluation Criterion Five. *The hospital is located in a Primary Care HPSA.* 2 POINTS.

☐ Evaluation Criterion Six. *The hospital is in a rural area (as defined under section 1886(d)(2)(D)(ii) of the Act) and is or will be on or after July 1, 2011, a training site for a rural track residency program (as specified under §413.79(k)), but is unable to count all of the FTE residents training in the rural track because the rural hospital's FTE cap is lower than its unweighted count of allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011.* 1 POINT.

BILLING CODE 4120–01–C

Application Process and CMS Central Office and Regional Office Mailing Addresses for Receiving Increases in FTE Resident Caps

In order for hospitals to be considered for increases in their FTE resident caps, each qualifying hospital must submit a timely application. The following information must be submitted on applications to receive an increase in FTE resident caps:

- The name and Medicare provider number of the hospital.
- The name of the Medicare contractor to which the hospital submits its Medicare cost report.
- The total number of requested FTE resident slots for direct GME or IME, or both, up to 75 direct GME FTE and 75 IME FTE per hospital.
- A completed copy of the CMS Evaluation Form for each residency program for which the hospital intends to use the requested increase in FTE residents.
- Source documentation to support the assertions made by the hospital on the CMS Evaluation Form.
- FTE resident counts for direct GME and IME and FTE resident caps for direct GME and IME reported by the hospital in the most recent as-filed cost report. (Include copies of Worksheets E, Part A, E–3, Part IV, *and if a hospital received an increase to its FTE cap(s) under section 422 of the MMA,* a copy of E–3, Part VI).
- As part of its application, we are proposing that the hospital must include the documentation that it used to arrive at its direct GME and IME primary care FTE counts, including a copy of Worksheet E–3, Part IV for direct GME, and if the hospital has an OB/GYN program, the rotation schedules corresponding to the 3 most recent cost reporting periods ending prior to March 23, 2010 for OB/GYN, and the rotation schedules for all primary care residency programs used to establish the IME primary care FTE count corresponding to the 3 most recent cost reporting periods ending prior to March 23, 2010.
- An attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, of the following information:

"I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under federal law. Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil, and administrative action, fines and/or imprisonment may result. I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the books and records of the hospital in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents."

The completed application and supporting documentation (as described above) must be submitted to the CMS Central Office and the CMS Regional Office for the region in which the applicant hospital is located. The application must be received on or before December 1, 2010. The addresses of the CMS central office and regional offices are listed below.

CMS Central and CMS Regional Office Mailing Addresses for Applications for Increases in FTE Resident Caps

Central Office

Centers for Medicare and Medicaid Services (CMS)
Director, Division of Acute Care
7500 Security Boulevard
Mail Stop C4–08–06
Baltimore, Maryland 21244
(410) 786–4548

Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region I
JFK Federal Building
Room 23275
Boston, MA 02203
Phone: (617) 565–1331

Region II (New York, New Jersey, U.S. Virgin Islands, and Puerto Rico)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region II
26 Federal Plaza, 38th Floor
New York, NY 10278
Phone: (212) 616–2545

Region III (Delaware, Maryland, Pennsylvania, Virginia and West Virginia, and the District of Columbia)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region III
Public Ledger Building, Suite 216
150 South Independence Mall West
Philadelphia, PA 19106
Phone: (215) 861–4140

Region IV (Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennessee)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region IV
Atlanta Federal Center
61 Forsyth Street, SW., Suite 4T20
Atlanta, GA 30303–8909
Phone: (404) 562–7300

Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region V
233 North Michigan Avenue, Suite 600
Chicago, IL 60601
Phone: (312) 886–6432

Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region VI
1301 Young Street, Suite 714
Dallas, TX 75202
Phone: (214) 767–6423

Region VII (Iowa, Kansas, Missouri, and Nebraska)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region VII
Richard Bolling Federal Building
Room 235
601 East 12th Street
Kansas City, MO 64106
(816) 564–1843

Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region VIII
Colorado State Bank Building
1600 Broadway, Suite 700
Denver, CO 80202

Phone: (303) 844–2111

Region IX (Arizona, California, Hawaii, and Nevada and Territories of American Samoa, Guam and the Commonwealth of the Northern Mariana Islands)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region IX
90 7th Street, Suite 5–300 (SW)
San Francisco, CA 94103–6708
Phone: (415) 744–3501

Region X (Alaska, Idaho, Oregon, and Washington)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Medicare Financial Management
Region X
2201 Sixth Avenue, MS/RX–46
Seattle, WA 98121
Phone: (206) 615–2094

E. Preservation of Resident Cap Positions From Closed Hospitals (Section 5506 of the Affordable Care Act) (§ 412.105(f)(1)(ix)(B) and § 413.79(o)(2))

1. Background

As we explain in Section XVII.A. of this proposed rule, Medicare makes both direct GME and IME payments to hospitals that train residents in approved medical residency training programs. Direct GME payments are made in accordance with section 1886(h) of the Act, based generally on hospital-specific PRAs, the number of FTE residents a hospital trains, and the hospital's Medicare patient share. IME payments are made in accordance with section 1886(d)(5)(B) of the Act, based generally on the ratio of the hospital's FTE residents to the number of hospital beds. Accordingly, the calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count; generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. In an attempt to end the implicit incentive for hospitals to increase the number of FTE residents, Congress instituted a cap on the number of allopathic and osteopathic residents a hospital is allowed to count for direct GME and IME purposes under the provisions of section 1886(h)(4)(F) of the Act for direct GME and section 1886(d)(5)(B)(v) of the Act for IME. Dental and podiatric residents were not included in this statutorily mandated cap. For most hospitals, the limit, or cap, is the unweighted number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996. Thus, each teaching hospital FTE resident cap is unique to the number of FTE residents that it trained in the hospital's most recent cost reporting period ending on or before December 31, 1996.

Under existing regulations at § 413.79(h) for direct GME and § 412.105(f)(1)(ix) for IME, a hospital that is training FTE residents at or in excess of its FTE resident caps and takes in residents displaced by the closure of another teaching hospital may receive a temporary increase to its FTE residents caps so that it may receive direct GME and IME payment associated with those displaced FTE residents. However, those temporary FTE resident cap increases are associated with those specific displaced FTE residents, and the increases expire as those displaced residents complete their training program. Thus, if a teaching hospital closes, its direct GME and IME FTE resident cap slots would be "lost," because those cap slots are associated with a specific hospital's Medicare provider agreement, which would be retired upon the hospital's closure. The closure of a teaching hospital, particularly if it is a large academic medical center, could mean not only the displacement of hundreds of residents, but also the permanent loss of hundreds of Medicare-funded residency training slots and a sophisticated GME infrastructure that could take many years to rebuild, threatening the availability of health care services in a community. Section 5506 of the Affordable Care Act addresses this situation by amending section 1886(h)(4)(H) of the Act to add a new clause (vi) that instructs the Secretary to establish a process by regulation under which, in the event a teaching hospital closes, the Secretary will permanently increase the FTE resident caps for hospitals that meet certain criteria by the number of FTE resident positions in the closed hospital's training programs.

Section 5506 of the Affordable Care Act specifically instructs the Secretary to increase the FTE resident caps for other hospitals based upon the FTE resident positions in teaching hospitals that closed "on or after a date that is 2 years before the date of enactment" (that is, March 23, 2008). Although certain of the FTE cap increases granted pursuant to section 5506 will be based on hospital closures that occurred prior to this notice and comment rulemaking procedure, the process we are proposing to establish in the CY 2011 OPPS Final Rule would also be used for all future teaching hospital closures. We are in the process of instructing the Medicare contractors to notify us of every teaching hospital that has closed since March 23, 2008, and of the direct GME and IME FTE caps for each of those closed hospitals. We plan to use this information to determine how many slots are currently available for increases to other hospitals' FTE resident caps.

We note that section 1886(h)(4)(H)(vi)(IV) of the Act, as added by section 5506(a) of the Affordable Care Act, states that "The aggregate number of increases in the otherwise applicable resident limits for the hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after" March 23, 2008. For purposes of implementing this section 1886(h)(4)(H)(vi)(IV), we are proposing to interpret "the number of resident positions" to mean the number that is equal to the IME and direct GME FTE resident caps of a hospital that closed, or will close. We do not believe the intent of this provision is to distribute and pay for more FTE resident slots than the amount equal to a closed hospital's IME and direct GME FTE resident caps, in the instance where a closed hospital was training more FTE residents than its FTE resident caps. Further, in the situation where a closed hospital was training FTE residents below its caps, we believe that for the sake of ensuring that a community could retain up to its full training strength, we believe it is appropriate to distribute, not the actual number of slots the closed hospital had been training prior to its closure, but the number of FTE resident slots equal to the IME and direct GME FTE caps of the closed hospital.

2. Definition of a "Closed Hospital"

Section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act, states that "the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program closes on or after" March 23, 2008, the Secretary shall increase the FTE resident caps of other hospitals accordingly (emphasis added). Under existing regulations at § 489.52 and § 413.79(h), "closure of a hospital" means the hospital terminates its Medicare provider agreement. We are

proposing to define a "closed teaching hospital" for purposes of section 5506 in a similar manner, but would also specify that the FTE resident cap slots of the hospital that closed no longer exist as part of any other hospital's permanent FTE resident cap. Thus, we are proposing that this provision would not apply to hospitals that declare bankruptcy but are still participating under the same Medicare provider agreement, nor would it apply to teaching hospitals that remain open, but close one or more residency programs. It also would not apply to mergers, because in the case of a merger, the Medicare provider agreement of one hospital is subsumed into the provider agreement of the surviving provider; no provider agreement is retired, even if operations at one facility are scaled back or ceased.

However, we are proposing that the proposed revised definition of hospital closure for purposes of implementing section 5506 *would* apply in the case of acquisitions, where the new owner *retires* the Medicare provider agreement of the hospital it purchased, thus abdicating the FTE resident cap slots associated with that provider agreement, even if the new owner will continue to operate the hospital exactly as it had been operated before the acquisition (that is, makes no changes to the bed size, infrastructure, services, and GME programs). We believe this is appropriate because section 5506 of the Affordable Care Act specifically addresses hospital "closure" and ensures preservation of the FTE cap slots within a community when a teaching hospital does "close," based on specified criteria for redistributing the slots from the closed hospital to increase the FTE caps for other hospitals. However, as we explain further below, it is possible for the new hospital formed in an acquisition to receive preference in receiving an increase to its FTE resident caps based on redistributed slots from the closed hospital that it acquired.

Section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a), also states that "the Secretary shall, by regulation, establish a process under which, in the case where a hospital (*other than a hospital described in clause (v)*) with an approved medical residency program closes * * *" (emphasis added). A hospital described in section 1886(h)(4)(H)(v) of the Act is an entity that enters into a provider agreement pursuant to section 1866(a) of the Act to provide hospital services on the same physical site previously used by Medicare Provider No. 05–0578. Accordingly, we are proposing not to redistribute any FTE cap slots associated with Medicare Provider Number 05–0578.

3. Priority for Hospitals in Certain Areas

Section 1886(h)(4)(H)(vi)(II), as added by section 5506(a) of the Affordable Care Act, specifies that the Secretary shall distribute the FTE cap increases in the following priority order, "with preference given within each category to hospitals that are members of the same affiliated group" (as defined by the Secretary) as the closed hospital:

- First, to hospitals located in the same core-based statistical area (CBSA) as, or in a CBSA contiguous to, the hospital that closed.
- Second, to hospitals located in the same State as the closed hospital.
- Third, to hospitals located in the same region as the hospital that closed.
- Fourth, if the slots have not yet been fully distributed, to qualifying hospitals in accordance with the criteria established under section 5503 ("Distribution of Additional Residency Positions") of the Affordable Care Act.

First, we are proposing to use the same pre-reclassification CBSAs that are used for wage index purposes under the IPPS in determining which hospitals are located in the same or contiguous CBSAs as the CBSA in which the hospital that closed was located, without regard to any reclassifications made under the provisions of §§ 412.102, 412.103, 412.230, 412.232, 412.234, and 412.235 of the regulations. Second, we are proposing to define "State" in the second priority category to include Puerto Rico and the District of Columbia. Third, we are proposing to define "region" in the third priority category as Census Region, consistent with the use of the term elsewhere in the GME regulations. (The term is used for purposes of establishing direct GME PRAs of certain new teaching hospitals at § 413.77(e)(1)(iii).) Fourth, as specified in the fourth priority category, we are proposing to employ the criteria for redistribution of residency positions described in section 5503 of the Affordable Care Act, as implemented in the proposed revised regulations at § 413.79(n), should there be any slots not redistributed under the first through third priority categories.

With regard to members of the same Medicare GME affiliated group, we are proposing to give priority within each category to hospitals that are members of the same Medicare GME affiliated group as the hospital that closed. A Medicare GME affiliated group, as defined at § 413.75(b), consists of hospitals that enter into a Medicare GME affiliation agreement, also as defined at § 413.75(b), for the purpose of cross-training residents and that, under the terms of the agreement, aggregate and make temporary adjustments to their respective individual FTE resident caps. To provide flexibility to hospitals that have affiliated with the hospital that closed, we are proposing to refer to the most recent Medicare GME affiliation agreement of which the closed hospital was a member. Hospitals that were listed as participants of the Medicare GME affiliated group on that most recent affiliation agreement before the closure of the hospital will receive preference in receiving FTE cap increases based on the redistributed slots.

4. Application Process

We are proposing to establish an application process for hospitals to apply to CMS to receive an increase in FTE caps based on slots from closed hospitals. Section 5506 of the Affordable Care Act did not specify an effective date or an application deadline for hospitals to request an increase to their caps when a hospital closes. Accordingly, with respect to the first application process to be implemented for section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act, and which includes all teaching hospital closures back to March 23, 2008, we are proposing that the application deadline would be January 1, 2011. For future teaching hospital closures, we are proposing that we would inform the public through an appropriate medium that increases to hospitals' FTE resident caps are available for redistribution due to the closure of a teaching hospital, and the application deadline would be 4 months following the issuance of that notice to the public.

5. Ranking Criteria

Unlike the application process for FTE cap increases under section 1886(h)(8) of the Act as added by section 5503 of the Affordable Care Act, we are not proposing to establish a "point" system to distinguish between hospitals within each of the first three priority categories. Rather, within each of the three first statutory priority categories in section XVII.E.3. of this proposed rule (that is, same or contiguous CBSAs, same State, and same Region), we are proposing to rank categories in which we would assign slots *first* to hospitals that fall within the first ranking category *before* assigning slots to those hospitals that fall within the second ranking category, and would assign slots to those hospitals that fall within the second ranking category *before* assigning slots to hospitals in the

third ranking category, and so forth. We are not proposing to use these ranking categories within the fourth priority category because, under that fourth priority category, the Secretary would use the process established under section 5503 for section 1886(h)(8) of the Act. In order to maintain stability in existing GME programs, these proposed ranking categories generally give preference to applying hospitals that demonstrate a commitment to continue training residents in the same programs that the closed hospital operated, or that had a training relationship with the closed hospital (such as a Medicare GME affiliation agreement).

• *Ranking Criterion One.* The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, same program director, and same (or many of the same) teaching staff). We are proposing this ranking criterion because we understand that there are situations where, when a hospital is acquired and its provider agreement is retired and a new provider agreement is established in the place of the old one, the new formed "acquiring" hospital continues to operate the GME programs seamlessly and in the same manner as under the previous provider agreement. If this situation occurs, we believe the new hospital with the new provider agreement is demonstrating a strong commitment to not only maintain the GME programs in the community for the long term (that is, continuity), but to also allow the residents that were at the hospital when the change in provider agreement occurred to continue to train there, such that no residents are displaced and no training is interrupted.

Alternatively, it is possible that perhaps a year or more prior to a hospital's closure, the hospital closed some or all of its residency programs, and another hospital assumed an entire program (or programs) at the time of the residency program's closure, and the applying hospital has continued to operate that program seamlessly, as it had been operated at the hospital that ultimately closed. Since the applying hospital has also demonstrated a strong commitment to continuity of the residency program(s) in the community by assuming the program(s) even prior to the other hospital's closure, we are proposing that the applying hospital would be categorized in Ranking Criterion One.

• *Ranking Criterion Two.* The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital *received* slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. We are proposing this ranking criterion because section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act, directs the Secretary to give preference to hospitals that are members of the same affiliated group as the hospital that closed. We believe that, generally, if the applying hospital was affiliated to *receive* slots from the hospital that closed, then the applying hospital was relying on that number of FTE resident slots that it received in order to maintain its fair share of the cross-training of the residents in the jointly operated programs. In the absence of those slots received from the closed hospital, the applying hospital may not be able to continue training that number of FTE residents, and those same residents would not only be displaced from the closed hospital, but might essentially become "displaced" from the affiliated hospitals in which they were used to doing a portion of their training. Accordingly, we are proposing this ranking criterion to allow hospitals that were affiliated with the closed hospitals to at least maintain their fair share of the training of the residents in the programs that they had jointly operated with the closed hospital. We note that we are proposing this ranking criterion regarding affiliated hospitals as second, after the first ranking criterion regarding applying hospitals that assume an entire program or programs from the closed hospital because, even though section 5506 of the Affordable Care Act directs the Secretary to give preference to members of the same affiliated group, we believe that a hospital that assumes the responsibility for an entire program or programs demonstrates a commitment to maintain the programs to an even greater degree than does a hospital that was affiliated with the hospital that closed and may only be maintaining a portion of the residency program or programs.

• *Ranking Criterion Three.* The applying hospital took in residents displaced by the closure of the hospital, but is not assuming an entire program or programs, and will use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training (that is, the applying hospital is permanently expanding its own existing programs). Similar to Ranking Criterion Two, hospitals fitting into Ranking Criterion Three also demonstrate a commitment to protect residents displaced by a hospital's closure, and to ensure that there is a degree of continuity in the community with respect to the particular training program or programs that the closed hospital operated. However, because an applying hospital fitting into this category was not part of the same Medicare GME affiliated group as the closed hospital, we are proposing that this category would be ranked as third, below Ranking Criterion Two which relates to hospitals that were members of the same affiliated group as the closed hospital.

The next five proposed ranking criteria would apply in the instance where there are still slots available from the closed hospital after distributing slots to hospitals falling within the first three ranking criteria. Thus, hospitals fitting into Ranking Criteria Four through Eight would not fit into Ranking Criteria One, Two, or Three, but they can demonstrate that they will use the slots in a manner that is consistent with current Medicare policy goals, as indicated in section 5503 of the Affordable Care Act, such as using the slots for a geriatrics or for other primary care residency programs, or for a general surgery residency program.

• *Ranking Criterion Four.* The applying hospital does not fit into Ranking Criteria One, Two, or Three, and will use additional slots to establish a new or expand an existing geriatrics residency program.

• *Ranking Criterion Five.* The applying hospital does not fit into Ranking Criteria One, Two, or Three, is located in a Primary Care HPSA, and will use all the additional slots to establish a new or expand an existing primary care residency program.

• *Ranking Criterion Six.* The applying hospital does not fit into Ranking Criteria One, Two, or Three, and will use all the additional slots to establish a new or expand an existing primary care residency program.

• *Ranking Criterion Seven.* The applying hospital does not fit into Ranking Criteria One, Two, or Three, and will use all the additional slots to establish a new or expand an existing general surgery residency program.

• *Ranking Criterion Eight.* The applying hospital does not fit into Ranking Criteria One through Seven.

6. Demonstrated Likelihood of Filling the Positions Within a Certain Time Period

Section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act, does not place a limit on the number of slots an applying hospital may request, although under section 1886(h)(4)(H)(iv)(IV) of the Act, the Secretary must ensure that the aggregate number of increases to hospitals' FTE residents caps are equal to the FTE residents caps of the hospital that closed. However, section 1886(h)(4)(H)(iv)(III) of the Act specifies that the Secretary may only award slots to an applying hospital "if the Secretary determines that the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years." We are proposing that hospitals *must provide documentation* to demonstrate the likelihood of filling requested slots under section 5506 within 3 years. For example, the applying hospital would document that it does not have sufficient room under its FTE resident caps to take in the additional residents, and has approval from the relevant accrediting body to take over the closed hospital's residency program(s), or expand its own residency program(s) to reflect a permanent commitment to train additional residents. We are proposing that "within 3 years" would mean within the 3 academic years immediately following the application deadline to receive slots after a particular hospital closes. For example, where the application deadline is January 1, 2011, the immediately following academic year is July 1, 2011, and therefore, hospitals must demonstrate the likelihood of filling their slots by June 30, 2014.

7. No Duplication of FTE Cap Slots

Section 5506(d) of the Affordable Care Act specifies that "the Secretary shall give consideration to the effect of the amendments made by this section on any temporary adjustment to a hospital's FTE cap under § 413.79(h) * * * (as in effect on the date of enactment of this Act) in order to ensure that there is no duplication of FTE slots * * *" Under existing regulations at § 413.79(h), hospitals that take in residents that are displaced by the closure of another hospital may receive temporary increases to their FTE resident caps so that they may receive payment for training the specific displaced residents. The temporary cap adjustment lasts only for the duration of a specific displaced resident's training. In distributing slots permanently under section 5506, we may need to be cognizant of the number of FTE residents for whom a temporary FTE cap adjustment was provided, and when those residents will complete their training, at which point the temporary slot associated with those displaced residents would be available for permanent redistribution.

We believe that it will only be necessary to delay permanent assignment of FTE cap slots in instances where if, after fulfilling the requests of hospitals that qualify to receive additional slots under Ranking Criteria One, Two, and Three, there are still excess slots available. In the case where an applying hospital fits within Ranking Criterion One, we are proposing to revise the existing regulations at § 413.79(h) limiting temporary cap adjustments for displaced *residents by the number of FTE residents in the program(s) in which the applying hospital is operating seamlessly.* We are proposing to immediately assign permanently that number of FTE slots to the qualifying hospital. For example, if teaching hospital B assumes an entire internal medicine program with 20 FTEs from closed hospital A, no temporary FTE cap adjustment under § 413.79(h) would be needed for those internal medicine residents, and teaching hospital B would immediately receive a permanent FTE resident cap increase of 10 FTE residents. Similarly, in the case where an applying hospital fits within Ranking Criterion Two, we are proposing to revise the existing regulations at § 413.79(h) limiting temporary cap adjustments for displaced residents *by the number of FTE residents that the applying hospital received under the terms of the affiliation agreement from the closed hospital.* We are proposing to immediately assign permanently that number of FTE slots to the qualifying hospital. For example, if teaching hospital D had received 30 FTE slots from closed hospital C under the terms of a Medicare GME affiliation agreement for the purposes of a shared rotational arrangement (as defined at § 413.75(b)) for a general surgery program, teaching hospital D would immediately receive a permanent FTE resident cap increase of 30 FTE residents, which would enable hospital D to continue to receive direct GME and IME payment for its share of training 30 general surgery residents.

Lastly, in the case where an applying hospital fits within Ranking Criterion Three, we are proposing to revise § 413.79(h) to provide for temporary cap adjustments for displaced residents *by the number of displaced FTE residents the applying hospital takes in,* and to immediately assign permanently that number of FTE slots to the qualifying hospital. For example, if Hospital E takes in three FTE displaced residents in a family medicine program, and not only trains those three displaced residents until they complete their training, but permanently expands its existing family medicine program such that it will add three more FTEs in the place of three that completed their training, we would immediately assign three FTEs permanently to Hospital E, bypassing any temporary adjustment under § 413.79(h). Accordingly, there would be no duplication of FTE slots when distributing slots to hospitals that qualify under the first three ranking criteria.

If, after distributing the slots from a closed hospital to increase the FTE caps for applying hospitals that fall within Ranking Criteria One, Two, and Three, there are still excess slots available, it is possible that those excess slots might be associated with displaced residents for whom temporary cap adjustments under § 413.79(h) *are* necessary. That is, it is possible that in the case where applying hospitals do not permanently assume *all* of the closed hospital's residents and programs, temporary cap transfers under § 413.79(h) would be necessary to allow the remaining residents to complete their training. Therefore, we are proposing to distribute the slots accordingly to increase the FTE resident caps for hospitals that fall within Ranking Criteria Four through Seven. However, to avoid duplicate FTE counting, we would only permanently assign the slots to the qualified hospitals falling within Ranking Criteria Four through Seven once the displaced residents have completed their training and their temporary cap adjustments have expired.

We are proposing to add new regulations text at § 412.105(f)(1)(ix)(B) for IME and § 413.79(o)(2)) for direct GME to reflect the provisions of section 5506 of the Affordable Care Act. In addition, we have proposed some very minor changes to direct GME and IME existing text in order to clarify meaning and standardize the terminology that is used throughout.

8. Other Payment Issues Regarding Hospitals That Receive Increase in FTE Caps Based on Slots From Closed Hospitals

We note that section 1886(h)(4)(H)(vi) of the Act, as added by the Affordable Care Act, makes no reference to section 1886(h)(4)(G) or 1886(d)(5)(B)(vi)(II) of

the Act, which are the provisions concerning the rolling average count of FTE residents. Furthermore, there is no mention of section 1886(d)(5)(B)(vi)(I) of the Act, the provision regarding the cap on the IME resident-to-bed ratio, in section 1886(h)(4)(H)(vi) either. That is, the statute does not provide for an exclusion from application of the rolling average for residents counted as a result of FTE cap increases under section 1886(h)(4)(H)(vi) of the Act, nor does the statute exempt these residents from the application of the cap on the IME resident-to-bed ratio. In light of the absence of a specific directive in section 1886(h)(4)(H)(vi) of the Act exempting those residents from application of the rolling average for direct GME and IME, and the cap on the IME resident-to-bed ratio, and with no apparent reason to treat residents counted as a result of the FTE cap increases under section (h)(4)(H)(vi) of the Act differently, we are proposing to require that if a hospital increases its direct GME or IME FTE count of residents as a result of an FTE resident cap increase under section 1886(h)(4)(H)(vi) of the Act, those FTE residents would be immediately subject to the rolling average calculation and the cap on the IME resident-to-bed ratio.

We also note that section 1886(h)(4)(H)(vi) of the Act for direct GME and section 1886(d)(5)(B)(v) of the Act for IME does not specify use of a special direct GME PRA or IME multiplier for residents counted by a hospital under an FTE cap increase received after the closure of another hospital. Therefore, we are proposing that residents counted by a hospital under a permanent adjustment to the hospital's FTE resident caps under the provisions of section 5506 of the Affordable Care Act would be paid for using the receiving hospital's otherwise applicable direct GME PRA (which is hospital-specific) and IME multiplier (which is the same for all hospitals). Further, as we have proposed with respect to FTE resident cap increases awarded under section 5503 (section XVII.D. of this proposed rule), we are proposing that these slots may not be used as part of the aggregate FTE resident cap under a Medicare GME affiliation agreement. We believe this prohibition is appropriate given that the receiving hospital has demonstrated that it needs the additional slots, and therefore, those slots should remain at the receiving hospital.

9. Application—No Reopening of Settled Cost Reports

Section 5506(c) of the Affordable Care Act specifies that the changes made by the provisions of sections 5506(a) and (b) should not be applied in a manner that would require the reopening of settled cost reports for which there is not a pending, jurisdictionally proper appeal on direct GME or IME payments as of March 23, 2010 (the date of the enactment of Pub. L. 111–148). Such language would typically be appropriate for a provision with a retroactive effective date (such as section 5505), and since section 5506 does not have a retroactive effective date, we are unsure of the purpose of this language in section 5506. Nevertheless, we are proposing to reflect this provision in the proposed revisions under § 412.105(f)(1)(ix)(B), and § 413.79(o)(2)(ii) of the regulations. In addition, as we explained previously regarding sections 5504 and 5505, we are proposing to interpret "pending, jurisdictionally proper appeal on direct GME or IME payments" to mean that in order for a hospital to request a change to its FTE count, direct GME or IME respectively, the "pending, jurisdictionally proper appeal" must be specific to direct GME or IME respectively. For example, in order for a hospital to increase its FTE count with regard to an Affordable Care Act provision that is unique to IME (such as inclusion in the IME count of didactic time occurring in the hospital as specified by new section 1886(d)(5)(B)(x)(II)), the hospital's "pending, jurisdictionally proper appeal" must be on an IME issue; IME FTEs or the available bed count. However, if the hospital's "pending, jurisdictionally proper appeal" is on an issue that only affects direct GME payments, such as the initial residency period or the Medicare patient load, that appeal would not be sufficient in order for the hospital to increase its FTE count with regard to an Affordable Care Act provision that is unique to IME, such as didactic time in the hospital setting.

BILLING CODE 4120–01–P

CMS Evaluation Form
As Part of the Application for the Increase in a Hospital's FTE Cap(s) Under Section 5506 of the Affordable Care Act: Preservation of FTE Cap Slots from Teaching Hospitals that Close

Directions: Please fill out the information below for each residency program for which the applicant hospital intends to use the increase in its FTE cap(s). The applicant hospital is responsible for complying with the other requirements listed in the CY 2011 Hospital Outpatient Prospective Payment System rule in order to complete its application for the increase in its FTE cap(s) under section 5506 of Public Law 111-148.

NAME OF HOSPITAL: _____

MEDICARE PROVIDER NUMBER: _____

NAME OF MEDICARE CONTRACTOR: _____

NAME OF SPECIALTY TRAINING PROGRAM: _____

(Check one): □ Allopathic Program □ Osteopathic Program

NUMBER OF FTE SLOTS REQUESTED FOR PROGRAM:

Direct GME: _____ **IME:** _____

Section A: Demonstrated Likelihood of Filling the FTE Slots

Demonstrated Likelihood: Hospital must provide documentation to demonstrate the likelihood of filling requested slots under section 5506 within 3 years. For example, the applying hospital would document that it does not have sufficient room under its FTE resident caps to take in the additional residents, and has approval from the relevant accrediting body to take over the closed hospital's residency program(s), or expand its own residency program(s) to reflect a permanent commitment to train additional residents.

(1) Hospital will establish this newly approved residency program or will expand an existing residency program. **(The hospital must check at least one of the following, if applicable.)**

☐ Application for approval of the new residency program has been submitted to the ACGME, AOA or the ABMS. **(The hospital must attach a copy.)**

☐ The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program. **(The hospital must attach a copy.)**

☐ The hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the new or expanded program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). **(The hospital must attach a copy.)**

(2) Hospital does not have sufficient room under its direct GME FTE cap or IME FTE cap, or both, and has or is seeking approval from the relevant accrediting body to take over the closed hospital's residency program(s), or expand its own residency program(s) to reflect a permanent commitment to train additional residents. **(The hospital must check at least one of the following, if applicable.)**

☐ Application for approval of the residency program has been submitted to the ACGME, AOA or the ABMS. **(The hospital must attach a copy.)**

☐ The hospital has submitted an institutional review document or program information form concerning the program in an application for approval of the program. **(The hospital must attach a copy.)**

☐ The hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the program, or other types of communication from the accrediting bodies concerning the program approval process (such as notification of site visit). **(The hospital must attach a copy.)**

(3) Hospital will likely fill the slots requested. **(The hospital must check the following, if applicable.)**

☐ The hospital does not have sufficient room under its direct GME FTE cap or IME FTE cap, or both. **(Copies of EACH of the following must be attached.)**

- Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor documenting on Worksheet E, Part A, Worksheet E-3, Part VI, and Worksheet E-3, Part VI the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

- Copies of the most recent residency match information concerning the number of residents at the hospital in its existing programs.

- Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for direct GME and IME.

(4) Applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. **(Copies of EACH of the following must be attached.)**

- Copies of the most recent Medicare GME affiliation agreement of which the applying hospital and the closed hospital were a member of before the hospital closed.

- Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor documenting on Worksheet E, Part A, Worksheet E-3, Part VI, and Worksheet E-3, Part VI the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

- Copies of the most recent accreditation letters for all of the hospital's training programs in which the hospital had a shared rotational arrangement (as defined at §413.75(b)) with the closed hospital.

Section B. Level Priority Category

(Place an "X" in the appropriate box that is applicable to the level priority category that describes the applicant hospital.)

a) □ First, to hospitals located in the same core-based statistical area (CBSA) as, or in a CBSA contiguous to, the hospital that closed.

b) □ Second, to hospitals located in the same State as the closed hospital.

c) ☐ Third, to hospitals located in the same region as the hospital that closed.

d) ☐ Fourth, if the slots have not yet been fully distributed, to qualifying hospitals in accordance with the criteria established under section 5503, "Distribution of Additional Residency Positions"

Section C. Evaluation Criteria

(Place an "X" in the box for each criterion that is appropriate for the applicant hospital and for the program for which the increase in the FTE cap is requested.)

☐ Ranking Criterion One. *The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, same program director, same (or many of the same) teaching staff)*

☐ Ranking Criterion Two. *The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement.*

☐ Ranking Criterion Three. *The applying hospital took in residents displaced by the closure of the hospital, but is not assuming an entire program or programs, and will*

use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training (that is, the applying hospital is permanently expanding its own existing programs).

☐ Ranking Criterion Four.- *The applying hospital does not fit into Ranking Criteria 1, 2, or 3, and will use additional slots to establish a new or expand an existing geriatrics residency program.*

☐ Ranking Criterion Five.- *The applying hospital does not fit into Ranking Criteria 1, 2, or 3, is located in a Primary Care HPSA, and will use all the additional slots to establish a new or expand an existing primary care residency program.*

☐ Ranking Criterion Six.- *The applying hospital does not fit into Ranking Criteria 1, 2, or 3, and will use all the additional slots to establish a new or expand an existing primary care residency program.*

☐ Ranking Criterion Seven.- *The applying hospital does not fit into Ranking Criteria 1, 2, or 3, and will use all the additional slots to establish a new or expand an existing general surgery residency program.*

☐ Ranking Criterion Eight.- *The applying hospital does not fit into Ranking Criteria 1 through 7.*

Application Process and CMS Central Office and Regional Office Mailing Addresses for Receiving Increases in FTE Resident Caps

BILLING CODE 4120–01–C

In order for hospitals to be considered for increases in their FTE resident caps, each qualifying hospital must submit a timely application. The following information must be submitted on applications to receive an increase in FTE resident caps:

- The name and Medicare provider number, and Medicare contractor (to which the hospital submits its cost report) of the hospital.
- The total number of requested FTE resident slots for direct GME or IME, or both.
- A completed copy of the CMS Evaluation Form for each residency program for which the hospital intends to use the requested increase in FTE residents.
- Source documentation to support the assertions made by the hospital on the CMS Evaluation Form.
- FTE resident counts for direct GME and IME and FTE resident caps for direct GME and IME reported by the hospital in the most recent as-filed cost report. (Include copies of Worksheets E, Part A, E–3, Part IV, *and if a hospital received an increase to its FTE cap(s) under section 422 of the MMA,* a copy of E–3, Part VI).
- An attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, of the following information:

"I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under federal law. Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil, and administrative action, fines and/or imprisonment may result. I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the

books and records of the hospital in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents."

The completed application and supporting documentation (as described above) must be submitted to the CMS Central Office and the CMS Regional Office for the region in which the applicant hospital is located. The addresses of the CMS Central Office and Regional Offices are listed below.

CMS Central and CMS Regional Office Mailing Addresses for Applications for Increases in FTE Resident Caps

Central Office

Centers for Medicare and Medicaid Services (CMS)
Director, Division of Acute Care
7500 Security Boulevard
Mail Stop C4–08–06
Baltimore, Maryland 21244
(410) 786–4548

Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region I
JFK Federal Building
Room 23275
Boston, MA 02203
Phone: (617) 565–1331

Region II (New York, New Jersey, U.S. Virgin Islands, and Puerto Rico)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region II
26 Federal Plaza, 38th Floor
New York, NY 10278
Phone: (212) 616–2545

Region III (Delaware, Maryland, Pennsylvania, Virginia and West Virginia, and the District of Columbia)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region III
Public Ledger Building, Suite 216
150 South Independence Mall West
Philadelphia, PA 19106
Phone: (215) 861–4140

Region IV (Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennessee)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region IV
Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20
Atlanta, GA 30303–8909
Phone: (404) 562–7300

Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region V
233 North Michigan Avenue, Suite 600
Chicago, IL 60601
Phone: (312) 886–6432

Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region VI
1301 Young Street, Suite 714
Dallas, TX 75202
Phone: (214) 767–6423

Region VII (Iowa, Kansas, Missouri, and Nebraska)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region VII
Richard Bolling Federal Building
Room 235
601 East 12th Street
Kansas City, MO 64106
(816) 564–1843

Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region VIII
Colorado State Bank Building
1600 Broadway, Suite 700
Denver, CO 80202
Phone: (303) 844–2111

Region IX (Arizona, California, Hawaii, and Nevada and Territories of American Samoa, Guam and the Commonwealth of the Northern Mariana Islands)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region IX
90 7th Street, Suite 5–300 (SW)
San Francisco, CA 94103–6708
Phone: (415) 744–3501

Region X (Alaska, Idaho, Oregon, and Washington)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region X
2201 Sixth Avenue, MS/RX–46
Seattle, WA 98121
Phone: (206) 615–2094

XVIII. Proposed Changes to Whole Hospital and Rural Provider Exceptions to the Physician Self-Referral Prohibition and Related Changes to Provider Agreement Regulations

A. Background

Section 1877 of the Act, also known as the physician self-referral law: (1) Prohibits a physician from making referrals for certain "designated health services" (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation), unless an exception applies; and (2) prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for those DHS furnished as a result of a prohibited referral. The Act establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions that pose no risk of program or patient abuse.

Section 1877(d) of the Act sets forth additional exceptions related to ownership or investment interests held by a physician (or an immediate family member of a physician) in an entity that furnishes DHS. Section 1877(d)(1) of the Act provides that an ownership or investment interest in a hospital located in Puerto Rico shall not be considered to be an ownership or investment interest. Section 1877(d)(2) of the Act provides an exception for ownership or investment interests in rural providers. In order for an entity to qualify for the exception, the DHS must be furnished in a rural area (as defined in section 1886(d)(2) of the Act) and substantially

all of the DHS furnished by the entity are furnished to individuals residing in a rural area. Section 1877(d)(3) of the Act provides an exception, known as the "whole hospital" exception, for ownership or investment interests in a hospital located outside of Puerto Rico, provided that the referring physician is authorized to perform services at the hospital and the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital).

B. Changes Made by the Affordable Care Act Relating to the Whole Hospital and Rural Provider Exceptions to Ownership and Investment Prohibition

Section 6001(a) of the Affordable Care Act amended the whole hospital and rural provider exceptions to impose additional restrictions on physician ownership or investment in hospitals to qualify for such exceptions. The statute defines a "physician owner or investor" in a hospital as a physician or an immediate family member of a physician who has a direct or indirect ownership or investment interest in the hospital. We will refer to hospitals with such "physician owners or investors" as "physician-owned hospitals."

Section 6001(a)(2) of the Affordable Care Act provides that in order to satisfy the whole hospital exception, a physician-owned hospital must meet the requirements described in a new section 1877(i)(1) of the Act no later than September 23, 2011. Section 6001(a)(1) amended the rural provider exception to require that hospitals located in rural areas also satisfy the requirements of new section 1877(i)(1) of the Act no later than September 23, 2011.

Section 6001(a)(3) of the Affordable Care Act, as amended by the HCERA, sets forth the terms of new section 1877(i)(1) of the Act. Under section 1877(i)(1) of the Act, a hospital must:

(1) Have physician owners or investors and a provider agreement in effect no later than December 31, 2010;

(2) Not expand facility capacity beyond the number of operating rooms, procedure rooms, and beds for which the hospital was licensed as of March 23, 2010, unless an exception is granted by the Secretary;

(3) Comply with certain reporting and disclosure requirements and not condition any physician ownership or investment interests directly or indirectly on a physician making or influencing referrals to or generating other business for the hospital;

(4) Comply with certain requirements designed to ensure that all ownership and investment interests in the hospital are bona fide;

(5) Inform patients before admission if the hospital does not have a physician available on the premises during all hours and receive a signed acknowledgment that the patient understands this fact; and

(6) Not have been converted from an ASC on or after March 23, 2010.

In addition, section 1877(i)(2) of the Act requires the Secretary to collect, publish, and update on an annual basis on the CMS Web site (*http://www.cms.hhs.gov*) the physician and other ownership information submitted by hospitals under section 1877(i)(1)(C)(*i*) of the Act. Section 1877(i)(3) of the Act requires the Secretary to create an exception process related to the prohibition on expansion of facility capacity and publish in the **Federal Register** the final decision with respect to each applicant hospital.

Section 6001(b)(1) of the Affordable Care Act requires the Secretary to establish policies and procedures to ensure compliance with the requirements described in section 1877(i)(1) of the Act, which may include unannounced site reviews of hospitals. Section 6001(b)(2) of the Affordable Care Act requires the Secretary, beginning no later than May 1, 2012, to conduct audits to determine whether hospitals are in compliance with the requirements of new section 1877(i)(1).

As noted above, physician-owned hospitals must meet the requirements of new section 1877(i)(1) of the Act not later than 18 months after the date of enactment (that is, by September 23, 2011). We have received numerous inquiries concerning how this language relates to several of the requirements set forth in section 1877(i)(1) of the Act that specify earlier deadlines. We believe that compliance with all requirements must occur no later than September 23, 2011, and failure to satisfy earlier deadlines will preclude use of the revised exceptions after the earlier deadline has passed. For example, section 1877(i)(1)(A) of the Act provides that the hospital must have had physician ownership or investment on December 31, 2010, and a provider agreement in effect on that date. Failure to obtain a provider agreement that is effective on or before December 31, 2010, will preclude use of the revised rural provider and whole hospital exceptions on and after January 1, 2011. Another example can be seen in section 1877(i)(1)(D)(i) of the Act, which provides that the percentage of the total value of physician ownership or investment interests held in the hospital, in the aggregate, must not exceed such percentage as of March 23, 2010. Therefore, if a hospital has no physician ownership or investment as of March 23, 2010, and later adds physician owners or investors, the hospital will not satisfy the whole hospital and rural provider exceptions. Most of the provisions within section 1877(i)(1) of the Act do not specify an explicit deadline for compliance. Thus, we are proposing that the deadline for compliance with all provisions within section 1877(i)(1) of the Act that do not contain an explicit deadline is September 23, 2011, that is, 18 months after the date of enactment.

Below, we discuss changes we are proposing to make to our regulations in response to section 6001 of the Affordable Care Act, as amended.

C. Proposed Changes to Physician Self-Referral Regulations

In order to conform our regulations to the amendments made to the rural provider exception by section 6001(a)(1) of the Affordable Care Act, we are proposing to revise § 411.356(c)(1) to specify that, in the case where the rural provider is a hospital, the hospital must meet the requirements of proposed new § 411.362 no later than September 23, 2011.

Similarly, we are proposing to revise § 411.356(c)(3) to add a new paragraph (iv) that provides that the hospital must meet the requirements in new § 411.362 not later than September 23, 2011. In new § 411.362, we set forth the additional requirements for both exceptions as mandated by section 1877(i)(1) of the Act.

1. Physician Ownership and Provider Agreement

Section 1877(i)(1)(A) of the Act requires that, in order to use the rural provider and whole hospital exception under section 1877(D)(3)(d) of the Act, the hospital must have physician ownership or investment on December 31, 2010, and a provider agreement under section 1866 of the Act in effect on this date. We are proposing to incorporate these requirements in § 411.362(b)(1) of the regulations.

Section 1877(i)(5) of the Act defines a "physician owner or investor" as a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital. We are proposing to incorporate this statutory definition in § 411.362(a)(1) of the regulations.

2. Limitation on Expansion of Facility Capacity

Section 1877(i)(1)(B) of the Act requires that the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after March 23, 2010, be no greater than the number of operating rooms, procedure rooms, and beds for which the hospital was licensed on that date. However, section 1877(i)(3)(C) of the Act authorizes the Secretary to permit a physician-owned hospital to increase capacity above its "baseline number of operating rooms, procedure rooms, and beds." Section 1877(i)(3)(C)(iii) of the Act, as amended by section 1106(2)(B) of the HCERA, defines the term "baseline number of operating rooms, procedure rooms, and beds" to mean "the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of [March 23, 2010] (or, in the case of a hospital that did not have a provider agreement in effect as of that date, but does have an agreement in effect on December 31, 2010, the effective date of such provider agreement)." Although section 1877(i)(1)(B) of the Act does not contain language regarding facility capacity as of the effective date of a provider agreement issued between March 23, 2010 and December 31, 2010, we must read sections 1877(i)(1)(B) and 1877(i)(3)(C)(iii) of the Act together and interpret them harmoniously. Accordingly, in proposed § 411.362(b)(2), we specify that the hospital will be limited to the number of operating rooms, procedure rooms, and beds for which the hospital is licensed on March 23, 2010, or if the hospital did not have a provider agreement in effect as of that date, but does have an agreement in effect on December 31, 2010, the effective date of such provider agreement.

The limitation on expansion of facility capacity applies to operating rooms, procedure rooms, and beds for which the hospital is licensed. It is important to note that the limitation on expansion applies to operating rooms and procedure rooms regardless of whether a State licenses these rooms. Referrals are prohibited if made by physician owners and investors after facility expansion and prior to the Secretary's granting of an exception to the capacity restriction. Exceptions for expanding facility capacity will protect only those referrals made after the exception is granted.

Section 1877(i)(3)(G) of the Act specifies that "the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed)." Under our proposed definition of procedure rooms at § 411.362(a)(2), the term is limited to the types of rooms specified in the statute. Although the statute would permit us to define "procedure rooms" to include rooms where other services are performed, we are not proposing to do so at this time. We encourage public comments on whether "procedure rooms" should include rooms where additional services, such as CT or PET scans, or other services, are performed.

Section 1877(i)(3)(A) of the Act gives the Secretary until January 1, 2012, to promulgate regulations concerning the process for a hospital to apply for an exception and provides that the implementation of this process must be completed by February 1, 2012. We plan to issue a separate rulemaking document that will provide for implementation of this exceptions process.

3. Preventing Conflicts of Interest

Section 1877(i)(1)(C)(i) of the Act requires the hospital to submit to the Secretary an annual report containing a detailed description of the identity of each physician owner or investor and any other owners or investors of the hospital, and the nature and extent of all ownership and investment interests in the hospital. We plan to propose procedures for this reporting requirement in a separate rulemaking.

Section 1877(i)(1)(C)(ii)–(iv) of the Act requires hospitals to: (1) Develop procedures requiring a referring physician owner or investor to disclose (in time to permit the patient to make a meaningful decision about receipt of care) his or her ownership interest to the patient and, if applicable, the treating physician's ownership or investment interest; (2) not condition any physician ownership or investment interests either directly or indirectly on the physician making or influencing referrals to the hospital or otherwise generating business for the hospital; and (3) disclose on any public Web site for the hospital and in any public advertising that it is owned or invested in by physicians. Compliance with these three requirements must be achieved no later than September 23, 2011.

To incorporate these requirements into our regulations, we are proposing to: (1) Add § 411.362(b)(3)(ii)(A) to specify that a hospital must require each referring physician owner or investor to agree, as a condition of continued medical staff membership or admitting privileges, to provide written disclosure of his or her ownership or investment interest in the hospital (and, if applicable, the treating physician's ownership or investment interest in the hospital) to all patients the physician refers to the hospital, at the time the referral is made; (2) add § 411.362(b)(3)(ii)(B) to specify that a hospital may not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital; and (3) add § 411.362(b)(3)(ii)(C) to specify that the hospital must disclose on any public Web site for the hospital and in any public advertising that the hospital is owned or invested in by physicians.

Proposed § 411.362(b)(3)(ii)(A) defines the procedures that a hospital must have in place to require its physician owners and investors to make certain patient disclosures. We do not believe the disclosures to be made by physicians will be burdensome. For example, a physician owner or investor could provide a written, form notice to each patient that discloses the physician's ownership or investment interest in the hospital, informs the patient that his or her treating physician may have an ownership or investment interest in the hospital, and directs the patient to review an attached list identifying all other physician owners or investors in the hospital. This notice may be used by the patient to make a meaningful decision regarding his or her receipt of care.

We are soliciting public comments on several different issues relating to preventing conflicts of interest. First, we are seeking public comments on the benefits and drawbacks of our proposal, discussed above, relating to the procedures hospitals must have in place to require referring physician owners and investors to make the patient disclosures set forth in section 1877(i)(1)(C)(ii) of the Act. We are interested in receiving information about other methods and alternative approaches to address this issue and what should constitute sufficient hospital procedures to require such disclosures to a patient by a referring physician owner or investor.

Second, we are aware that a patient may have multiple conditions for which there are a variety of physician specialists who are responsible for different aspects of a patient's care, even though the statute refers to a single "treating physician." We are not

proposing to define "treating physician." We will consider treating physicians to be those physicians who are responsible for any aspect of a patient's care or treatment. We welcome public comments on this approach.

Finally, we encourage public comments on the methods a hospital should be required to use in disclosing its physician ownership or investment in public advertising pursuant to section 1877(i)(1)(C)(iv) of the Act. For example, we are interested in comments on whether a hospital should be required to disclose physician ownership or investment on its homepage, any particular page on its Web site (for example, an "About Us" page), or all pages on its Web site; the types of media that constitute, or do not constitute, public advertising; and whether a minimum font size should be required for the disclosure.

4. Ensuring *Bona Fide* Investment

Section 1877(i)(1)(D) of the Act sets forth seven different requirements related to ensuring *bona fide* investment in order for hospitals to qualify for the rural provider and whole hospital exceptions set forth in the physician self-referral law. First, the percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate may not exceed such percentage as of March 23, 2010. Second, any ownership or investment interests that the hospital offers to a physician owner or investor must not be offered on more favorable terms than the terms offered to a person who is not a physician owner or investor. Third, the hospital (or any owner or investor in the hospital) must not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor. Fourth, the hospital (or any owner or investor in the hospital) must not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital. Fifth, ownership or investment returns must be distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital. Sixth, physician owners and investors must not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital. Lastly, the hospital must not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor. We note that additional or different factors may be relevant to a determination of whether an investment is *bona fide* for purposes of complying with other laws, including fraud and abuse laws.

We are proposing to add § 411.362(b)(4) to incorporate these provisions in our regulations. We recognize that section 1877(i)(1)(A) of the Act provides that the hospital must have had physician ownership or investment on December 31, 2010, while section 1877(i)(1)(D)(i) of the Act assumes the existence of physician ownership or investment on March 23, 2010 and further provides that the percentage of the total value of physician ownership or investment interests held in the hospital, in the aggregate, on that date must not increase. Reading these provisions together, we conclude the following: (i) If a hospital had no physician ownership or investment as of March 23, 2010, it will not qualify for the whole hospital or rural provider exceptions if it adds any physician owners or investors after that date; and (ii) if a hospital had physician ownership or investment as of March 23, 2010, it may reduce the number of physician owners or investors, provided that the percentage of the total value of physician ownership or investment interests, in the aggregate, remains the same or decreases.

The second through seventh requirements tied to ensuring *bona fide* investment (sections 1877(i)(1)(D)(ii) through 1877(i)(1)(D)(vii) of the Act) do not specify any deadlines for compliance. Accordingly, compliance with the second through seventh requirements must be achieved no later than September 23, 2011.

If we determine that further guidance related to any aspect of section 1877(i)(1)(D) of the Act is necessary, we will provide clarification in future rulemaking. Furthermore, a hospital may request an advisory opinion (pursuant to §§ 411.370 through 411.389) for a determination of whether an existing or proposed arrangement meets the requirements for hospitals to ensure that investment is *bona fide*.

5. Patient Safety

Section 1877(i)(1)(E) of the Act, as added by the Affordable Care Act, requires a hospital that is owned or invested in by physicians to disclose to a patient before admission if it does not have a physician available on the premises to provide services during all hours that the hospital is providing services to such patient. Following this disclosure, the hospital must receive a signed acknowledgment of such fact from the patient. In addition, the hospital must have the capacity to provide assessment and initial treatment for patients and refer and transfer such patients to hospitals with the capability to treat the patients involved. We see no reason to treat the safety of inpatients differently than outpatients. Accordingly, given the language and purpose of the statute, we propose to apply these patient safety requirements to inpatients as well as outpatients. Hospitals must meet these requirements no later than September 23, 2011. We are proposing to incorporate these provisions into our regulations at § 411.362(b)(5).

6. Conversion From ASC

Section 1877(i)(1)(F) of the Act, as added by the Affordable Care Act, also prohibits the use of the rural provider and whole hospital exceptions by physician-owned hospitals that were converted from an ASC to a hospital on or after March 23, 2010. We are proposing to add § 411.362(b)(6) to reflect this provision in our regulations.

7. Publication of Information Reported

As discussed in section XVIII.B. of this proposed rule, section 1877(i)(1)(C) of the Act, as added by the Affordable Care Act, requires the hospital to submit to the Secretary an annual report containing a detailed description of the identity of each physician owner or investor and any other owners or investors of the hospital and the nature and extent of all ownership and investment interests in the hospital. The process for collecting this information must be determined no later than September 23, 2011. Section 1877(i)(2) of the Act requires that the Secretary publish, and update on an annual basis, the information submitted by hospitals under section 1877(i)(1)(C) of the Act on the CMS Web site. As with the annual report requirement set forth in section XVIII.B. of this proposed rule, we are not making a proposal related to this provision at this time.

8. Enforcement

Section 6001(b)(1) of the Affordable Care Act requires the Secretary to

establish policies and procedures to ensure compliance with the requirements described in section 1877(i) of the Act, and states that these policies and procedures may include unannounced site reviews of hospitals. Section 6001(b)(2) of the Affordable Care Act requires the Secretary, beginning not later than May 1, 2012, to conduct audits to determine if physician-owned hospitals are in compliance with section 1877(i)(1) of the Act. We will comply with the statutory mandate, but are not proposing any regulations on this topic at this time.

D. Proposed Related Changes to Provider Agreement Regulations

Section 1866 of the Act states that a provider of services shall be qualified to participate in the Medicare program and shall be eligible for Medicare payments if it files a Medicare provider agreement and abides by the requirements applicable to Medicare provider agreements. These requirements are incorporated in our regulations at 42 CFR part 489, Subparts A and B (Provider Agreements and Supplier Approval). Section 1861(e) of the Act defines the term "hospital." Section 1861(e)(9) of the Act defines a hospital and authorizes the Secretary to establish requirements as determined necessary in the interest of patient health and safety. Section 5006 of the Deficit Reduction Act of 2005 mandated the Secretary to develop a strategic and implementing plan to address certain issues with respect to physician ownership of specialty hospitals. As part of that plan, we used our authority under sections 1866 and 1861(e)(9) of the Act (as well as our general rulemaking authority under sections 1102 and 1871 of the Act) to impose certain additional requirements on physician-owned hospitals as part of their provider agreements. These new requirements were established in the FY 2008 IPPS final rule with comment period (72 FR 47385 through 47391) and the FY 2009 IPPS final rule (73 FR 48686 through 48688).

Specifically, we amended the regulations at § 489.3 governing Medicare provider agreements to define a "physician-owned hospital" as any participating hospital (including a CAH) in which a physician or immediate family member of a physician has an ownership or investment interest, unless the ownership or investment interest satisfies the exceptions at § 411.356(a) or (b) regarding publicly-traded securities and mutual funds. In addition, we added a new provision at § 489.20(u)(1) to require a physician-owned hospital to agree to furnish patients with written notice, in a manner reasonably designed to be understood by all patients, that it is physician-owned and that the list of physician owners is available upon request. Further, we added a new provision at § 489.20(u)(2) to compel hospitals to require that all physician owners who are also members of the hospital's medical staff to disclose, in writing, their ownership interest in the hospital (and that of any immediate family member) to all patients they refer to the hospital, as a condition of continued medical staff membership. Patient disclosure is required at the time the physician makes a referral.

We also added a new provision to require that hospitals and CAHs: (1) Furnish all patients written notice at the beginning of their inpatient hospital stay or outpatient service if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week; and (2) describe how the hospital or CAH will meet the medical needs of any patient who develops an emergency medical condition at a time when no physician is present in the hospital or CAH. These requirements are codified at § 489.20(w). The requirements of § 489.20(u) and (w) were made applicable to both inpatient hospital stays and outpatient services because, as we stated in the FY 2008 IPPS final rule with comment period, these provisions are in the interest of the health and safety of all individuals who receive services in these institutions. The notice requirements are intended to permit individuals to make more informed decisions regarding their treatment.

We are proposing to modify the Medicare provider agreement regulations in Subpart B of Part 489 in order to make the rules consistent with new § 411.362, as required by the Affordable Care Act. Furthermore, incorporating the additional requirements of the Affordable Care Act is in the best interest of the health and safety of individuals who receive services in hospitals and CAHs. With respect to § 489.20(u), we are proposing to: (1) Add a provision in § 489.20(u)(1)(ii) to specify that the hospital must disclose on any public Web site for the hospital and in any public advertising that it is owned or invested in by physicians; (2) amend § 489.20(u)(2) to specify that a referring physician owner or investor must also disclose in writing, if applicable, the treating physician's ownership or investment interest in the hospital; and (3) add § 489.20(u)(3) to specify that a hospital may not condition any physician ownership or investment interests either directly or indirectly on the physician making or influencing referrals to the hospital or otherwise generating business for the hospital.

Regarding § 489.20(w), we are proposing to specify that, in the case of a hospital where a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week, before admitting a patient or providing an outpatient service, the hospital must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during all hours services are rendered to the patient.

We encourage public comments on whether the changes to the provider agreement regulations (Part 489) are necessary or whether the amendments and additions made to the whole hospital and rural provider exceptions within subpart J of Part 411 of our regulations are sufficient to provide guidance relating to section 6001 of the Affordable Care Act.

XX. Files Available to the Public Via the Internet

A. Information in Addenda Related to the CY 2011 Hospital OPPS

Addenda A and B to this proposed rule provide various data pertaining to the proposed CY 2011 payment for items and services under the OPPS. Addendum A, which includes a list of all proposed APCs to be payable under the OPPS, and Addendum B, which includes a list of all active HCPCS codes with their proposed CY 2011 OPPS payment status and comment indicators, are available to the public by clicking "Hospital Outpatient Regulations and Notices" on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/.*

For the convenience of the public, we also are including on the CMS Web site a table that displays the HCPCS code data in Addendum B sorted by proposed APC assignment, identified as Addendum C.

Addendum D1 defines the payment status indicators that we are proposing to use in Addenda A and B. Addendum D2 defines the comment indicators that we are proposing to use in Addendum B. Addendum E lists the proposed HCPCS codes that we propose would only be payable to hospitals as inpatient procedures and would not be payable under the OPPS. Addendum L contains the proposed out-migration wage adjustment for CY 2011. Addendum M lists the proposed HCPCS codes that would be members of a composite APC

and identifies the composite APC to which each would be assigned. This addendum also identifies the proposed status indicator for the HCPCS code and a proposed comment indicator if there is a proposed change in the code's status with regard to its membership in the composite APC. Each of the proposed HCPCS codes included in Addendum M has a single procedure payment APC, listed in Addendum B, to which it would be assigned when the criteria for assignment to the composite APC are not met. When the criteria for payment of the code through the composite APC are met, one unit of the composite APC payment is paid, thereby providing packaged payment for all services that are assigned to the composite APC according to the specific I/OCE logic that applies to the APC. We refer readers to the discussion of composite APCs in section II.A.2.e. of this proposed rule for a complete description of the composite APCs.

These addenda and other supporting OPPS data files are available on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/.*

B. Information in Addenda Related to the CY 2011 ASC Payment System

Addenda AA and BB to this proposed rule provide various data pertaining to the proposed CY 2011 payment for the covered surgical procedures and covered ancillary services for which ASCs may receive separate payment. Addendum AA lists the proposed ASC covered surgical procedures and the proposed CY 2011 payment indicators and payment rates for each procedure. Addendum BB displays the proposed ASC covered ancillary services, and their proposed CY 2011 payment indicators and payment rates. All proposed ASC relative payment weights and payment rates for CY 2011 are a result of applying the revised ASC payment system methodology established in the final rule for the revised ASC payment system published in the **Federal Register** on August 2, 2007 (72 FR 42470 through 42548) to the CY 2011 OPPS and MPFS ratesetting information.

Addendum DD1 defines the proposed payment indicators that are used in Addenda AA and BB. Addendum DD2 defines the proposed comment indicators that are used in Addenda AA and BB.

Addendum EE (available only on the CMS Web site) lists the surgical procedures that we are proposing to exclude from Medicare payment if furnished in ASCs. The proposed excluded procedures listed in Addendum EE are surgical procedures that would be assigned to the OPPS inpatient list, would not be covered by Medicare, would be reported using a CPT unlisted code, or have been determined to pose a significant safety risk or are expected to require an overnight stay when performed in ASCs.

These addenda and other supporting ASC data files are included on the CMS Web site at: *http://www.cms.gov/ASCPayment/.* The MPFS data files are located at: *http://www.cms.gov/PhysicianFeeSched/.*

The links to all of the proposed FY 2011 IPPS wage index-related tables (that we are proposing to use for the CY 2011 OPPS) that were published in the June 2, 2010 supplemental FY 2011 IPPS/LTCH PPS proposed rule (75 FR 30918) are accessible on the CMS Web site at: *http://www.cms.gov/AcuteInpatientPPS/WIFN.*

XXI. Collection of Information Requirements

A. Legislative Requirement for Solicitation of Comments

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and to solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 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.

B. Proposed Requirements Specified in the Regulation Text

This proposed rule contains the following proposed information collection requirements specified in regulatory text:

1. ICRs Regarding Redistribution of Medical Residency Slots

Existing regulations at § 413.78 outline the requirements for the determination of the total number of FTE residents in determining direct GME payments to hospitals. Section XVII.B.2.c. of the preamble of this proposed rule discusses the requirement for hospitals that share the costs of resident training in nonprovider settings, as permitted by the Affordable Care Act, to count a proportional share of the time and to record that proportion in a written agreement. We are proposing that this proportion must be included on a distinct written agreement for hospitals that pay nonhospital sites concurrently, without a written agreement as described in existing regulations. The burden associated with this requirement is the time and effort put forth by the hospital to prepare a written agreement. We estimate it would take one hospital 15 minutes to meet this requirement. Hospitals that already have a written agreement with a nonhospital site may include the proportion on that existing agreement.

In section XVII.B.2.d. of the preamble of this proposed rule, we discuss the requirement under the Affordable Care Act for hospitals to maintain records of the amount of time that their residents spend training in nonhospital sites, and to compare that time to the time spent by their residents in nonprovider sites in a base year as the Secretary may specify. We believe that a large part of the information that hospitals would be required to record for the purposes of this provision is contained in rotation schedules, which all hospitals are already required to maintain. Therefore, we do not believe that this requirement poses an undue administrative burden for the purposes of the PRA.

Existing regulations at § 412.105 and § 413.79 outline the requirements for the determination of the weighted number of FTE residents for IME and direct GME payments to hospitals. In sections XVII.B.4. and 5. of the preamble of this proposed rule, we discuss our proposals that a hospital seeking an adjustment to the limit on its unweighted resident count under section 5503 or section 5506 of the Affordable Care Act must provide documentation justifying the adjustment. Sections XVII.B.4. and 5. of the preamble of this proposed rule specify the information that a request would have to include. These requirements are exempt from the PRA in accordance with the provisions of the Affordable Care Act.

2. ICRs Regarding Basic Commitments of Providers (§ 489.20) and Additional Requirements Concerning Physician Ownership and Investment in Hospitals (§ 411.362)

Current § 489.20(u)(1) states that, in the case of a physician-owned hospital as defined in § 489.3, the hospital must furnish written notice to all patients at the beginning of their hospital stay or

outpatient visit that the hospital is a physician-owned facility. The burden associated with the requirements in this section is the time and effort necessary for a hospital to furnish written notice to all patients that the hospital is a physician-owned hospital. Whereas this requirement is subject to the PRA, the associated burden is currently approved under OMB control number 0938–1034, with an expiration date of February 28, 2011.

Our proposed amendment to § 489.20(u)(1) and proposed new § 411.362(b)(3)(ii)(C) would require disclosure by a hospital on any public Web site for the hospital and in any public advertising that the hospital is owned or invested in by physicians. The burden associated with this disclosure requirement is the time and effort necessary for hospitals to draft and post such a disclosure on their Web sites (where applicable) and to include such a disclosure in any existing or future public advertising that the hospitals may utilize. We estimate that 265 hospitals must comply with this requirement. In addition, we estimate that it will take each hospital 1 hour to develop and place this information on its Web site and/or in a public advertisement. The estimated annual hospital burden associated with placing the aforementioned information in Web sites, public advertisement, or both is 265 hours at a cost of $3,993.55. In addition, we estimate that it will take 30 minutes annually for a hospital to review and update the information contained in its Web site, public advertising or both. The estimated annual burden associated with the annual review and update of the information is 132.5 hours at a cost of $1,996.77.

Our proposed amendment to § 489.20(u)(2) and proposed new § 411.362(b)(3)(ii)(A) would require the hospital to have procedures in place to require that each referring physician agree, as a condition of his or her continued medical staff membership or admitting privileges, to provide written disclosure of his or her ownership or investment interest in the hospital (and, if applicable a treating physician's ownership or investment interest in the hospital) to all patients whom the physician refers to the hospital. These provisions impose a burden on both hospitals and physicians.

With respect to hospitals, the burden associated with this requirement is the time and effort necessary for hospitals to develop, draft, and implement changes to its medical staff bylaws and other policies governing admitting privileges. Approximately 265 hospitals would be required to comply with these requirements. We estimate that it will require a hospital's general counsel 2 hours to revise a hospital's medical staff bylaws and policies governing admitting privileges. Therefore, the total annual hospital burden would be 530 hours at a cost of $32,875.90.

With respect to physicians, the burden associated with this requirement is the time and effort necessary for a referring physician owner or investor to develop a list of all other physician owners or investors in the hospital and draft a form notice to patients that discloses the referring physician's ownership or investment interest in the hospital, informs the patient that a treating physician(s) of the patient may have an ownership or investment interest in the hospital, and directs the patient to review a list identifying all other physician owners or investors in the hospital. This list may be used by patients in making their health care decisions. Under existing § 489.20(u)(1), hospitals are currently required to provide a list of their physician owners or investors to patients upon request at the beginning of their inpatient stay or outpatient visit. Because hospitals already maintain lists of their owners and investors, we estimate that it will take each physician 1 hour annually to obtain such a list from the hospital, draft a disclosure notice, and make copies that will be distributed to patients. In addition, we estimate that it will take 30 seconds to provide the disclosure notice to each patient and an additional 30 seconds to record proof of disclosure in each patient's medical record.

Although we can estimate the number of physician-owned hospitals, we are unable to quantify the number of physicians (or their immediate family members) who possess an ownership or investment interest in hospitals. There are limited data available concerning physician ownership in hospitals. The studies to date, including those by CMS and the GAO, pertain to physician ownership in specialty hospitals (cardiac, orthopedic, and surgical hospitals). These specialty hospitals published data concerning the average percentage of shares of direct ownership by physicians (less than 2 percent), indirect ownership through group practices, and the aggregate percentage of physician ownership, but did not publish the number of physician owners in these types of hospitals. More importantly, § 489.20(u)(2) applies to physician ownership in any type of hospital. Our other research involved a review of enrollment data. However, the CMS Medicare enrollment application (CMS–855) requires physicians to report only those ownership interests that are 5 percent or more (direct or indirect), and thus, most physician ownership is not captured. While we acknowledge there is a burden associated with this ICR, we have no way to quantify this requirement's burden. Therefore, because we are unable to estimate the total physician burden associated with this reporting requirement, we are assigning 1 burden hour to this requirement and we are also seeking public comment pertaining to this burden allocation and will reevaluate this issue in the final rule stage of rulemaking.

Existing § 489.20(w) requires hospitals, as defined in § 489.24(b), to furnish all patients notice in accordance with § 482.13(b)(2), at the beginning of their hospital stay or outpatient visit if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week. The notice must indicate how the hospital will meet the medical needs of any inpatient who develops an emergency medical condition, as defined in § 489.24(b), at a time when there is no physician present in the hospital. The burden associated with this requirement is the time and effort necessary for each hospital to develop a standard notice to furnish to its patients. Although this requirement is subject to the PRA, the associated burden is approved under OMB control number 0938–1034, with a current expiration date of February 28, 2011.

Our proposed new §§ 489.20(w)(2) and 411.362(b)(5)(i) would require that, following a hospital's disclosure to a patient that it does not have a physician available during all hours that the hospital is providing services to such patient, the hospital must obtain a signed acknowledgment from the patient stating that the patient understands that no physician is available for that period. The burden associated with this requirement is the time and effort necessary for each hospital to add an acknowledgment line to its current form, disclose the form to the patient, obtain the patient's signature, and copy and record the form in the patient's medical record. The requirements in proposed § 489.20(w) would apply to all hospitals (not just physician-owned hospitals), as defined in § 489.24(b). We estimate that there are approximately 2,557 hospitals and CAHs that may not have a physician on-site at all times. We estimate that it will take each hospital 30 minutes to amend its current disclosure form to add an acknowledgment line, an additional 30 seconds to obtain the patient's

signature, and an additional 30 seconds to include a copy of the notice in the patient's medical record. The estimated annual burden associated with developing an amended form, obtaining patient signatures, and copying and recording the form is 1,196,932.6 hours at a cost of $18,518,081.15.

C. Associated Information Collections Not Specified in Regulatory Text

In this proposed rule, we make reference to proposed associated information collection requirements that are not discussed in the regulation text contained in this document. The following is a discussion of those requirements.

1. Hospital Outpatient Quality Data Reporting Program (HOP QDRP)

As previously stated in section XVI. of this proposed rule, the quality data reporting program for hospital outpatient care, known as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), has been generally modeled after the quality data reporting program for hospital inpatient services, the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. Section 109(a) of the MIEA–TRHCA (Pub. L. 109–432) amended section 1833(t) of the Act by adding a new subsection (17) which affects the annual payment update factor applicable to OPPS payments for services furnished by hospitals in outpatient settings on or after January 1, 2009. Section 1833(t)(17)(A) of the Act states that subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Act) that fail to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act will incur a 2.0 percentage point reduction to their annual payment update factor. Section 1833(t)(17)(B) of the Act requires that hospitals submit quality data in a form and manner, and at a time, that the Secretary specifies. Section 1833(t)(17)(A)(ii) of the Act specifies that any reduction would apply only to the payment year involved and would not be taken into account in computing the applicable annual payment update factor for a subsequent payment year. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities.

2. HOP QDRP Quality Measures for the CY 2012, CY 2013 and CY 2014 Payment Determinations

In the CY 2009 final rule with comment period (73 FR 68766), we retained the seven chart-abstracted measure we used in CY 2009 and adopted 4 new claims-based imaging measures for use in CY 2010, bringing the total number to 11 measures. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637), we adopted the same 11 measures and the same data submission requirements related to the 7 data abstracted measures for CY 2011 payment determinations. For the CY 2012 payment update, we are proposing that hospitals continue to submit data for the existing 7 chart-abstracted measures (we would continue to use the 4 claims-based measures) and to add 1 new chart-abstracted AMI measure, 4 additional claims-based imaging efficiency measures, and 1 structural measure regarding Health IT. These 17 measures are listed in the table below. For the CY 2013 payment determination, we are proposing that hospitals continue to submit data for all of the nonclaims-based measures previously adopted for the CY 2012 payment determination (we would continue to use the claims-based measures previously adopted), and to adopt 1 new structural measure on tracking clinical results, and 6 new chart-abstracted measures for the CY 2013 payment determination on the topics of HOPD care transitions, and ED efficiency, for a total of 24 measures. For the CY 2014 payment determination, we are proposing that hospitals continue to submit data for all of the measures previously adopted for the CY 2013 payment determination (we would continue to use the claims-based measures previously adopted), and to adopt 6 new chart-abstracted measures on the topics of diabetes care and exposure time for procedures using fluoroscopy, for a total of 30 measures. These proposed measures are listed below.

BILLING CODE 4120–01–P

Proposed HOP QDRP Measurement Sets to be Used for the CY 2012, CY 2013 and CY 2014 Payment Determinations
OP-1: Median Time to Fibrinolysis
OP-2: Fibrinolytic Therapy Received Within 30 Minutes
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4: Aspirin at Arrival
OP-5: Median Time to ECG
OP-6: Timing of Antibiotic Prophylaxis
OP-7: Prophylactic Antibiotic Selection for Surgical Patients
OP-8: MRI Lumbar Spine for Low Back Pain
OP-9: Mammography Follow-up Rates
OP-10: Abdomen CT – Use of Contrast Material
OP-11: Thorax CT – Use of Contrast Material
The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data*
Preoperative Evaluation for Low Risk Non Cardiac Surgery Risk Assessment*
Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI post CABG*
Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)*
Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*
Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with *Probable Cardiac Chest Pain*) Received within 60 minutes of arrival *
Median Time from ED Arrival to ED Departure for Discharged ED Patients**
Transition Record with Specified Elements Received by Discharged Patients**
Tracking Clinical Results between Visits**
Door to Diagnostic Evaluation by a Qualified Medical Professional**
ED- Median Time to Pain Management for Long Bone Fracture **
ED- Patient Left Before Being Seen**
ED- Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival **
Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetic Patients***
Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetic Patients***
Diabetes Mellitus: High Blood Pressure Control in Diabetic Patients***
Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients***
Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients***
Exposure Time Reported for Procedures Using Fluoroscopy***

* Proposed new measure for CY 2012 payment determination.
** Proposed new measure for CY 2013 payment determination.
*** Proposed new measure for CY 2014 payment determination.

BILLING CODE 4120–01–C

For the CY 2012 payment determination, hospitals would submit data related to the 8 chart-abstracted measures and we would calculate the 8 claims-based measures using administrative paid claims data and not require additional hospital data submissions. For the structural measure, hospitals would enter data into a Web-based collection tool.

As part of the data submission process pertaining to the 17 measures listed above for the CY 2012 payment determination, hospitals must also complete and submit a notice of participation in the HOP QDRP. By submitting this document, hospitals agree that they will allow CMS to publicly report the quality measures as required by the HOP QDRP.

For the CY 2012 payment determination, the burden associated with this section is the time and effort associated with completing the notice of participation as well as collecting and submitting the data on the eight data abstracted measures and the one structural measure. We estimate that there will be approximately 3,200 respondents per year. For hospitals to collect and submit the information on the required measures, we estimate it will take 35 minutes per sampled case. We estimate there will be a total of 930,000 cases per year, approximately 290 cases per year per respondent. The estimated annual burden associated with the aforementioned submission requirements for chart-abstracted data is 542,500 hours (930,000 cases per year × 0.583 hours/case). For the structural measure, we estimate that it will require 10 minutes per hospital for one instance per year; the estimated annual burden associated with this requirement is 533 hours (3,200 hospitals × 0.167 hours per hospital).

We invite public comment on the burden associated with these information collection requirements.

3. Proposed HOP QDRP Validation Requirements

In addition to requirements for submitting of quality data, hospitals must also comply with the requirements for data validation in CY 2012. Similar to our proposed policy for the FY 2012 RHQDAPU program (75 FR 23991 through 23993), we are proposing to validate data from 800 randomly selected hospitals each year under the HOP QDRP, beginning with the CY 2012 payment determination. We note that, because the 800 hospitals would be selected randomly, every HOP QDRP-participating hospital would be eligible each year for validation selection. For each selected hospital, we would randomly select up to 48 patient episodes of care per year (12 per quarter) for validation purposes from the total number of cases that the hospital successfully submitted to the OPPS Clinical Warehouse during the applicable time period. However, if a selected hospital has submitted less than 12 cases in one or more quarters, only those cases available will be validated.

The burden associated with the proposed CY 2012 requirement is the time and effort necessary to submit validation data to a CMS contractor. We estimate that it will take each of the 800 sampled hospitals approximately 12 hours to comply with these data submission requirements. To comply with the requirements, we estimate each hospital must submit 48 cases for the affected year for review. We estimate that 800 hospitals must comply with these requirements to submit a total of 38,400 charts across all sampled hospitals. The estimated annual burden associated with the data validation process for CY 2012 and subsequent years is 9,600 hours.

We invite public comment on this information collection requirement.

4. Proposed HOP QDRP Reconsideration and Appeals Procedures

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68779), we adopted a mandatory reconsideration process that will apply to the CY 2010 payment decisions. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60654 through 60655), we continued this process for the CY 2011 payment update. We are proposing to continue this process for the CY 2012 payment update with some modifications. We have proposed to eliminate a requirement that the reconsideration request form be signed by the hospital CEO to facilitate electronic submission of the form and reduce hospital burden. Under this proposed process, the hospitals would be required to meet all of the requirements specified in section XVI.E. of this proposed rule. While there is burden associated with filing a reconsideration request, section 5 CFR 1320.4 of the Paperwork Reduction Act of 1995 excludes collection activities during the conduct of administrative actions such as redeterminations, reconsiderations, and/or appeals. Specifically, these actions are taken after the initial determination or denial of payment.

5. Additional Topics

While we are seeking OMB approval for the information collection requirements associated with the HOP QDRP and the data validation processes, we also are seeking public comment on several issues that may ultimately affect the burden associated with HOP QDRP and the data validation processes. Specifically, this proposed rule lists proposed quality measures for CY 2012 through CY 2014 payment determinations as well as other possible quality measures under consideration for CY 2013 and subsequent years. We also are soliciting public comments to explore the use of registries to comply with the HOP QDRP submission requirements, the use of EHRs as a data submission tool, the use of a standardized process for the retirement of HOP QDRP quality measures, the continued use of an extraordinary circumstance extension or waiver for reporting quality data, and the implementation of additional data validation conditions.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, (CMS–1504–P)

Fax: (202) 395–6974; or

E-mail: *OIRA_submission@omb.eop.gov*.

XXII. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this proposed rule, and, when we proceed with a subsequent document(s), we will respond to those comments in the preamble to that document(s).

XXIII. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

1. Executive Order 12866

Executive Order 12866 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 that have economically significant effects ($100 million or more in any 1 year) or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal government or communities (58 FR 51741).

We estimate that the effects of the OPPS provisions that would be implemented by this proposed rule would result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from proposed changes in this proposed rule as well as enrollment, utilization, and case-mix changes) in expenditures under the OPPS for CY 2011 compared to CY 2010 to be approximately $3.9 billion. Because this proposed rule for the OPPS is "economically significant" as measured by the $100 million threshold and also a major rule under the Congressional Review Act, we have prepared a regulatory impact analysis that, to the best of our ability, presents the costs and benefits of this rulemaking. Table 55 of this proposed rule displays the redistributional impact of the CY 2011 proposed changes on OPPS payment to various groups of hospitals.

We estimate that the effects of the ASC provisions that would be implemented by this proposed rule for the ASC payment system would not exceed $100 million in any 1 year and, therefore, are not economically significant. We estimate the total increase (from proposed changes in this proposed rule as well as enrollment, utilization, and case-mix changes) in expenditures under the ASC payment system for CY 2011 compared to CY 2010 to be approximately $0. However, because this proposed rule for the ASC payment system substantially affects ASCs, we have prepared a regulatory impact analysis of changes to the ASC payment system that, to the best of our ability, presents the costs and benefits of this rulemaking. Table 57 and Table 58 of this proposed rule display the redistributional impact of the CY 2011 changes on ASC payment, grouped by specialty area and then grouped by procedures with the greatest ASC expenditures, respectively.

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Many hospitals, other providers, ASCs, and other suppliers are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (hospitals having revenues of $34.5 million or less in any 1 year and ASCs having revenues of $10 million or less in any 1 year). (For details on the latest standards for health care providers, we refer readers to the SBA's Web site at: *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf* (refer to the 620000 series).)

For purposes of the RFA, we have determined that many hospitals and most ASCs would be considered small entities according to the SBA size standards. Individuals and States are not included in the definition of a small entity. Therefore, the Secretary has determined that this proposed rule would have a significant impact on a substantial number of small entities. Because we acknowledge that many of the affected entities are small entities, the analyses presented throughout this proposed rule constitute our proposed regulatory flexibility analysis. Therefore, we are soliciting public comments on our estimates and analyses of the impact of this proposed rule on those small entities.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside an urban area and has fewer than 100 beds. 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 urban areas. Thus, for OPPS purposes, we continue to classify these hospitals as urban hospitals. We believe that the proposed changes to the OPPS in this proposed rule would affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Also, the changes to the ASC payment system in this proposed rule would affect rural ASCs. Therefore, the Secretary has determined that this proposed rule would have a significant impact on the operations of a substantial number of small rural hospitals.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) 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 $135 million. This proposed rule would not mandate any requirements for State, local, or tribal governments, nor would it affect private sector costs.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined the OPPS and ASC provisions included in this proposed rule in accordance with Executive Order 13132, Federalism, and have determined that they would not have a substantial direct effect on State, local or tribal governments, preempt State law, or otherwise have a Federalism implication. As reflected in Table 55 below, we estimate that OPPS payments to governmental hospitals (including State and local governmental hospitals) would increase by 2.2 percent under this proposed rule. While we do not know the number of ASCs with government ownership, we anticipate that it is small. We believe that the provisions related to payments to ASCs in CY 2011 would not affect payments to any ASCs owned by government entities.

The following analysis, in conjunction with the remainder of this document, demonstrates that this proposed rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act.

This proposed rule would affect payments to a substantial number of small rural hospitals and a small number of rural ASCs, as well as other

classes of hospitals and ASCs, and some effects may be significant.

B. Effects of OPPS Changes in This Proposed Rule

We are proposing to make several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We also are required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments, including pass-through payments and outlier payments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this proposed rule, we are proposing to update the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2011, as we discuss in sections II.B. and II.C., respectively, of this proposed rule. We discuss our implementation of section 10324 of the Affordable Care Act, as amended by HCERA, authorizing a wage index of 1.00 for certain frontier states. We also are proposing to revise the relative APC payment weights using claims data for services furnished from January 1, 2009, through December 31, 2009, and updated cost report information. We are proposing to continue the current payment adjustment for rural SCHs, including EACHs. We are proposing an adjustment for cancer hospitals identified under 1886(d)(1)(B)(v) of the Act in accordance with section 3138 of the Affordable Care Act, as amended by HCERA. Finally, we list the 18 drugs and biologicals in Table 20 of this proposed rule that we are proposing to remove from pass-through payment status for CY 2011.

Under this proposed rule, we estimate that the proposed update change to the conversion factor and other adjustments (but not including the effects of outlier payments, pass-through estimates, the expiration of section 508 wages on September 30, 2010, and the application of the frontier wage adjustment for CY 2011) as provided by the statute would increase total OPPS payments by 2.1 percent in CY 2011. The proposed changes to the APC weights, the changes to the wage indices, the continuation of a payment adjustment for rural SCHs, including EACHs, and the proposed payment adjustment for cancer hospitals would not increase OPPS payments because these changes to the OPPS are budget neutral. However, these proposed updates do change the distribution of payments within the budget neutral system as shown in Table 55 below and described in more detail in this section. We also estimate that the total change in payments between CY 2010 and CY 2011, considering all payments, including changes in estimated total outlier payments, pass-through payments, the expiration of additional money for specified section 508 reclassification and special exception wages indices, and the application of the frontier adjustment outside of budget neutrality, would increase total OPPS payments by 2.2 percent.

1. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options are discussed throughout this proposed rule. Some of the major issues discussed in this proposed rule and the options considered are discussed below.

a. Alternatives Considered for the Extension of Waiver of Deductible to Services Furnished in Connection With or in Relation to a Colorectal Screening Test That Becomes Diagnostic

Section 4104(c)(2)of the Affordable Care Act waives the deductible with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test. We are proposing for CY 2011 that the deductible be waived for all surgical services furnished on the same date as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test. As discussed in detail in XII.B.3 of this rule, we are proposing to implement this provision by creating a HCPCS modifier that hospitals would append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service. The claims processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance or copayment would continue to apply to the diagnostic test and other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

We considered three alternatives for the extension of waiver of deductible to services furnished in connection with or in relation to a colorectal screening test that becomes diagnostic for CY 2011. The first alternative we considered, but are not proposing, was to define a limited set of colonoscopy codes to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy, screening flexible sigmoidoscopy, or barium enema. We did not choose this alternative because it is virtually impossible to create a valid and complete list of appropriate procedures to handle all situations, due to the range of problems that could be identified and complications that could occur with any invasive procedures.

Furthermore, we believe this alternative would be complex to implement. Although this alternative narrows the potential for hospitals to abuse the waiver of the deductible by applying it to unrelated services, we believe the potential for abuse of the waiver of the deductible to be minimal. The Part B deductible is a fixed amount that the beneficiary pays before Medicare begins to pay and typically would be met after receiving one to two services.

The second alternative we considered, but are not proposing, was to define a broader, but still limited set of codes (for example, selected surgical services) to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy, screening flexible sigmoidoscopy, or barium enema. Although this alternative would encompass a broader set of codes, we believe it is virtually impossible to create a valid and complete list of appropriate procedures to handle all situations, due to the range of problems that could be identified and complications that could occur with any invasive procedures. While we acknowledge that this alternative narrows the potential for abuse of the waiver of the deductible, we believe the potential for abuse is minimal and that this alternative would be complex to implement. For these reasons we did not choose to define a broader set of limited codes to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy, screening flexible sigmoidoscopy, or barium enema.

The third alternative we considered, and the one we are proposing for CY 2011, is to apply the waiver to any surgical procedure on the same date as a screening colonoscopy, flexible sigmoidoscopy, or barium enema that

providers report is "in connection with or as a result of" the procedure that began as a screening test. We are proposing to create a HCPCS modifier that providers would append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service. We chose this alternative because we believe it provides the greatest ease of public understanding and provider application. We believe that this alternative is appropriate because we believe that it would be very rare for an unrelated surgery to occur on the same date as one of these scheduled screening tests. Moreover, we believe that the risk of improper expenditures would be very small under this policy because it is the deductible, and not the coinsurance, that is waived for the related procedures other than the screening tests. As noted above, the Part B deductible is a fixed amount that the beneficiary pays before Medicare begins to pay and typically would be met after receiving one to two services.

b. Alternatives Considered for Payment of the Acquisition and Pharmacy Overhead Costs of Drugs and Biologicals That Do Not Have Pass-Through Status

We are proposing that, for CY 2011, the OPPS would make payment for separately payable drugs and biologicals at ASP+6 percent, and this payment would continue to represent combined payment for both the acquisition and pharmacy overhead costs of separately payable drugs and biologicals. As discussed in detail in section V.B.3. of this proposed rule, we believe that approximately $150 million of the estimated $593 million in pharmacy overhead cost currently attributed to coded packaged drugs with an ASP and $50 million of the estimated $628 million in pharmacy overhead cost currently attributed to coded and uncoded packaged drugs without an ASP should, instead, be attributed to separately payable drugs and biologicals to provide an adjustment for the pharmacy overhead costs of these separately payable products. As a result, we also are proposing to reduce the cost of packaged drugs and biologicals that is included in the payment for procedural APCs to offset the $200 million adjustment to payment for separately payable drugs and biologicals. We are proposing that any redistribution of pharmacy overhead cost that may arise from CY 2011 final rule claims data would occur only from some drugs and biologicals to other drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals under the OPPS.

We considered three alternatives for payment of the acquisition and pharmacy overhead costs of drugs and biologicals that do not have pass-through status for CY 2011. The first alternative we considered, but are not proposing, was to continue our standard policy of comparing the estimated aggregate cost of separately payable drugs and biologicals in our claims data to the estimated aggregate ASP dollars for separately payable drugs and biologicals, using the ASP as a proxy for average acquisition cost, to calculate the estimated percent of ASP that would serve as the best proxy for the combined acquisition and pharmacy overhead costs of separately payable drugs and biologicals (70 FR 68642). Under this standard methodology, using April 2010 ASP information and costs derived from CY 2009 OPPS claims data, we estimated the combined acquisition and overhead costs of separately payable drugs and biologicals to be ASP plus 0 percent. As discussed in section V.B.3. of this proposed rule, we also determined that the combined acquisition and overhead costs of packaged drugs are 283 percent of ASP. We did not choose this alternative because we believe that this analysis indicates that our standard drug payment methodology has the potential to "compress" the calculated costs of separately payable drugs and biologicals to some degree. Further, we recognize that the attribution of pharmacy overhead costs to packaged or separately payable drugs and biologicals through our standard drug payment methodology of a combined payment for acquisition and pharmacy overhead costs depends, in part, on the treatment of all drugs and biologicals each year under our annual drug packaging threshold. Changes to the packaging threshold may result in changes to payment for the overhead cost of drugs and biologicals that do not reflect actual changes in hospital pharmacy overhead cost for those products.

The second alternative we considered, but are not proposing, was to adopt the APC Panel's February 2010 recommendation to redistribute a larger portion of the overhead cost from packaged drugs to separately payable drugs for payment of drugs and biologicals that do not have pass-through status. We did not choose this alternative because, as we discussed in V.B.3. of this proposed rule, we are not confident that we know the amount of overhead cost available for redistribution in the uncoded packaged drugs and, therefore, do not know if it is appropriate to redistribute more payment from uncoded packaged drugs to separately paid drugs. Presenters at the APC Panel meeting provided analyses suggesting that the uncoded packaged drug cost contain exactly the same drugs as those in the coded packaged drug cost, leading to a recommendation that we could assume the same proportional amount of overhead cost appears in the uncoded packaged drug cost as observed in the coded packaged drug cost in order to increase the amount of "overhead" drug cost available for redistribution from uncoded packaged drugs to separately payable drugs. However, we do not believe we should assume that the costs reported under uncoded pharmacy revenue code lines are for the same drugs and biologicals, with the same ASPs, and overhead costs as the costs of packaged drugs and biologicals reported with a HCPCS code. For these reasons, we are not accepting the APC Panel's recommendation to redistribute a larger portion of overhead costs from packaged drugs to separately payable drugs for CY 2011.

The third alternative we considered and the one we are proposing for CY 2011 is to continue our CY 2010 redistribution methodology and redistribute $200 million in overhead costs from packaged coded and uncoded drugs to separately payable drugs which would result in a payment for non-pass-through separately payable drugs and biologicals at ASP+6 percent, which would continue to represent a combined payment for both the acquisition costs of separately payable drugs and the pharmacy overhead costs applicable to these products. We also are proposing to reduce the cost of packaged drugs that is included in the payment for procedural APCs to offset the $200 million adjustment to payment for separately payable drugs and biologicals, resulting in payment for packaged drugs and biologicals of ASP+186 percent under our proposal. We chose this alternative because we believe that it provides the most appropriate redistribution of pharmacy overhead costs associated with drugs and biologicals, based on the analyses discussed in section V.B.3. of this proposed rule, and is the alternative that is most consistent with the principles of a prospective payment system.

c. Alternatives Considered for the Physician Supervision of Hospital Outpatient Services

As we discussed extensively in previous sections, the goal of the proposal on supervision is to address

the concerns that have been brought to our attention since we issued our last rule on this subject in CY 2010. The primary issue raised by CAHs, rural hospitals and other small hospitals both during CY 2010 rulemaking and, in particular, following CY 2010 rulemaking was difficulty in staffing their facilities to meet our requirement for direct supervision of all outpatient therapeutic services, but especially services that involve a significant amount of monitoring by auxiliary staff, that may extend past regular business hours, and that typically are lower clinical complexity and risk. We focused on these issues for our CY 2011 proposal, and we are proposing to define a limited set of outpatient therapeutic services as "nonsurgical extended duration therapeutic services" that would require, at a minimum, direct supervision during an initial period followed by general supervision for the remaining duration of the service. We are proposing to select therapeutic services that are nonsurgical, that can last a significant period of time, that have a substantial monitoring component, and that have a low risk of requiring the physician's or appropriate non-physician practitioner's physical presence to furnish assistance and direction after the initiation of the service. Specifically, for observation services, IV hydration, and several injection procedures identified in Table 37 of this proposed rule, CMS would require direct supervision only at the initiation of the service and would then allow general supervision for the remainder of the service. We would apply the current definitions of general and direct supervision delineated at 42 CFR 410.32(b)(3)(i) and § 410.27(a)(1)(iv), respectively. General supervision would thus mean that the service is furnished under the physician's or non-physician practitioner's overall direction and control, but his or her physical presence is not required during the performance of the service. Direct supervision would mean that the physician or non-physician practitioner is immediately available throughout the performance of the service to furnish assistance and direction, but he or she does not need to be present in the room when the service is being performed. We are proposing to define "initiation of the service" as the beginning portion of a service ending when the patient is stable and the supervising physician or appropriate non-physician practitioner believes the remainder of the service can safely be delivered under his or her general direction and control without needing his or her physical presence on the hospital campus or in the PBD of the hospital. Under this proposal, we would continue to uphold direct supervision as the minimum standard of supervision for all outpatient therapeutic services, which we continue to believe is appropriate for ensuring some minimum level of quality and safety in purchased hospital outpatient services that are provided incident to physicians' services.

We considered but did not propose two other avenues of offering flexibility while largely maintaining our minimum requirement for direct supervision of outpatient therapeutic services. First, we considered offering hospitals the flexibility of broadening the list of nonsurgical extended duration therapeutic services to include more complex and potentially acute services like chemotherapy administration and blood transfusions, which some stakeholders also maintain do not require direct supervision. Because we were concerned that these services had a higher probability of needing a physician or non-physician practitioner to redirect service, we reasoned that we would have to require hospitals to create internal guidelines specifying a supervision level and protocols for staffing that supervision level for every nonsurgical extended duration therapeutic service. We considered minimum requirements for these internal supervision guidelines, including annual review and approval by a governing committee, periodic internal evaluation of their implementation, and the ability to make these guidelines available to auditors if requested. Further, auditors would review those guidelines if a quality or patient safety event would occur. Given the complexity of these services and the probability that direct supervision would be necessary to ensure a minimum level of quality and safety, we concluded that we should continue to require direct supervision for these services. We also chose not to propose this internal guidelines alternative because a variable standard of supervision for these services could be administratively difficult for us to audit and evaluate. Finally, we chose not to propose this option because we believed that hospitals might find it burdensome to create and maintain customized internal guidelines, especially without a clear means of assessing whether their internal guidelines and implementation of those guidelines would meet audit standards.

Second, we considered whether, for payment purposes, we should deliberately exclude CAHs from all supervision requirements. We acknowledge that statutory provisions allow CAHs some flexibility in their staffing requirements to operate with more nursing staff and non-physician practitioners rather than physicians if those are the practitioners that are available, and that our regulations recognize those reduced staffing requirements in the CoPs by establishing that, at a minimum, the physician or non-physician practitioner must be available, but not necessarily physically present on the CAH campus. Some have suggested that these requirements reduce the quality and safety of CAH services, and that CAHs should disclose their reduced staffing levels to patients prior to providing services. We did not choose to propose this option because we believe that Medicare should purchase the same basic level of safety and quality from CAHs as from all other hospitals, and for all beneficiaries, especially small rural hospitals with a small number of beds. We do not believe that these small rural hospitals paid under the OPPS through section 1833(t) of the Act and CAHs paid at reasonable cost under section 1834(g) of the Act have such different resource constraints that they require different staffing rules for purposes of supervision. In fact, with payment at cost, we reasoned that CAHs might be better able than other small hospitals to hire staff to provide direct supervision of therapeutic outpatient services.

In summary, we are proposing to define a list of nonsurgical extended duration therapeutic services for a policy of direct supervision followed by general supervision after the initiation of the service because this alternative is responsive to the primary concerns raised by CAHs and small rural hospitals, because it is administratively feasible to implement, and because we believe it continues to support our policy of direct supervision. We believe that this proposed policy will maintain an adequate level of safety and quality of care in the therapeutic services for hospital outpatients that Medicare purchases.

2. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the proposed CY 2011 policy changes on various hospital groups. We post on the CMS Web site our hospital-specific estimated payments for CY 2011 with the other supporting documentation for this proposed rule. To view the hospital-specific estimates, we refer readers to the CMS Web site at: *http://www.cms.hhs.gov/*

HospitalOutpatientPPS/. Select "regulations and notices" from the left side of the page and then select "CMS–1504–P" from the list of regulations and notices. The hospital-specific file layout and the hospital-specific file are listed with the other supporting documentation for this proposed rule. We show hospital-specific data only for hospitals whose claims were used for modeling the impacts shown in Table 55 below. We do not show hospital-specific impacts for hospitals whose claims we were unable to use. We refer readers to section II.A.2. of this proposed rule for a discussion of the hospitals whose claims we do not use for ratesetting and impact purposes.

We estimate the effects of the proposed individual policy changes by estimating payments per service, while holding all other payment policies constant. We use the best data available, but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters. As we have done in previous rules, we are soliciting public comment and information about the anticipated effects of our proposed changes on providers and our methodology for estimating them.

3. Estimated Effects of This Proposed Rule on Hospitals

Table 55 below shows the estimated impact of this proposed rule on hospitals. Historically, the first line of the impact table, which estimates the change in payments to all hospitals, has always included cancer and children's hospitals, which are held harmless to their pre-BBA payment-to-cost ratio. We also include CMHCs in the first line that includes all providers because we include CMHCs in our weight scalar estimate.

We present separate impacts for CMHCs in Table 55 because CMHCs are paid only for partial hospitalization services and CMHCs are a different provider type from hospitals. For CY 2010, CMHCs and hospitals were paid under two APCs for services under the OPPS: APC 0172 (Level 1 Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). For CY 2011, we are proposing to pay CMHCs under APC 0172 (Level I Partial Hospitalization (3 services) for CMHCs) and APC 0173 (Level II Partial Hospitalization (4 or more services) for CMHCs), and to pay hospitals for partial hospitalization services under APC 0175 (Level I Partial Hospitalization (3 services) for Hospital-based PHPs) and APC 0176 (Level II Partial Hospitalization (4 or more services) for Hospital-based PHPs). We display the impact on CMHCs of this proposed policy change below and we discuss the impact on CMHCs in section XXII.B.4. of this proposed rule.

We also present separate impacts for cancer hospitals in Table 55 to illustrate the impact associated with our CY 2011 proposal for an adjustment for cancer hospitals authorized by section 3138 of the Affordable Care Act, as amended by HCERA, and discussed in section II.F. of this proposed rule. Cancer hospitals are held harmless to the proportional amount of payment they received before the OPPS was implemented in 2001. We discuss the impact of this adjustment on cancer hospitals in section XXII.B.5 of this proposed rule.

The estimated increase in the total payments made under the OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service mix. Section 3137 of the Affordable Care Act, as amended by the HCERA, extended additional payment to section 508 reclassification hospitals and special exception hospital wages outside budget neutrality through September 30, 2010. The amounts attributable to these reclassifications are incorporated into the CY 2010 estimates in Table 55. Section 10324 of the Affordable Care Act, as amended by HCERA, further authorized additional expenditures outside budget neutrality for hospitals in certain frontier states to have a wage index of 1.00. The amounts attributable to this Frontier state wage index adjustment are incorporated into the CY 2011 estimates in Table 55.

Table 55 shows the estimated redistribution of hospital and CMHC payments among providers as a result of APC reconfiguration and recalibration; wage indices and the rural adjustment; the cancer hospital adjustment; the combined impact of the APC recalibration, wage and rural adjustment effects, the cancer hospital adjustment, and the market basket update to the conversion factor; the Frontier wage index adjustment; and, finally, estimated redistribution considering all proposed payments for CY 2011 relative to all payments for CY 2010, including the impact of changes in the outlier threshold, expiring section 508 wage indices, and changes to the pass-through payment estimate. We did not model an explicit budget neutrality adjustment for the rural adjustment for SCHs because we are not proposing to make any changes to the policy for CY 2011. Because the proposed updates to the conversion factor, including the update of the market basket and the subtraction of additional money dedicated to pass-through payment for CY 2011, are applied uniformly across services, observed redistributions of payments in the impact table for hospitals largely depend on the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change), and the impact of the wage index changes on the hospital. However, total payments made under this system and the extent to which this proposed rule would redistribute money during implementation also would depend on changes in volume, practice patterns, and the mix of services billed between CY 2010 and CY 2011 by various groups of hospitals, which CMS cannot forecast.

Overall, the proposed OPPS rates for CY 2011 would have a positive effect for providers paid under the OPPS, resulting in a 2.2 percent estimated increase in Medicare payments. Removing cancer and children's hospitals, because their payments are held harmless to the pre-BBA ratio between payment and cost, and CMHCs suggests that these proposed changes would result in a 2.1 percent estimated increase in Medicare payments to all other hospitals.

To illustrate the impact of the proposed CY 2011 changes, our analysis begins with a baseline simulation model that uses the final CY 2010 weights, the FY 2010 final IPPS wage indices that include reclassifications, and the final CY 2010 conversion factor. Column 2 in Table 55 shows the independent effect of the proposed changes resulting from the reclassification of services among APC groups and the recalibration of APC weights, based on 12 months of CY 2009 OPPS hospital claims data and the most recent cost report data. We modeled the effect of the proposed APC recalibration changes for CY 2011 by varying only the weights (the final CY 2010 weights versus the proposed CY 2011 weights calculated using the service mix and volume in the CY 2009 claims used for this proposed rule) and calculating the percent difference in weight. Column 2 also reflects the effect of the proposed changes resulting from the APC reclassification and recalibration changes and any changes in multiple procedure discount patterns or conditional packaging that occur as a result of the proposed changes in the relative magnitude of payment weights.

Column 3 reflects the independent effects of the proposed updated wage indices, including the application of budget neutrality for the rural floor

policy on a nationwide basis. This column excludes the effects of the frontier wage index adjustment, which is not budget neutral and is shown in column 6. We did not model a budget neutrality adjustment for the rural adjustment for SCHs because we are making no changes to the policy for CY 2011. We modeled the independent effect of updating the wage indices by varying only the wage indices, holding APC relative weights, service mix, and the rural adjustment constant and using the proposed CY 2011 scaled weights and a CY 2010 conversion factor that included a budget neutrality adjustment for the effect of changing the wage indices between CY 2010 and CY 2011.

Column 4 demonstrates the independent effect of the cancer hospital payment adjustment. We modeled the independent effect of the cancer adjustment by varying only the payment to cancer hospitals after applying provider specific adjustments that cumulatively result in the proposed 40.5 percent adjustment while holding APC relative weights, service mix, the rural adjustment and wage indices constant and using a CY 2010 conversion factor.

Column 5 demonstrates the combined "budget neutral" impact of APC recalibration (that is, Column 2), the wage index update (that is, Column 3), the cancer hospital adjustment (that is, Column 4), as well as the impact of updating the conversion factor with the adjusted market basket update. We modeled the independent effect of the budget neutrality adjustments and the adjusted market basket update by using the weights and wage indices for each year, and using a CY 2010 conversion factor that included the market basket update and a budget neutrality adjustment for differences in wage indices.

Column 6 demonstrates the impact of the budget neutral adjustments and the market basket update reflected in Column 5 combined with the non-budget neutral Frontier wage index adjustment, discussed in section II.C.1. of this proposed rule.

Finally, Column 7 depicts the full impact of the proposed CY 2011 policies on each hospital group by including the effect of all the proposed changes for CY 2011 (including the APC reconfiguration and recalibration shown in Column 2) and comparing them to all estimated payments in CY 2010 (these CY 2010 estimated payments include the payments resulting from the non-budget neutral increases to wage indices under section 508 of Public Law 108–173 as extended by Public Law 111–148). Column 7 shows the combined budget neutral effects of Columns 2 through 5, plus the impact of the Frontier wage index adjustment; the proposed change to the fixed-dollar outlier threshold from $2,175 to $2,025 as discussed in section II.G. of this proposed rule; the expiration of section 508 reclassifications; the change in the HOP QDRP payment reduction for the small number of hospitals in our impact model that failed to meet the reporting requirements (see section XVI.D. of this proposed rule); and the impact of increasing the estimate of the percentage of total OPPS payments dedicated to transitional pass-through payments. Of the 106 hospitals that failed to meet the HOP QDRP reporting requirements for the full CY 2010 update (and assumed, for modeling purposes, to be the same number for CY 2011), we included 24 in our model because they had both CY 2009 claims data and recent cost report data. We estimate that the cumulative effect of all changes for CY 2011 would increase payments to all providers by 2.2 percent for CY 2011. We modeled the independent effect of all changes in Column 7 using the final weights for CY 2010 and the proposed weights for CY 2011. We used the final conversion factor for CY 2010 of $67.241, which was announced in the notice describing implementation of the Affordable Care Act provisions published around the same time as this proposed rule and the proposed CY 2011 conversion factor of $68.267 discussed in section II.B. of this proposed rule.

Column 7 also contains simulated outlier payments for each year. We used the charge inflation factor used in the FY 2011 IPPS/RY 2011 LTCH PPS proposed rule of 5.16 percent (1.0516) to increase individual costs on the CY 2009 claims, and we used the most recent overall CCR in the April 2010 Outpatient Provider-Specific File (OPSF) (75 FR 24068). Using the CY 2009 claims and a 5.16 percent charge inflation factor, we currently estimate that outlier payments for CY 2010, using a multiple threshold of 1.75 and a fixed-dollar threshold of $2,175, would be approximately 0.85 percent of total payments. Outlier payments of 0.85 percent are incorporated in the CY 2010 comparison in Column 7. We used the same set of claims and a charge inflation factor of 10.59 percent (1.1059) and the CCRs in the April 2010 OPSF, with an adjustment of 0.9890, to reflect relative changes in cost and charge inflation between CY 2009 and CY 2011, to model the CY 2011 outliers at 1.0 percent of total payments using a multiple threshold of 1.75 and a fixed-dollar threshold of $2,025.

Column 1: Total Number of Hospitals

The first line in Column 1 in Table 55 shows the total number of providers (4,140), including cancer and children's hospitals and CMHCs for which we were able to use CY 2009 hospital outpatient claims to model CY 2010 and CY 2011 payments, by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2010 or CY 2011 payment and entities that are not paid under the OPPS. The latter entities include CAHs, all-inclusive hospitals, and hospitals located in Guam, the U.S. Virgin Islands, Northern Mariana Islands, American Samoa, and the State of Maryland. This process is discussed in greater detail in section II.A. of this proposed rule. At this time, we are unable to calculate a disproportionate share (DSH) variable for hospitals not participating in the IPPS. Hospitals for which we do not have a DSH variable are grouped separately and generally include freestanding psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals. We show the total number (3,871) of OPPS hospitals, excluding the hold-harmless cancer and children's hospitals and CMHCs, on the second line of the table. We excluded cancer and children's hospitals because section 1833(t)(7)(D) of the Act permanently holds harmless cancer hospitals and children's hospitals to their proportional payment relative to reasonable cost prior to payment under the OPPS and, therefore, we removed them from our impact analyses. We show the isolated impact on 207 CMHCs at the bottom of the impact table and discuss that impact separately below. We show the isolated impact on the 11 cancer hospitals in the last row of the impact table.

Column 2: Proposed APC Changes Due to Reassignment and Recalibration

This column shows the combined effects of the reconfiguration, recalibration, and other policies (such as our proposal to set payment for separately payable drugs and biologicals at ASP+6 percent with an accompanying reduction in the amount of cost associated with packaged drugs and biologicals and changes in payment for PHP services). Overall, we estimate that proposed changes in APC reassignment and recalibration across all services paid under the OPPS would increase payments to urban hospitals by 0.5 percent. We estimate that both large and other urban hospitals would see an increase of 0.5 percent, all attributable to recalibration. We estimate that urban hospitals billing fewer than 11,000 lines

for OPPS services would experience increases of 1.1 to 1.3 percent, while urban hospitals billing 11,000 or more lines for OPPS services would see increases of 0.5 to 0.8 percent.

Overall, we estimate that rural hospitals would experience an increase of 0.5 percent as a result of changes to the APC structure. We estimate that rural hospitals of all bed sizes would experience increases of 0.4 to 0.7 percent as a result of APC recalibration. We estimate that rural hospitals that report fewer than 5,000 lines for OPPS services would experience a decrease of 0.4 percent, while rural hospitals that report more than 5,000 lines for OPPS services would see increases of 0.5 percent to 0.6 percent.

Among teaching hospitals, we estimate that the impact resulting from APC recalibration would include an increase of 0.5 percent for major and minor teaching hospitals.

Classifying hospitals by type of ownership suggests that voluntary and governmental hospitals would see an increase of 0.5 percent, and proprietary hospitals would see an estimated increase of 0.6 percent.

Finally, we estimate that hospitals for which DSH payments are not available would experience decreases of 1.5 to 1.8 percent. We estimate that most other classes of hospitals would experience modest increases from CY 2010 to CY 2011 resulting from APC recalibration.

Column 3: Proposed New Wage Indices and the Effect of the Rural Adjustment

This column estimates the impact of applying the proposed FY 2011 IPPS wage indices for the CY 2011 OPPS without the influence of the Frontier wage index adjustment or the expiration of the section 508 wage index adjustment, which are not budget neutral. The Frontier wage index adjustment is reflected in the combined impact shown in columns 6 and 7. The expiring section 508 adjustment is reflected in column 7. We are not changing the rural payment adjustment for CY 2011. We estimate that the combination of updated wage data and nationwide application of rural floor budget neutrality would redistribute payment among regions. We also updated the list of counties qualifying for the section 505 out-migration adjustment. Overall, we estimate that urban hospitals would experience an increase of 0.1 percent from CY 2010 to CY 2011, and that rural hospitals would experience a decrease of 0.3 percent as a result of the updated wage indices. We estimate that hospitals in rural New England States and rural West North Central States would experience decreases of 1.9 and 0.8 percent, respectively. We estimate that urban Pacific and rural West South Central States would experience increases of 1.1 percent and 0.6 percent, respectively.

Column 4: Cancer Hospital Adjustment

This column estimates the budget neutral impact of applying the proposed hospital-specific CY 2011 cancer adjustment, authorized by section 3138 of the Affordable Care Act, as amended by the HCERA, which results in an aggregate increase in payments to dedicated cancer hospitals of 40.5% for the CY 2011 OPPS. We estimate that all other hospitals will experience a decrease of 0.7 percent in CY 2011 as a result of redistributing payments to the cancer hospitals under this proposed adjustment.

Column 5: All Proposed Budget Neutrality Changes and Market Basket Update

We estimate that the addition of the proposed market basket update of 2.15 percent (which includes the reduction to the OPD fee schedule update factor of 0.25 percentage points as required by section 3401(i) and 10319(g) of the Affordable Care Act and section 1105(e) of HCERA) would mitigate the negative impacts on hospital payments for CY 2011 created by the budget neutrality adjustments made in Columns 2, 3, and 4. Hospitals for which DSH is not available (generally hospitals not paid under the IPPS, including freestanding psychiatric, rehabilitation, and long-term care hospitals) experience the smallest increases of between 0.2 and 0.5 percent. In general, Column 5 shows that all hospitals would experience an estimated increase of 2.0 percent, attributable to the 2.15 percent OPD fee schedule update factor increase (that is, the market basket) combined with the budget neutrality adjustments.

Overall, we estimate that these proposed changes would increase payments to urban hospitals by 2.1 percent. We estimate that large urban hospitals would experience an increase of 2.2 percent, and "other" urban hospitals would experience a 1.9 percent increase. We estimate that rural hospitals would experience a 1.6 percent increase as a result of the proposed market basket update and other budget neutrality adjustments. We estimate that rural hospitals that bill less than 5,000 lines of OPPS services would experience an increase of 1.4 percent and that rural hospitals that bill more than 5,000 lines of OPPS services would experience increases of 1.5 to 2.3 percent.

Among teaching hospitals, we estimate that the observed impacts resulting from the market basket update and other budget neutrality adjustments would include an increase of 2.0 and 1.9 percent, respectively, for major and minor teaching hospitals.

Classifying hospitals by type of ownership suggests that voluntary, proprietary, and governmental hospitals would experience estimated increases of 1.9 percent, 2.2 percent, and 2.0 percent, respectively.

Column 6: Frontier Wage Index Adjustment

This column shows the impact of all budget neutrality adjustments, application of the 2.15 percent OPD fee schedule update factor, and the non-budget neutral impact of applying the Frontier wage adjustment (that is, the Frontier wage index change in addition to all changes reflected in column 5).

We estimate that hospitals in the urban West North Central and urban Mountain States will experience increases of 2.5 and 2.3 percent, respectively. Hospitals in the rural regions of the West North Central and Mountain States would experience estimated increases of 2.3 and 4.1 percent, respectively.

Column 7: All Proposed Changes for CY 2011

Column 7 compares all proposed changes for CY 2011 to estimated final payment for CY 2010, including the change in the outlier threshold, payment reductions for hospitals that failed to meet the HOP QDRP reporting requirements, the influence of the expiration of the section 508 wage adjustment, and the difference in pass-through estimates that are not included in the combined percentages shown in Column 6. This column includes estimated payment for a handful of hospitals receiving reduced payment because they did not meet their hospital outpatient quality measure reporting requirements; however, we estimate that the anticipated change in payment between CY 2010 and CY 2011 for these hospitals would be negligible. (We further discuss the estimated impacts of hospitals' failure to meet these requirements below in section XXII.D. of this proposed rule.) Overall, we estimate that providers would experience an increase of 2.2 percent under this proposed rule in CY 2011 relative to total spending in CY 2010. The projected 2.2 percent increase for all providers in Column 7 of Table 55 reflects the proposed 2.15 percent adjusted OPD fee schedule update factor increase, less 0.06 percent for the

change in the pass-through estimate between CY 2010 and CY 2011, plus 0.15 percent for the difference in estimated outlier payments between CY 2010 (0.85 percent) and CY 2011 (1.0 percent), and less 0.09 percent due to the expiration of the special, non-budget neutral wage index payments made under section 508, plus .09 percent due to the Frontier wage index adjustment. When we exclude cancer and children's hospitals (which are held harmless to their pre-OPPS costs) and CMHCs, the estimated increase is 2.1 percent.

We estimate that the combined effect of all changes for CY 2011 would increase payments to urban hospitals by 2.1 percent. We estimate that large urban hospitals would experience a 2.2 percent increase, while "other" urban hospitals would experience an increase of 2.0 percent. We estimate that urban hospitals that bill less than 5,000 lines of OPPS services would experience an increase of 3.3 percent, and we estimate that all urban hospitals that bill more than 5,000 lines of OPPS services would experience increases between 2.1 percent and 3.4 percent.

Overall, we estimate that rural hospitals would experience a 1.8 percent increase as a result of the combined effects of all changes for CY 2011. We estimate that rural hospitals that bill less than 5,000 lines of OPPS services would experience an increase of 3.4 percent and rural hospitals that bill greater than 5,000 lines of OPPS services would experience increases ranging from 1.7 percent to 2.5 percent.

Among teaching hospitals, we estimate that the impacts resulting from the combined effects of all changes would include an increase of 2.1 percent for both major and minor teaching hospitals.

Classifying hospitals by type of ownership, we estimate that proprietary hospitals would gain 2.3 percent, governmental hospitals would experience an increase of 2.2 percent, and voluntary hospitals would experience an increase of 2.0 percent.

4. Estimated Effects of This Proposed Rule on CMHCs

The bottom of Table 55 demonstrates the isolated impact on CMHCs. CMHCs are currently paid under two APCs for services under the OPPS: APC 0172 (Level 1 Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). This proposed rule proposes to further refine payment within these Partial Hospitalization APCs for CY 2011 by providing two payment rates for Partial Hospitalization services for each provider type (CMHCs and hospital-based PHPs). Specifically, APC 0172 would be retitled: "Level I Partial Hospitalization (3 services) for CMHCs;" APC 0173 would be retitled: "Level II Partial Hospitalization (4 or more services) for CMHCs;" new APC 0175 would be titled "Level I Partial Hospitalization (3 services) for Hospital-based PHPs" and new APC 0176 would be titled: "Level II Partial Hospitalization (4 or more services) for Hospital-based PHPs." We are proposing payment rates for each APC based on the cost data derived from claims and cost reports for the provider type to which the APC is specific. We modeled the impact of this APC policy change assuming that CMHCs would continue to provide the same number of days of PHP care, with each day having either three services or four or more services, as seen in the CY 2009 claims data. We excluded days with one or two services. Because the relative weights for APC 0172 (Level 1 Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)) both decline in CY 2011 to reflect CMHC cost data for Partial Hospitalization services provided by CMHCs under this proposed rule, we estimate that there would be a 44.0 percent decrease in payments to CMHCs due to these APC policy changes (shown in Column 2).

Column 3 shows that the estimated impact of adopting the CY 2011 wage index values would result in a 0.9 percent increase in payments to CMHCs. We note that all providers paid under the OPPS, including CMHCs, would receive a 2.15 percent adjusted market basket increase. Combining this proposed market basket increase, along with proposed changes in APC policy for CY 2011 and the proposed CY 2011 wage index updates, the proposed cancer hospital adjustment, proposed changes in outlier and pass-through payments, and the expiration of section 508 wages, we estimate that the combined impact on CMHCs for CY 2011 would be a 41.7 percent decrease in payment.

The impact on hospitals of the proposed changes to payment rates to hospitals for partial hospitalization services is reflected in the impact of all proposed changes on hospitals.

5. Estimated Effects of This Proposed Rule on Cancer Hospitals

The bottom of Table 55 demonstrates the isolated impact on the 11 cancer hospitals meeting the classification criteria in 1886(d)(1)(B)(v) of the Act. Section 3138 of the Affordable Care Act, as amended by HCERA, authorized the Secretary to conduct a study to determine if these hospitals are more costly than other hospitals paid under the OPPS, and if they are more costly, the Secretary shall make an appropriate adjustment that is budget neutral. As discussed in section II.F. of this proposed rule, we found that these hospitals are more costly and proposed an adjustment. These cancer hospitals currently are held harmless under section 1833(t)(7)(D) of the Act, and most of them receive additional payments outside budget neutrality. In general, the effect of this proposal is to make more payments to cancer hospitals than received under the OPPS, but within budget neutrality, effectively redistributing money from other hospitals to fund this adjustment. The proposed adjustment is hospital-specific, raising payment for each hospital to 86.7 percent of reasonable cost.

Column 2 demonstrates cancer hospitals receiving a modest increase of 0.3 percent after recalibration of the APC groups and weights. Column 3 shows that the estimated impact of adopting the CY 2011 wage index values would result in a 0.1 percent increase in payments to cancer hospitals within the PPS. Column 4 demonstrates the budget neutral impact of applying a hospital-specific adjustment to the 11 designated cancer hospitals. We estimate that the cancer hospitals will experience an aggregate increase in payment of 40.5%. All providers paid under the OPPS would receive a 2.15 percent adjusted market basket increase under this proposal. Combining this proposed market basket increase, along with proposed changes in APC policy for CY 2011 and the proposed CY 2011 wage index updates, the proposed cancer hospital adjustment, proposed changes in outlier and pass-through payments, and the expiration of section 508 wages, we estimate that the combined impact on cancer hospitals within the PPS system would be a 39.9 percent increase. Cancer hospitals remain eligible for hold harmless payments to the extent that their PPS amount, including the cancer adjustment, is less than the estimated amount of payment they would have received under reasonable cost payment for any given year.

BILLING CODE 4120–01–P

TABLE 55. ESTIMATED IMPACT OF THE PROPOSED CY 2011 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	New Cancer Hospital Adjustment (4)	Comb (cols 2,3) with Market Basket Update (5)	Frontier Wage Index Adjustment (6)	All Changes (7)
ALL PROVIDERS *	4,140	0.0	0.0	0.0	2.1	2.2	2.2
ALL HOSPITALS	3,871	0.5	0.0	-0.7	2.0	2.1	2.1
(excludes hospitals permanently held harmless and CMHCs)							
URBAN HOSPITALS	2,893	0.5	0.1	-0.7	2.1	2.1	2.1
LARGE URBAN	1,569	0.5	0.2	-0.7	2.2	2.2	2.2
(GT 1 MILL.)							
OTHER URBAN	1,324	0.5	0.0	-0.7	1.9	2.1	2.0
(LE 1 MILL.)							
RURAL HOSPITALS	978	0.5	-0.3	-0.7	1.6	1.9	1.8
SOLE COMMUNITY	391	0.5	-0.4	-0.7	1.5	2.0	1.8
OTHER RURAL	587	0.5	-0.3	-0.7	1.7	1.8	1.9
BEDS (URBAN)							
0 - 99 BEDS	976	0.7	0.0	-0.7	2.2	2.4	2.4
100-199 BEDS	855	0.6	0.1	-0.7	2.1	2.2	2.1
200-299 BEDS	453	0.6	0.0	-0.7	2.1	2.2	2.2
300-499 BEDS	413	0.5	0.1	-0.7	2.1	2.2	2.2
500 + BEDS	196	0.4	0.0	-0.7	1.9	1.9	2.0
BEDS (RURAL)							
0 - 49 BEDS	347	0.4	0.1	-0.7	1.9	2.2	2.2
50- 100 BEDS	375	0.6	-0.5	-0.7	1.6	1.7	1.7
101- 149 BEDS	146	0.5	-0.3	-0.7	1.7	1.9	1.8
150- 199 BEDS	62	0.6	-0.2	-0.7	1.9	2.4	2.3
200 + BEDS	48	0.5	-0.6	-0.7	1.4	1.4	1.4
VOLUME (URBAN)							
LT 5,000 Lines	593	1.3	0.3	-0.7	3.0	3.2	3.3
5,000 - 10,999 Lines	159	1.1	0.5	-0.7	3.1	3.3	3.4
11,000 - 20,999 Lines	243	0.8	0.2	-0.7	2.5	2.5	2.6
21,000 - 42,999 Lines	528	0.6	0.3	-0.7	2.4	2.4	2.3
GT 42,999 Lines	1,370	0.5	0.0	-0.7	2.0	2.1	2.1

	Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	New Cancer Hospital Adjustment (4)	Comb (cols 2,3) with Market Basket Update (5)	Frontier Wage Index Adjustment (6)	All Changes (7)
VOLUME (RURAL)							
LT 5,000 Lines	76	-0.4	0.4	-0.7	1.4	3.2	3.4
5,000 - 10,999 Lines	96	0.6	0.3	-0.7	2.3	2.4	2.5
11,000 - 20,999 Lines	198	0.5	0.0	-0.7	2.0	2.3	2.2
21,000 - 42,999 Lines	308	0.5	-0.2	-0.7	1.8	2.0	2.0
GT 42,999 Lines	300	0.5	-0.4	-0.7	1.5	1.8	1.7
REGION (URBAN)							
NEW ENGLAND	150	0.5	-0.6	-0.7	1.4	1.4	1.3
MIDDLE ATLANTIC	362	0.6	-0.2	-0.7	1.9	1.9	1.7
SOUTH ATLANTIC	447	0.6	-0.1	-0.7	2.0	2.0	2.1
EAST NORTH CENT.	466	0.5	0.1	-0.7	2.1	2.1	2.0
EAST SOUTH CENT.	178	0.4	-0.3	-0.7	1.6	1.6	1.6
WEST NORTH CENT.	187	0.5	-0.2	-0.7	1.8	2.5	2.5
WEST SOUTH CENT.	472	0.5	0.1	-0.7	2.1	2.1	2.2
MOUNTAIN	192	0.5	-0.1	-0.7	1.9	2.3	2.4
PACIFIC	391	0.5	1.1	-0.7	3.0	3.0	3.2
PUERTO RICO	48	0.1	-0.4	-0.7	1.2	1.2	1.4
REGION (RURAL)							
NEW ENGLAND	24	0.6	-1.9	-0.7	0.2	0.2	0.3
MIDDLE ATLANTIC	67	0.6	-0.3	-0.7	1.8	1.8	1.9
SOUTH ATLANTIC	164	0.6	-0.3	-0.7	1.8	1.8	1.9
EAST NORTH CENT.	127	0.5	-0.6	-0.7	1.4	1.4	1.3
EAST SOUTH CENT.	177	0.4	-0.3	-0.7	1.7	1.7	1.6
WEST NORTH CENT.	103	0.5	-0.8	-0.7	1.2	2.3	2.1
WEST SOUTH CENT.	216	0.3	0.6	-0.7	2.4	2.4	2.4
MOUNTAIN	70	0.6	0.2	-0.7	2.2	4.1	3.9
PACIFIC	30	0.5	-0.1	-0.7	2.0	2.0	1.7
TEACHING STATUS							
NON-TEACHING	2,890	0.5	0.0	-0.7	2.0	2.1	2.1
MINOR	699	0.5	0.0	-0.7	1.9	2.1	2.1
MAJOR	282	0.5	0.0	-0.7	2.0	2.0	2.1
DSH PATIENT PERCENT							
0	6	2.3	0.0	-0.7	3.7	3.7	4.0
GT 0 - 0.10	396	0.7	0.1	-0.7	2.2	2.3	2.3

	Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	New Cancer Hospital Adjustment (4)	Comb (cols 2,3) with Market Basket Update (5)	Frontier Wage Index Adjustment (6)	All Changes (7)
0.10 - 0.16	395	0.5	0.0	-0.7	2.0	2.1	2.0
0.16 - 0.23	771	0.4	-0.2	-0.7	1.7	1.9	1.9
0.23 - 0.35	997	0.5	0.0	-0.7	2.0	2.1	2.1
GE 0.35	723	0.6	0.2	-0.7	2.2	2.2	2.4
DSH NOT AVAILABLE **	583	-1.8	0.5	-0.7	0.2	0.2	0.2
URBAN TEACHING/DSH							
TEACHING & DSH	889	0.5	0.0	-0.7	2.0	2.1	2.1
NO TEACHING/DSH	1,445	0.6	0.1	-0.7	2.2	2.2	2.2
NO TEACHING/NO DSH	6	2.3	0.0	-0.7	3.7	3.7	4.0
DSH NOT AVAILABLE**	553	-1.5	0.5	-0.7	0.5	0.5	0.6
TYPE OF OWNERSHIP							
VOLUNTARY	2,064	0.5	0.0	-0.7	1.9	2.1	2.0
PROPRIETARY	1,230	0.6	0.1	-0.7	2.2	2.3	2.3
GOVERNMENT	577	0.5	0.0	-0.7	2.0	2.1	2.2
CMHCs	207	-44.0	0.9	-0.7	-41.7	-41.7	-41.7
Cancer Hospitals	11	0.3	0.1	40.5	43.2	43.2	39.9

Column (1) shows total hospitals.

Column (2) shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on 2009 hospital claims data.

Column (3) shows the budget neutral impact of updating the wage index by applying the FY 2011 hospital inpatient wage index. We did not propose any changes to the rural adjustment.

Column (4) shows the budget neutral impact of applying a hospital-specific adjustment to all OPPS services at the 11 designated cancer hospitals.

Column (5) shows the impact of all budget neutrality adjustments and the addition of the market basket update.

Column (6) shows the non-budget neutral impact of applying the frontier adjustment

Column (7) shows the additional adjustments to the conversion factor resulting from a change in the pass-through estimate and adds outlier payments. This column also shows the expiration of section 508 wages on September 30, 2010 and the application of the Frontier wage adjustment for CY 2011.

*These 4,140 providers include children and cancer hospitals, which are held harmless to pre-BBA payments, and CMHCs.

** Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

BILLING CODE 4120–01–C

6. Estimated Effect of This Proposed Rule on Beneficiaries

For services for which the beneficiary pays a copayment of 20 percent of the payment rate, the beneficiary share of payment would increase for services for which the OPPS payments would rise and would decrease for services for which the OPPS payments would fall. For example, for a service assigned to Level IV Needle Biopsy/Aspiration Except Bone Marrow (APC 0037) in the CY 2010 OPPS, the national unadjusted copayment is $228.76, and the minimum unadjusted copayment is $208.46. For CY 2011, the national unadjusted copayment for APC 0037 would be $228.76, the same rate in effect for CY 2010. The minimum

unadjusted copayment for APC 0037 would be $215.24 or 20 percent of the CY 2011 national unadjusted payment rate for APC 0037 of $1,076.16. The minimum unadjusted copayment would rise because the payment rate for APC 0037 would rise for CY 2011. In all cases, the statute limits beneficiary liability for copayment for a procedure to the hospital inpatient deductible for the applicable year. The CY 2010 hospital inpatient deductible is $1,100. The CY 2011 hospital inpatient deductible is not yet available.

In order to better understand the impact of changes in copayment on beneficiaries, we modeled the percent change in total copayment liability using CY 2009 claims. We estimate, using the claims of the 4,140 hospitals and CMHCs on which our modeling is based, that total beneficiary liability for copayments would decline as an overall percentage of total payments, from 22.4 percent in CY 2010 to 22.1 percent in CY 2011.

7. Conclusion

The changes in this proposed rule would affect all classes of hospitals and CMHCs. We estimated that some classes of hospitals would experience significant gains and others less significant gains, but all classes of hospitals would experience positive updates in OPPS payments in CY 2011 with one exception. We estimate that CMHCs would see an overall decrease in payment of 41.7 percent due to the recalibration of payment rates for Partial Hospitalization services at CMHCs which bases payment for CMHCs on cost report and claims data submitted by CMHCs. Specifically, dedicated cancer hospitals would experience an aggregate increase in payment of 40.5 percent, although because the cancer adjustment is hospital-specific, dedicated cancer hospitals will experience different increases.

Table 55 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements that would result in a 2.2 percent increase in payments for all services paid under the OPPS in CY 2011, after considering all changes to APC reconfiguration and recalibration, as well as the adjusted market basket increase, wage index changes, including the Frontier wage index adjustment and the expiration of section 508 wage index reclassifications, the cancer hospital adjustment, estimated payment for outliers, and changes to the pass-through payment estimate. The accompanying discussion, in combination with the rest of this proposed rule, constitutes a regulatory impact analysis.

8. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 56, we have prepared an accounting statement showing the CY 2011 estimated hospital OPPS incurred benefit impact associated with the proposed CY 2011 hospital outpatient market basket update shown in this proposed rule based on the FY 2011 President's Budget. All estimated impacts are classified as transfers.

TABLE 56--ACCOUNTING STATEMENT: CY 2011 ESTIMATED HOSPITAL OPPS TRANSFERS FROM CY 2010 TO CY 2011 ASSOCIATED WITH THE PROPOSED CY 2011 HOSPITAL OUTPATIENT MARKET BASKET UPDATE

Category	Transfers
Annualized Monetized Transfers	$0.7 billion
From Whom to Whom	Federal Government to outpatient hospitals and other providers who received payment under the hospital OPPS
Total	$0.7 billion

C. Effects of ASC Payment System Changes in This Proposed Rule

On August 2, 2007, we published in the **Federal Register** the final rule for the revised ASC payment system, effective January 1, 2008 (72 FR 42470). In that final rule, we adopted the methodologies to set payment rates for covered ASC services to implement the revised payment system so that it would be designed to result in budget neutrality as required by section 626 of Public Law 108–173; established that the OPPS relative payment weights would be the basis for payment and that we would update the system annually as part of the OPPS rulemaking cycle; and provided that the revised ASC payment rates would be phased-in over 4 years. During the 4-year transition to full implementation of the ASC payment rates, payments for surgical procedures performed in ASCs that were on the CY 2007 ASC list of covered surgical procedures were made using a blend of the CY 2007 ASC payment rate and the ASC payment rate calculated according to the ASC standard ratesetting methodology for the applicable transitional year. In CY 2009, we paid ASCs using a 50/50 blend, in which payment was calculated by adding 50 percent of the CY 2007 ASC rate for a surgical procedure on the CY 2007 ASC list of covered surgical procedures and 50 percent of the CY 2009 ASC rate calculated according to the ASC standard ratesetting methodology for the same procedure. For CY 2010, we transitioned the blend to a 25/75 blend of the CY 2007 ASC rate and the CY 2010 ASC payment rate calculated according to the ASC standard ratesetting methodology. Beginning in CY 2011, we would pay ASCs for all covered surgical procedures, including those on the CY 2007 ASC list, at the ASC payment rates calculated according to the ASC standard ratesetting methodology.

ASC payment rates are calculated by multiplying the ASC conversion factor by the ASC relative payment weight. As discussed fully in section XV. of this proposed rule, we set the proposed CY 2011 ASC relative payment weights by scaling CY 2011 ASC relative payment weights by the ASC scalar of 0.9090. The estimated effects of the updated relative payment weights on payment rates during this first year of full implementation of the ASC payment rates calculated according to the ASC standard ratesetting methodology are varied and are reflected in the estimated payments displayed in Tables 57 and 58 below.

Beginning in CY 2011, section 3401 of the Affordable Care Act requires that the annual update to the ASC payment system, which is the consumer price index for all urban consumers (CPI–U), be reduced by the productivity adjustment. The Affordable Care Act defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period). We calculated the CY 2011 ASC conversion factor by adjusting the CY 2010 ASC conversion factor by 1.0006 to account for changes in the pre-floor and pre-reclassified hospital wage indices between CY 2010 and CY 2011 and by applying the CY 2011 MFP-adjusted CPI–U of 0 percent (1.6 percent CPI–U minus 1.6 percent MFP). The proposed CY 2011 ASC conversion factor is $41.898.

1. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen specific options are discussed throughout this proposed rule. Some of the major ASC issues discussed in this proposed rule and the options considered are discussed below.

a. Alternatives Considered for Office-Based Procedures

According to our final policy for the revised ASC payment system, we designate as office-based those procedures that are added to the ASC list of covered surgical procedures in CY 2008 or later years and that we determine are predominantly performed in physicians' offices based on consideration of the most recent available volume and utilization data for each individual procedure HCPCS code and/or, if appropriate, the clinical characteristics, utilization, and volume of related HCPCS codes. We establish payment for procedures designated as office-based at the lesser of the MPFS nonfacility practice expense payment amount or the ASC rate developed according to the standard methodology of the revised ASC payment system.

In developing this proposed rule, we reviewed the full CY 2009 utilization data for all surgical procedures added to the ASC list of covered surgical procedures in CY 2008 or later years and for those procedures for which the office-based designation is temporary in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60605 through 60608). Based on that review, and as discussed in section XV.C.1.b. of this proposed rule, we are proposing to newly designate six surgical procedures as permanent office-based (four of which we are also proposing to add to the ASC list of covered surgical procedures for CY 2011) and to make permanent the office-based designations of three existing surgical procedures that have temporary office-based designations in CY 2010. We also are proposing temporary office-based designations for 7 procedures in CY 2011. We considered two alternatives in developing this policy.

The first alternative we considered was to make no change to the procedure payment designations. This would mean that we would pay for the 9 procedures we are proposing to designate as permanently office-based and the 7 procedures we are proposing to designate as temporarily office-based at an ASC payment rate calculated according to the standard ratesetting methodology of the revised ASC payment system. We did not select this alternative because our analysis of the data and our clinical review indicated that all 9 procedures we are proposing to designate as permanently office-based as well as the 7 procedures that we are proposing to designate temporarily as office-based could be considered to be predominantly performed in physicians' offices. Consistent with our final policy adopted in the August 2, 2007 final rule (72 FR 42509 through 42513), we were concerned that making payments at the standard ASC payment rate for the 9 procedures designated as office-based and 7 procedures designated as temporarily office-based could create financial incentives for the procedures to shift from physicians' offices to ASCs for reasons unrelated to clinical decisions regarding the most appropriate setting for surgical care. Further, consistent with our policy, we believe that when adequate data become available to make permanent determinations about procedures with temporary office-based designations, maintaining the temporary designation is no longer appropriate.

The second alternative we considered and the one we are proposing for CY 2011 is to designate six additional procedures as office-based for CY 2011 and to make permanent the office-based designations of three of the procedures with temporary office-based designations in CY 2010. We also are proposing to designate 7 procedures as temporarily office-based in CY 2011. We chose this alternative because our claims data and clinical review indicate that these procedures could be considered to be predominantly performed in physicians' offices. We believe that designating these procedures as office-based, which results in the CY 2010 ASC payment rate for these procedures potentially being capped at the CY 2010 physicians' office rate (that is, the MPFS nonfacility practice expense payment amount), if applicable, is an appropriate step to ensure that Medicare payment policy does not create financial incentives for such procedures to shift unnecessarily from physicians' offices to ASCs, consistent with our final policy adopted in the August 2, 2007 final rule.

b. Alternatives Considered for Covered Surgical Procedures

According to our final policy for the revised ASC payment system, we designate as covered all surgical procedures that we determine would not be expected to pose a significant risk to beneficiary safety or would not be expected to require an overnight stay when performed on Medicare beneficiaries in an ASC.

In developing this proposed rule, we reviewed the clinical characteristics and full CY 2009 utilization data, if applicable, for all procedures reported by Category III CPT codes implemented July 1, 2010, and surgical procedures that were excluded from ASC payment for CY 2010. Based on this review, we identified 8 new surgical procedures described by Category III CPT codes that were new for July 2010 and 5 surgical procedures excluded from ASC payment for CY 2010, that we determined were appropriate for addition to the ASC list of covered surgical procedures. We considered two alternatives in developing this policy.

The first alternative we considered was to make no change to the ASC list of covered surgical procedures for CY 2010. We did not choose this alternative because our analysis of data and clinical review indicated that the 13 procedures we are designating as covered surgical procedures for CY 2011 would not be expected to pose a significant risk to beneficiary safety in ASCs and would not be expected to require an overnight stay. Consistent with our final policy, we were concerned that by continuing to exclude them from the list of ASC covered surgical procedures, we may unnecessarily limit beneficiaries' access to the services in the most clinically appropriate settings.

The second alternative we considered and the one we are proposing for CY 2011 was to designate 13 additional procedures as ASC covered surgical procedures for CY 2011. We chose this alternative because our claims data and clinical review indicate that these procedures would not be expected to

pose a significant risk to beneficiary safety and would not be expected to require an overnight stay, and thus they meet the criteria for inclusion on the list of ASC covered surgical procedures. We believe that adding these procedures to the list of covered surgical procedures is an appropriate step to ensure that beneficiary access to services is not limited unnecessarily.

c. Alternatives Considered for the Extension of Waiver of Deductible to Services Furnished in Connection With or in Relation to a Colorectal Screening Test That Becomes Diagnostic

Section 4104(c)(2) of the Affordable Care Act waives the deductible with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test. We are proposing for CY 2011 that the deductible be waived for all surgical services furnished in an ASC on the same date as a planned screening colonoscopy or planned flexible sigmoidoscopy as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test (we note that barium enemas are not ASC covered ancillary or surgical procedures). As discussed in detail under the alternatives considered for the OPPS (section XXII.B.1.a above), we considered three alternatives for the extension of waiver of deductible to services furnished in connection with or in relation to a colorectal screening test that becomes diagnostic for CY 2011. The first alternative we considered, but are not proposing for the reasons previously discussed, was to define a limited set of colonoscopy codes to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy or screening flexible sigmoidoscopy. The second alternative we considered, but are not proposing for the reasons previously discussed, was to define a broader, but still limited set of codes (for example, selected surgical services) to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy or screening flexible sigmoidoscopy. The third alternative we considered, and the one we are proposing for CY 2011, is to apply the waiver to any surgical procedure on the same date as a screening colonoscopy or flexible sigmoidoscopy performed in an ASC that providers report began as a screening test. As we discuss above, we chose this alternative because we believe it provides the greatest ease of public understanding and provider application. We believe that this alternative is appropriate because we believe that it would be very rare for an unrelated surgery to occur on the same date as one of these scheduled screening tests. Moreover, we believe that the risk of improper expenditures would be very small under this policy because it is the deductible, and not the coinsurance, that is waived for the related procedures other than the screening tests (that is, the Part B deductible is a fixed amount that the beneficiary pays before Medicare begins to pay and typically would be met after receiving one to two services).

2. Limitations of Our Analysis

Presented here are the projected effects of the proposed changes for CY 2011 on Medicare payment to ASCs. A key limitation of our analysis is our inability to predict changes in ASC service mix between CY 2009 and CY 2011 with precision. We believe that the net effect on Medicare expenditures resulting from the proposed CY 2011 changes would be small in the aggregate for all ASCs. However, such changes may have differential effects across surgical specialty groups as ASCs continue to adjust to the payment rates based on the policies of the revised ASC payment system. We are unable to accurately project such changes at a disaggregated level. Clearly, individual ASCs would experience changes in payment that differ from the aggregated estimated impacts presented below.

3. Estimated Effects of This Proposed Rule to ASCs

Some ASCs are multispecialty facilities that perform the gamut of surgical procedures, from excision of lesions to hernia repair to cataract extraction; others focus on a single specialty and perform only a limited range of surgical procedures, such as eye, digestive system, or orthopedic procedures. The combined effect on an individual ASC of the proposed update to the CY 2011 payments would depend on a number of factors, including, but not limited to, the mix of services the ASC provides, the volume of specific services provided by the ASC, the percentage of its patients who are Medicare beneficiaries, and the extent to which an ASC provides different services in the coming year. The following discussion presents tables that display estimates of the impact of the proposed CY 2011 update to the revised ASC payment system on Medicare payments to ASCs, assuming the same mix of services as reflected in our CY 2009 claims data. Table 57 depicts the estimated aggregate percent change in payment by surgical specialty or ancillary items and services group by comparing estimated CY 2010 payments to estimated proposed CY 2011 payments, and Table 58 shows a comparison of estimated CY 2010 payments to estimated proposed CY 2011 payments for procedures that we estimate would receive the most Medicare payment in CY 2011.

Table 57 shows the estimated effects on aggregate proposed Medicare payments under the revised ASC payment system by surgical specialty or ancillary items and services group. We have aggregated the surgical HCPCS codes by specialty group, grouped all HCPCS codes for covered ancillary items and services into a single group, and then estimated the effect on aggregated payment for surgical specialty and ancillary items and services groups. The groups are sorted for display in descending order by estimated Medicare program payment to ASCs. The following is an explanation of the information presented in Table 57.

- Column 1—*Surgical Specialty or Ancillary Items and Services Group* indicates the surgical specialty into which ASC procedures are grouped or the ancillary items and services group which includes all HCPCS codes for covered ancillary items and services. To group surgical procedures by surgical specialty, we used the CPT code range definitions and Level II HCPCS codes and Category III CPT codes, as appropriate, to account for all surgical procedures to which the Medicare program payments are attributed.
- Column 2—*Estimated ASC Payments* were calculated using CY 2009 ASC utilization (the most recent full year of ASC utilization) and CY 2010 ASC payment rates. The surgical specialty and ancillary items and services groups are displayed in descending order based on estimated CY 2010 ASC payments.
- Column 3—*Estimated CY 2011 Percent Change (Fully Implemented Payment Rates)* is the aggregate percentage increase or decrease in Medicare program payment to ASCs for each surgical specialty or ancillary items and services group that would be attributable to proposed updates to ASC payment rates for CY 2011 compared to CY 2010.

As seen in Table 57, we estimate that the proposed update to ASC rates for CY 2011 would result in a 1 percent decrease in aggregate payment amounts for eye and ocular adnexa procedures, a

6 percent decrease in aggregate payment amounts for digestive system procedures, and a 1 percent increase in aggregate payment amounts for nervous system procedures.

Generally, for the surgical specialty groups that account for less ASC utilization and spending, we estimate that the payment effects of the proposed CY 2011 update are positive. We estimate that ASC payments for procedures in those surgical specialties would increase in CY 2011. For instance, we estimate that, in the aggregate, payment for integumentary system procedures would increase by 3 percent under the proposed CY 2011 rates. We estimate similar effects for genitourinary, cardiovascular, musculoskeletal, respiratory, hematologic and lymphatic systems, and auditory system procedures as well.

An estimated increase in aggregate payment for the specialty group does not mean that all procedures in the group would experience increased payment rates. For example, the estimated modest increase for CY 2011 for nervous system procedures is likely due to increase in the ASC payment weight for some of the high volume procedures, such as CPT code 64721 (Neuroplasty and/or transposition; median nerve at carpal tunnel).

Also displayed in Table 57 is a separate estimate of Medicare ASC payments for the group of separately payable covered ancillary items and services. We estimate that aggregate payments for these items and services would decrease by 2 percent for CY 2011. The payment estimates for the covered surgical procedures include the costs of packaged ancillary items and services. In rules for years prior to CY 2010, we did not have ASC payment data for covered ancillary items and services because, prior to CY 2008, they were paid under other fee schedules or packaged into payment for the covered surgical procedures. Beginning with the CY 2010 OPPS/ASC rulemaking, we have utilization data for those services as well as for all of the covered surgical procedures provided in ASCs under the revised payment system.

TABLE 57—ESTIMATED IMPACT OF THE PROPOSED CY 2011 UPDATE TO THE ASC PAYMENT SYSTEM ON AGGREGATE CY 2011 MEDICARE PROGRAM PAYMENTS BY SURGICAL SPECIALTY OR ANCILLARY ITEMS AND SERVICES GROUP

Surgical Specialty Group (1)	Estimated CY 2010 ASC Payments (in Millions) (2)	Estimated CY 2011 Percent Change (Fully Implemented) (3)
Total	3,231	0
Eye and ocular adnexa	1,410	-1
Digestive system	697	-6
Nervous system	386	1
Musculoskeletal system	350	11
Genitourinary system	128	7
Integumentary system	122	3
Respiratory system	36	14
Cardiovascular system	24	4
Ancillary items and services	18	-2
Auditory system	8	9
Hematologic & lymphatic systems	4	15

Table 58 below shows the estimated impact of the proposed updates to the revised ASC payment system on aggregate ASC payments for selected surgical procedures during CY 2011. The table displays 30 of the procedures receiving the greatest estimated CY 2010 aggregate Medicare payments to ASCs. The HCPCS codes are sorted in descending order by estimated CY 2010 program payment.

- Column 1—*HCPCS code.*
- Column 2—*Short Descriptor* of the HCPCS code.
- Column 3—*Estimated CY 2010 Allowed Charges* were calculated using CY 2009 ASC utilization (the most recent full year of ASC utilization) and the CY 2010 ASC payment rates. The estimated CY 2010 allowed charges are expressed in millions of dollars.
- Column 4—*Estimated CY 2010 Percent Change (Fully Implemented Payment Rates)* reflects the percent differences between the estimated ASC payment for CY 2010 and the estimated payment for CY 2011 based on the proposed update.

As displayed in Table 58, 21 of the 30 procedures with the greatest estimated aggregate CY 2010 Medicare payment are included in the 3 surgical specialty groups that are estimated to account for the most Medicare payment to ASCs in CY 2011, specifically eye and ocular adnexa, digestive system, and nervous system surgical groups. Consistent with the estimated payment effects on the surgical specialty groups displayed in Table 57, the estimated effects of the proposed CY 2011 update on ASC payment for individual procedures shown in Table 58 are varied.

The ASC procedure for which the most Medicare payment is estimated to be made in CY 2010 is the cataract removal procedure reported with 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)). We estimate that the proposed update to the ASC rates would result in a 2 percent payment decrease for this procedure in CY 2011. The estimated payment effects on two of the three other eye and ocular adnexa procedures included in Table 58 are more significant. We estimate that the proposed payment rate for CPT code 66821 (Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)) would decrease by 9 percent and payment for CPT code 67904 (Repair eyelid defect) would increase by 9 percent.

We estimate that the proposed payment rates for all of the digestive system procedures included in Table 58 would decrease by 1 to 10 percent in CY 2011. Those estimated decreases are consistent with decreases in the previous 3 years under the revised ASC payment system and are expected because, under the previous ASC payment system, the payment rates for many high volume endoscopy procedures were almost the same as the payments for the procedures under the OPPS.

The estimated effects of the proposed CY 2011 update on the 9 nervous system procedures for which the most Medicare ASC payment is estimated to be made in CY 2010 would be variable. Our estimates indicate that the proposed CY 2011 update would result in payment increases of 2 to 10 percent for 5 of the 9 procedures and result in a 1 percent decrease for the other 4 nervous system procedures. The nervous system procedures for which we estimate a positive effect on CY 2010 payments include CPT codes 64721 (Neuroplasty and/or transposition; median nerve at carpal tunnel) and 64622 (Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level), which are expected to have payment increases of 10 percent and 6 percent, respectively.

The estimated payment effects for most of the remaining procedures listed in Table 58 would be positive. For example, the proposed payment rates for musculoskeletal CPT codes 29880 (Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving)) and 29881 (Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)) would be estimated to increase 10 percent over the CY 2010 transitional payment rates. Musculoskeletal procedures would be expected to account for a greater percentage of CY 2011 Medicare ASC spending as we estimate that payment for procedures in that surgical specialty group would increase under the revised payment system in CY 2011.

BILLING CODE 4120–01–P

TABLE 58.--ESTIMATED IMPACT OF THE PROPOSED UPDATE TO CY 2011 ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR SELECTED PROCEDURES

HCPCS Code*	Short Descriptor	Estimated CY 2010 Allowed Charges (in mil)	Estimated CY 2011 Percent change (fully implemented payment)
(1)	(2)	(3)	(4)
66984	Cataract surg w/iol, 1 stage	1,091	-2%
43239	Upper GI endoscopy, biopsy	162	-8%
45380	Colonoscopy and biopsy	129	-7%
45378	Diagnostic colonoscopy	109	-7%
45385	Lesion removal colonoscopy	88	-7%
66982	Cataract surgery, complex	73	-2%
62311	Inject spine l/s (cd)	66	-1%
66821	After cataract laser surgery	63	-9%
64483	Inj foramen epidural l/s	61	-1%
15823	Revision of upper eyelid	40	-5%
64493	Inj paravert f jnt l/s 1 lev	36	2%
G0105	Colorectal scrn; hi risk ind	32	-10%
63650	Implant neuroelectrodes	30	3%
29881	Knee arthroscopy/surgery	28	10%
45384	Lesion remove colonoscopy	28	-7%
G0121	Colon ca scrn not hi rsk ind	27	-10%
64721	Carpal tunnel surgery	26	10%
29826	Shoulder arthroscopy/surgery	24	16%
43235	Uppr gi endoscopy, diagnosis	24	-1%
29880	Knee arthroscopy/surgery	23	10%
52000	Cystoscopy	21	-7%
63685	Insrt/redo spine n generator	20	5%
29827	Arthroscop rotator cuff repr	20	12%
64622	Destr paravertebrl nerve l/s	17	6%
28285	Repair of hammertoe	17	11%
62310	Inject spine c/t	15	-1%
26055	Incise finger tendon sheath	14	7%
67904	Repair eyelid defect	13	9%
64623	Destr paravertebral n add-on	13	-1%
50590	Fragmenting of kidney stone	13	-4%

*Note that HCPCS codes proposed for deletion for CY 2010 are not displayed in this table.

BILLING CODE 4120–01–C

The previous ASC payment system served as an incentive to ASCs to focus on providing procedures for which they determined Medicare payments would support their continued operation. We note that, historically, the ASC payment rates for many of the most frequently performed procedures in ASCs were similar to the OPPS payment rates for the same procedures. Conversely, procedures with ASC payment rates that were substantially lower than the OPPS rates have historically been performed least often in ASCs. We believed that the revised ASC payment system would encourage greater efficiency in ASCs and would promote significant increases in the breadth of surgical procedures performed in ASCs because it distributes payments across the entire spectrum of covered surgical procedures based on a coherent system of relative weights that are related to the clinical and facility resource requirements of those procedures.

The CY 2009 claims data that we used to develop the proposed CY 2011 ASC payment system relative weights and rates reflect the second year of utilization under the revised payment system. Although the changes in the claims data are not large, the data reflect increased Medicare ASC spending for procedures that were newly added to the ASC list in CY 2008. Our estimates based on CY 2009 data indicate that for CY 2011 there would be especially noticeable increases in spending for respiratory systems, and hematologic and lymphatic systems, compared to the previous ASC payment system.

4. Estimated Effects of This Proposed Rule on Beneficiaries

We estimate that the proposed CY 2011 update to the ASC payment system would be generally positive for beneficiaries with respect to the new procedures that we are adding to the ASC list of covered surgical procedures and for those that we are designating as office-based for CY 2010. First, as discussed in section XV.D.1.d. of this proposed rule, we are proposing to waive either the coinsurance, the Part B deductible, or both for certain preventive services recommended by the USPSTF with a grade of A or B for any indication or population and that are appropriate for the individual to comply with sections 4104 and 10406 of the Affordable Care Act. Other than these services, the ASC coinsurance rate for all procedures is 20 percent. This contrasts with procedures performed in HOPDs, where the beneficiary is responsible for copayments that range from 20 percent to 40 percent of the procedure payment. Second, ASC payment rates under the revised payment system are lower than payment rates for the same procedures under the OPPS; therefore, the beneficiary coinsurance amount under the ASC payment system almost always would be less than the OPPS copayment amount for the same services. (The only exceptions would be if the ASC coinsurance amount exceeds the inpatient deductible. The statute requires that copayment amounts under the OPPS not exceed the inpatient deductible.) For new procedures that we are proposing to add to the ASC list of covered surgical procedures in CY 2011, as well as for procedures already included on the list, and that are furnished in an ASC rather than the HOPD setting, the beneficiary coinsurance amount would be less than the OPPS copayment amount. Furthermore, the proposed additions to the ASC list of covered surgical procedures would provide beneficiaries access to more surgical procedures in ASCs. Beneficiary coinsurance for services migrating from physicians' offices to ASCs may decrease or increase under the revised ASC payment system, depending on the particular service and the relative payment amounts for that service in the physician's office compared to the ASC. However, for those additional procedures that we are proposing to designate as office-based in CY 2011, the beneficiary coinsurance amount would be no greater than the beneficiary coinsurance in the physician's office.

In addition, as finalized in the August 2, 2007 final rule (72 FR 42521), in CY 2011, the final year of the 4-year transition to the ASC payment rates calculated according to the ASC standard ratesetting methodology of the revised ASC payment system, ASC payment rates for a number of commonly furnished ASC procedures would continue to be reduced, resulting in lower beneficiary coinsurance amounts for these ASC services in CY 2011.

5. Conclusion

The proposed updates to the ASC payment system for CY 2011 would affect each of the approximately 5,000 ASCs currently approved for participation in the Medicare program. The effect on an individual ASC would depend on its mix of patients, the proportion of the ASC's patients that are Medicare beneficiaries, the degree to which the payments for the procedures offered by the ASC are changed under the revised payment system, and the extent to which the ASC provides a different set of procedures in the coming year.

The CY 2011 proposed update to the revised ASC payment system includes an MFP-adjusted CPI–U increase factor of 0 percent that we estimate would result in the same amount of Medicare expenditures in CY 2011 than was estimated to be made in CY 2010. We estimate that the proposed update to the revised ASC payment system, including the addition of surgical procedures to the list of covered surgical procedures, would have minimal effect on Medicare expenditures compared to the estimated level of Medicare expenditures in CY 2010.

6. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table 59 below, we have prepared an accounting statement showing the classification of the expenditures associated with the statutorily authorized 0.0 percent update to the CY 2011 revised ASC payment system, based on the provisions of this proposed rule and the baseline spending estimates for ASCs in the FY 2011 President's Budget. This table provides our best estimate of Medicare payments to suppliers as a result of the proposed update to the CY 2011 ASC payment system, as presented in this proposed rule. All expenditures are classified as transfers.

TABLE 59.--ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS FROM CY 2010 TO CY 2011 AS A RESULT OF THE PROPOSED CY 2011 UPDATE TO THE REVISED ASC PAYMENT SYSTEM

Category	Transfers
Annualized Monetized Transfers	$0
From Whom to Whom	Federal Government to Medicare Providers and Suppliers
Total	$0

D. Effects of Proposed Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update

In section XVI. of the CY 2009 OPPS/ASC final rule with comment period (73 FR 68758), we discussed our requirements for subsection (d) hospitals to report quality data under the HOP QDRP in order to receive the full payment update for CY 2010. In section XVI. of this proposed rule, we proposed additional policies affecting the HOP QDRP for CY 2012, CY 2013, and CY 2014. We estimate that about 90 hospitals may not receive the full payment update in CY 2011. Most of these hospitals receive little to no OPPS reimbursement on an annual basis. However, at this time, information is not available to determine the precise number of hospitals that do not meet the requirements for the full hospital market basket increase for CY 2011. We also estimate that 90 hospitals may not

receive the full payment update in CY 2012. We are unable at this time to estimate the number of hospitals that may not receive the full payment update in CY 2013 and CY 2014.

In section XVI.E.3.a. of the CY 2010 OPPS/ASC final rule with comment period, for the CY 2011 payment update, as part of the validation process, we are requiring hospitals to submit paper copies of requested medical records to a designated contractor within the required timeframe. Failure to submit requested documentation can result in a 2 percentage point reduction in a hospital's update, but the failure to attain a validation score threshold would not. Of the 90 hospitals that we estimate would not receive the full payment update for CY 2011, we estimate that no more than 20 hospitals would fail the validation documentation submission requirement for the CY 2011 payment update.

In section XVI.E.3.b. of the CY 2010 OPPS/ASC final rule with comment period, we did not, at that time, adopt our proposal in the CY 2010 OPPS/ASC proposed rule (74 FR 35403) to expand the CY 2011 validation requirement for the CY 2012 payment update. Instead, we stated that we would consider the public comments we received on that proposal, as well as any analyses we conduct of the CY 2011 validation process, and propose a CY 2012 validation process as a part of the CY 2011 OPPS/ASC rulemaking. We believe that this approach would give HOP QDRP hospitals experience with the validation process and allow these hospitals sufficient time to prepare for the CY 2012 validation.

In this proposed rule, we are proposing to validate data submitted by 800 hospitals for purposes of the CY 2012 HOP QDRP payment determination. For CY 2011 and under our proposal for CY 2012 in this proposed rule, we stated that we would calculate the validation matches for CY 2011 (we note, however, that the validation results would not affect the CY 2011 payment update) and CY 2012 by assessing whether the measure data submitted by the hospital matches the independently reabstracted measure data. In addition, for the CY 2012 payment update in this proposed rule, we are proposing to validate data for only 800 hospitals out of the approximately 3,200 HOP QDRP participating hospitals. We believe that this approach is suitable for HOP QDRP data because it will: Produce a more reliable estimate of whether a hospital's submitted data have been abstracted accurately; provide more statistically reliable estimates of the quality of care delivered in each selected hospital as well as at the national level; and reduce overall hospital burden because most hospitals will not be selected to undergo validation each year. We have proposed a threshold of 75 percent as the threshold for the validation score because we believe this level is reasonable for hospitals to achieve while still ensuring accuracy of the data. Additionally, this level is consistent with what has been proposed in the RHQDAPU program (75 FR 23993). As a result, we believe that the effect of our proposed validation process for CY 2012 would be minimal in terms of the number of hospitals that would not meet all program requirements.

The validation requirement of a maximum of 12 cases per hospital per quarter will result in medical record documentation for approximately 9,600 cases per quarter being submitted to a designated CMS contractor. We would pay for the cost of sending this medical record documentation to the designated CMS contractor at the rate of 12 cents per page for copying and approximately $1.00 per case for postage. We have found, based on experience that an outpatient medical chart is up to 10 pages. Thus, as a result of validation requirements effective for the CY 2012 annual payment update, we would have expenditures of approximately $21,120 per quarter. Again, as we would pay for the data collection effort, we believe that a requirement for medical record documentation for a maximum of 12 cases per quarter for 800 hospitals represents a minimal burden to HOP QDRP-participating hospitals.

E. Effects of Proposed Changes in Payments to Hospitals for Direct GME and IME Costs

1. Redistribution of Residency Slots

As discussed in section XVII. of this proposed rule, section 5503 of the Affordable Care Act added a new section 1886(h)(8) to the Act that provides for reductions in the statutory FTE resident caps under Medicare for certain hospitals and authorizes a "redistribution" of the FTE resident slots resulting from the reduction in the FTE resident caps to other hospitals.

At this time, we are unable to project how many FTE resident slots will be available for redistribution under section 5503 of the Affordable Care Act. Unlike section 422 of the Medicare Modernization Act, which also provided for a redistribution of FTE resident slots but provided that the redistributed slots would be paid using the national average per resident amount (PRA) for direct GME payment purposes, section 5503 of the Affordable Care Act requires that hospitals be paid for their additional FTE resident slots using the hospitals' specific PRAs. Since we are unable to determine the number of FTE resident slots that will be redistributed under section 5503 or which hospitals will be receiving additional FTE resident slots, we cannot calculate a direct GME impact for section 5503. We do not know the PRAs and Medicare utilization rates of hospitals that will be receiving additional FTE resident slots. For purposes of determining an impact for IME payment purposes, section 5503 requires us to use an IME multiplier of 1.35, however, we do not know the intern and resident to bed ratio for the hospitals that will receive additional FTE resident slots or the volume or case mix of Medicare discharges at those hospitals. Therefore, we cannot determine a financial impact for purposes of direct GME and IME for this provision.

2. Counting Resident Time in Nonprovider Settings

In section XVII. of this proposed rule, we discuss our proposed implementation of several changes made by section 5504 of the Affordable Care Act with regard to counting resident time in nonprovider settings for GME and IME payment purposes. Specifically, section 5504 eliminates the requirement for hospitals to incur "all or substantially all of the costs for the training program in the nonhospital setting," and now hospitals must only incur the costs of the salaries and fringe benefits of residents who train in nonhospital sites It also allows more than one hospital to incur the costs of training programs at nonhospital settings, either directly or through a third party. In addition, section 5504 creates a recordkeeping requirement for hospitals to track the time residents spend training in nonhospital settings, which CMS must compare to analogous data from a base year.

With respect to the recordkeeping requirement, we are proposing that rotation schedules be the source for establishing the amount of time that residents spend training in nonhospital sites, both in the base year and in subsequent years. In addition, we are proposing that cost reporting periods beginning on or after July 1, 2009 and before June 30, 2010 be the base year against which we will compare subsequent years' data to determine if the amount of nonhospital training that occurs in subsequent years increases relative to that base year. We also are proposing that hospitals only need to maintain records of the direct GME FTE

count of resident training time in nonhospital settings. Finally, we are proposing to include several additional lines on the Medicare cost report for hospitals to submit these data. Hospitals would be required to report these data on a program-specific basis for their primary care programs, and on an overall hospital basis for their nonprimary care programs. These data will help CMS identify whether barriers to resident training in nonhospital sites continue to exist.

We do not believe that any of these proposed policies will have a significant financial impact on the Medicare program. While these policies may allow hospitals to count additional FTEs training in nonhospital sites, we do not believe that this constitutes significant financial impact on the Medicare program, since those residents would have been training at the hospital if they were not training at the nonhospital site. We note that the FTE slot redistribution discussed above that is required by section 5503 of the Affordable Care Act may have an impact on the hospitals' ability to increase the number of residents training at nonhospital sites, unless it moves the training that is currently conducted at the hospital to a nonhospital site. Therefore, the financial impact of section 5504 will be minimal.

3. Counting Resident Time for Didactic and Scholarly Activities and Other Activities

In section XVII. of this proposed rule, we discuss our proposals to implement the provisions of section 5505 of the Affordable Care Act that make several changes to existing CMS policy with respect to counting resident training time for didactic, scholarly and other activities. Specifically, section 5505(a) allows a hospital to count the time that residents spend training in an approved program in a "nonprovider setting that is primarily engaged in furnishing patient care" for direct GME purposes. Section 5505(b) allows nonpatient care activities to count toward resident time for IME purposes as well, but only in certain hospital settings. These nonpatient care activities do not include research activities that are not associated with the treatment or diagnosis of a particular patient. Section 5505 also allows hospitals to count the time spent by residents on vacation, sick leave, or other approved leave in the hospitals' direct GME and IME resident counts, as long as the leave time does not prolong the total time that the resident is participating in the approved training program. In our discussion of the provisions of section 5505, we described the definitions of the various new terms used in this section of the Affordable Care Act.

We do not believe that any of the proposed policies to implement section 5505 will have a significant financial impact on the Medicare program. While all of these provisions allow teaching hospitals to claim more resident training time on their respective cost reports, a hospital is limited as to how many resident FTEs it can count. In addition, we note that the FTE slot redistribution that is required by section 5503 of the Affordable Care Act discussed earlier may impact hospitals' ability to increase the number of residents training at nonhospital sites, unless a hospital moves the training that is currently conducted at the hospital to a nonhospital site. Therefore, the financial impact of section 5505 is minimal.

4. Preservation of Resident Cap Positions From Closed Hospitals

In section XVII.C. of this proposed rule, we discuss our proposals to implement section 5506 of the Affordable Care Act. Prior to the passage of the Affordable Care Act, if a teaching hospital closed, its direct GME and IME FTE resident cap slots would be "lost," because those slots are associated with a specific hospital's Medicare provider agreement. Section 5506 of the Affordable Care Act addresses this situation by instructing the Secretary to establish a process by regulation that would redistribute slots from teaching hospitals that close to hospitals that meet certain criteria.

Section 5506 applies to teaching hospitals that closed "on or after a date that is 2 years before the date of enactment," that is, March 23, 2008. Accordingly, although section 5506 does address certain teaching hospital closures that have already occurred, the focus of this provision is primarily on future teaching hospital closures, and ensuring that FTE resident cap slots are not lost to a community. We are unable to project which teaching hospitals will close, how many FTE resident slots they have, and to which hospitals those slots would be ultimately redistributed. Therefore, we cannot determine a financial impact for this provision.

F. Effects of Proposed Changes to Physician Self-Referral Regulations and Related Proposed Changes to Provider Agreement Regulations

Most physicians who have ownership or investment interests in hospitals ("physician-owned hospitals") and who refer DHS to the hospital, are subject to the physician self-referral prohibition, and are unable to qualify for the ownership and investment exception at section 1877(d)(1) of the Act. Section 1877(d)(1) of the Act provides an exception for ownership or investment in publicly traded securities in a corporation where there is stockholder equity exceeding $75 million at the end of the corporation's most recent fiscal year or on average during the previous 3 fiscal years; or the ownership or investment interest involves mutual funds in a company that has assets greater than $75 million. Studies by the OIG and GAO have concluded that physician-owned hospitals tend to be smaller and are unable to meet the $75 million threshold. Therefore, most physician-owned hospitals avail themselves of the rural provider or hospital ownership exceptions (sections 1877(d)(2) and (d)(3) of the Act, respectively). As discussed in section XVIII. of this proposed rule, section 6001 of the Affordable Care Act amended section 1877 of the Act to impose additional requirements in order to qualify for the rural provider and hospital ownership or investment exceptions. Our proposals under section XVIII. of this proposed rule would incorporate these requirements into our regulations.

Our proposed revisions to the regulations would limit the creation of new Medicare participating hospitals in which physician owners or investors intend to refer patients for DHS by requiring such hospitals to have physician ownership and a provider agreement in effect on December 31, 2010, as provided for by section 6001 of the Affordable Care Act. This proposed revision would affect facilities with physician ownership or investment that are currently under development but may be unable to have a provider agreement in effect on December 31, 2010. We believe there would only be a few facilities or hospital projects under development that would be unable to meet either of these criteria.

In addition to the effect on the creation of new physician-owned hospitals, the proposed revision of the regulations to incorporate the provisions of section 6001 of the Affordable Care Act would impact existing physician-owned hospitals that currently avail themselves of the rural provider or whole hospital exception. Specifically, a physician-owned hospital would be prohibited from expanding the number of beds, operating rooms, and procedure rooms beyond those for which it was licensed as of March 23, 2010, or, in the case of a hospital that did not have a provider agreement in effect as of this date but does have a provider agreement

in effect on December 31, 2010, the effective date of the provider agreement. We believe there are only a few hospitals that were in the midst of an expansion that was not completed by March 23, 2010 (or, in the case of a hospital that did not have a provider agreement in effect as this date but does have a provider agreement in effect on December 31, 2010), and thus, may not be able to use the new beds, operating rooms, and procedures rooms. We believe that most facilities and their investors were aware of the possible legislation that would limit facility expansion and, thus, did not continue to pursue expansion of their facilities.

Our proposed regulations would require hospitals to have procedures in place that require referring physicians to disclose to patients the referring physicians' ownership or investment interests in the hospital, as well as any ownership or investment interest in the hospital held by a treating physician. This proposal also would require hospitals to disclose on any public Web site for the hospital or in any public advertising that it is owned or invested in by physicians. Finally, under the proposed revision of the regulations, a hospital would not condition any physician ownership or investment either directly or indirectly on the physician making or influencing referrals to the hospital or otherwise generating business for the hospital. Most physician-owned hospitals comply with the current provisions of § 489.20(u). Thus, they have procedures in place to require referring physician owners or investors to disclose their ownership or investment interests to patients. We believe most physicians and hospitals will be minimally affected by the additional requirements.

Our proposed revisions to the regulations would require that hospitals must ensure that all ownership and investment interests are *bona fide,* a step that we believe most prudent hospitals are already undertaking. We believe most of the new statutory and proposed regulatory provisions would have little, if any, impact on physician-owned hospitals or physicians. The only provision that may have a minor impact is the provision found under section 1877(i)(1)(D)(*i*) of the Act and proposed § 411.362(b)(4)(i) that prohibits physician-owned hospitals from increasing the percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital by physician owners or investments beyond that which existed on March 23, 2010. Therefore, hospitals and other entities that own the hospital must monitor the percentages of ownership or investment to ensure that the percentage is not increased. We believe this proposal would have a minor effect on some hospitals and their physician owners or investors.

Our proposed revisions to the regulations also would require hospitals to take certain steps to ensure patient safety, most of which are practices or procedures that we believe most hospitals currently undertake. Building upon the safety requirements found in existing § 489.20(w), we are proposing to require under proposed §§ 411.362(b)(5)(i) and 489.20(w)(2) that, before admitting a patient, the hospitals must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during the time services are furnished to a patient. In addition, proposed §§ 411.362(b)(5)(ii) and 489.20(w)(1) would require hospitals to have the capacity to provide assessment and initial treatment for patients and the ability to refer and transfer patients to hospitals with the capability to treat the needs of the patient involved. We believe requesting a signed acknowledgment would impose a minimal burden on hospitals. Also, most hospitals currently have in place procedures to ensure that they have the capacity to provide assessment and initial treatment for patients and the ability to refer and transfer patients.

Lastly, our proposed revisions to the regulations would prohibit a facility that was previously an ASC and was converted into a hospital from qualifying for the rural provider or whole hospital ownership exceptions to the self-referral prohibition. Although we have no direct data on this point, we believe there are only a few ASCs that are being converted to a hospital, and, thus, the effect is minimal.

We believe that our proposals in XVIII. of this proposed rule would affect a relatively small number of physician-owned hospitals and physicians. We are uncertain of the exact numbers of hospitals with physician ownership or investment that would be impacted by the proposals and their restrictions. However, the most recent studies by CMS (August 8, 2006 Final Report to the Congress Required under Section 5006 of the Deficit Reduction Act of 2005) and MedPAC (June 2005 Report to the Congress) concluded that there were approximately 128 physician-owned specialty hospitals (those that focus primarily on patients with a cardiac condition, orthopedic condition, or those receiving a surgical procedure). We recognize that there are other hospitals with physician ownership that do not meet the definition of a specialty hospital but we do not have verifiable data on the number of these facilities. However, we have recently received information from a trade association representing physician-owned hospitals that there are approximately 265 hospitals that would be subject to the provisions of our proposed rule.

The proposed changes concerning disclosure of physician ownership in hospitals and patient safety are consistent with the physician self-referral statute and regulations, our existing regulations governing basic commitments of providers, and the current practices of most hospitals. Thus, our proposed requirements would present a negligible impact on physician-owned hospitals. Physician-owned hospitals would have a one-time cost associated with creating or modifying a notice to be used when a physician is not on the premises 24 hours a day. In addition, these hospitals would incur the costs associated with ensuring that a signed acknowledgment is received from patients. Similarly, the costs borne by individual physicians to implement the provisions would be limited to a one-time cost associated with developing a disclosure notice that discloses the ownership of the referring and, where applicable, the treating physician.

Overall, we believe that beneficiaries would be positively impacted by these proposed provisions. Specifically, additional information concerning disclosures of ownership and patient safety measures equip patients to make informed decisions about where they elect to receive care. Our proposals make no significant changes that have the potential to impede patient access to health care facilities and services. We believe that our proposals are necessary to conform our regulations to the amendments to section 1877 of the Act. We also believe the proposed regulations would help minimize anticompetitive behavior that can affect the decision as to where a beneficiary receives health care services and would possibly enhance the quality of the services furnished.

G. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the OMB.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Physician referral, Reporting and recordkeeping requirements.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 416

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 482

Grant programs—health, Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For reasons stated in the preamble of this document, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR Chapter IV as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for Part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 410.2 is amended by—

a. Under the definition of "Community mental health center (CMHC)", removing the word "and" at the end of paragraph (4); removing the period at the end of paragraph (5) and adding in its place "; and"; and adding a new paragraph (6).

b. Revising the definition of "Partial hospitalization services".

The additions and revisions read as follows:

§ 410.2 Definitions.

* * * * *

Community mental health center (CMHC) means an entity that—

* * * * *

(6) Provides at least 40 percent of its services to individuals who are not eligible for benefits under title XVIII of the Social Security Act.

* * * * *

Partial hospitalization services means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting and furnishes the services as described in § 410.43.

* * * * *

3. Section 410.27 is amended by—

a. Removing the word "and" at the end of paragraph (a)(1)(iii).

b. Adding a new paragraph (a)(1)(v).

c. Adding a new paragraph (a)(2).

d. Revising paragraph (b).

The addition and revisions read as follows:

§ 410.27 Outpatient hospital or CAH services and supplies incident to a physician or nonphysician practitioner service: Conditions.

(a) * * *

(1) * * *

(v) Certain nonsurgical extended duration therapeutic services that are designated by CMS as requiring direct supervision, as defined in (a)(1)(iv) of this section, by a physician or nonphysician practitioner only at the initiation of the service, after which general supervision, as defined in § 410.32(b)(3)(i), is required.

(A) Nonsurgical extended duration therapeutic services are services that can last a significant period of time, have a substantial monitoring component, and have a low risk of requiring the physician's or appropriate nonphysician practitioner's physical presence to furnish assistance and direction after the initiation of the service.

(B) Initiation of the service means the beginning portion of a service ending when the patient is stable and the supervising physician or appropriate nonphysician practitioner believes the remainder of the service can safely be delivered under his or her general direction and control without needing the supervising physician's or appropriate nonphysician practitioner's physical presence on the hospital campus or in the provider-based department of the hospital.

(2) In the case of partial hospitalization services, also meet the conditions of paragraph (d) of this section.

(b) Drugs and biologicals also are subject to the limitations specified in § 410.29.

* * * * *

4. Section 410.152 is amended by revising paragraph (i)(2) to read as follows:

§ 410.152 Amounts of payment.

* * * * *

(i) * * *

(2) For ASC services furnished on or after January 1, 2008, in connection with the covered surgical procedures specified in § 416.166 of this subchapter, except as provided in paragraphs (i)(2)(i), (i)(2)(ii), and (l) of this section, Medicare Part B pays the lesser of 80 percent of the actual charge or 80 percent of the prospective payment amount, geographically adjusted, if applicable, as determined under Subpart F of Part 416 of this subchapter. Part B coinsurance is 20 percent of the actual charge or 20 percent of the prospective payment amount, geographically adjusted, if applicable.

(i) If the limitation described in § 416.167(b)(3) of this subchapter applies, Medicare pays 80 percent of the amount determined under Subpart B of Part 414 of this subchapter and Part B coinsurance is 20 percent of the applicable payment amount, except as provided in paragraph (l) of this section.

(ii) Between January 1, 2008 and December 31, 2010, Medicare Part B pays 75 percent of the applicable payment amount for screening flexible sigmoidoscopies and screening colonoscopies, and Part B coinsurance is 25 percent of the applicable payment amount.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

5. The authority citation for Part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh and 1395nn).

6. Section 411.356 is amended by—

a. Republishing the introductory text of paragraph (c) and revising paragraph (c)(1).

b. Removing the word "and" at the end of paragraph (c)(3)(ii).

c. Removing the period at the end of paragraph (c)(3)(iii) and adding "; and" in its place.

d. Adding a new paragraph (c)(3)(iv).

The revision and addition read as follows:

§ 411.356 Exceptions to the referral prohibition related to ownership or investment interests.

* * * * *

(c) *Specific providers.* Ownership or investment in the following entities, for purposes of the services specified:

(1) A rural provider, in the case of DHS furnished in a rural area (as defined at § 411.351 of this subpart) by the provider. A "rural provider" is an entity that furnishes substantially all (not less than 75 percent) of the DHS that it furnishes to residents of a rural area and, for the 18-month period beginning on December 8, 2003 (or such other period as Congress may specify), is not a specialty hospital, and in the case where the entity is a hospital, the hospital meets the requirements of § 411.362 no later than September 23, 2011.

* * * * *

(3) * * *

(iv) The hospital meets the requirements described in § 411.362 not later than September 23, 2011.

7. A new § 411.362 is added to read as follows:

§ 411.362 Additional requirements concerning physician ownership and investment in hospitals.

(a) *Definitions.* For purposes of this section—

Physician owner or investor means a physician (or immediate family member of the physician) with a direct or an indirect ownership or investment interest in the hospital.

Procedure room means a room in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include an emergency room or department (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

(b) *General requirements.* (1) *Physician ownership and provider agreement.* The hospital had physician ownership or investment on December 31, 2010; and a provider agreement under section 1866 of the Act in effect on that date.

(2) *Prohibition on facility expansion.* The hospital may not increase the number of operating rooms, procedure rooms, and beds beyond that for which the hospital is licensed on March 23, 2010 (or, in the case of a hospital that did not have a provider agreement in effect as of this date, but does have a provider agreement in effect on December 31, 2010, the effective date of such agreement), unless an exception is granted by the Secretary pursuant to section 1877(i)(3) of the Social Security Act.

(3) *Disclosure of conflicts of interest.*

(i) [Reserved].

(ii) The hospital must—

(A) Require each referring physician owner or investor who is a member of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to provide written disclosure of his or her ownership or investment interest in the hospital (and, if applicable, the ownership or investment interest of any treating physician) to all patients whom the physician refers to the hospital. Disclosure must be required at the time the referral is made.

(B) Not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

(C) Disclose on any public Web site for the hospital or in any public advertising that the hospital is owned or invested in by physicians.

(4) *Ensuring bona fide investment.* The hospital satisfies the following criteria:

(i) The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of March 23, 2010.

(ii) Any ownership or investment interests that the hospital offers to a physician owner or investor are not offered on more favorable terms than the terms offered to a person who is not a physician owner or investor.

(iii) The hospital (or any owner or investor in the hospital) does not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor.

(iv) The hospital (or any owner or investor in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

(v) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor.

(5) *Patient safety.* The hospital satisfies the following criteria:

(i) If the hospital does not have a physician available on the premises to provide services during all hours in which the hospital is providing services to the patient, the hospital must disclose this information to the patient. Before providing services to the patient, the hospital must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during all hours services are furnished to the patient.

(ii) The hospital must have the capacity to provide assessment and initial treatment for all patients, and the ability to refer and transfer patients to hospitals with the capability to treat the needs of the patient that the hospital is unable to address. For purposes of this paragraph, the hospital inpatient stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or an outpatient service.

(6) *Prohibition on conversion from an ambulatory surgery center.* The hospital must not have been converted from an ambulatory surgical center to a hospital on or after March 23, 2010.

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

8. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), and sec. 124 of Pub. L. 106–113 (113 Stat. 1501A–332).

9. Section 412.105 is amended—

a. Revising paragraph (f)(1)(ii).

b. Revising paragraph (f)(1)(iii)(C).

c. Adding a new paragraph (f)(1)(iii)(D).

d. Revising paragraph (f)(1)(iv)(B).

e. Revising paragraph (f)(1)(iv)(C).

f. Revising paragraph (f)(1)(ix).

The revisions and addition read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(f) * * *

(1) * * *

(ii) In order to be counted, the resident must be assigned to one of the following areas:

(A) The portion of the hospital subject to the hospital inpatient prospective payment system.

(B) The outpatient department of a hospital that meets provider-based status as defined at § 413.65(a)(2) of this subchapter.

(C) The portions of a hospital located in Puerto Rico that are subject to the hospital inpatient prospective payment system, including off-campus outpatient departments that meet provider-based status as defined at § 413.65(a)(2) of this subchapter.

(D) The portions of a hospital that are reimbursed under a reimbursement system authorized under section 1814(b)(3) of the Act.

(E) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities, as defined in § 413.75(b) of this subchapter, under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth in § 413.78(c), (d), (e), (f), or (g) of this subchapter, as applicable, are met.

(iii) * * *

(C) Effective for cost reporting periods beginning on or after January 1, 1983, except for research activities described in paragraph (f)(1)(iii)(B) of this section, the time a resident is training in an approved medical residency program in a hospital setting, as described in paragraphs (f)(1)(ii)(A) through (f)(1)(ii)(D) of this section, must be spent in either patient care activities, as defined in § 413.75(b) of this subchapter, or in nonpatient care activities, such as didactic conferences and seminars, to be counted. This provision may not be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which, as of March 23, 2010, there is a pending, jurisdictionally proper appeal on direct GME or IME payments.

(D) Effective for cost reporting periods beginning on or after January 1, 1983, the time spent by a resident in an approved medical residency program on vacation, sick leave, or other approved leave that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program is countable. This provision may not be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which, as of March 23, 2010, there is a pending, jurisdictionally proper appeal on direct GME or IME payments.

(iv) * * *

(B)(1) Effective for portions of cost reporting periods beginning on or after July 1, 2005, a hospital's otherwise applicable FTE resident cap may be reduced if its reference resident level, as determined under § 413.79(c)(1)(ii)(A) of this subchapter, is less than its otherwise applicable FTE resident cap in a reference cost reporting period, in accordance with the provisions of § 413.79(c)(3) of this subchapter. The reduction is 75 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level.

(2) Effective for portions of cost reporting periods beginning on or after July 1, 2011, a hospital's otherwise applicable FTE resident cap may be reduced if its reference resident level, as determined under § 413.79(c)(1)(ii)(B) of this subchapter, is less than its otherwise applicable FTE resident cap in a reference cost reporting period, in accordance with the provisions of § 413.79(m) of this subchapter. The reduction shall take into account the hospital's FTE resident cap as reduced under paragraph (f)(1)(E)(iv)(B)(1). The reduction is 65 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level.

(C)(1) Effective for portions of cost reporting periods beginning on or after July 1, 2005, a hospital may qualify to receive an increase in its otherwise applicable FTE resident cap (up to 25 additional FTEs) if the criteria specified in § 413.79(c)(4) of this subchapter are met.

(2) Effective for portions of cost reporting periods beginning on or after July 1, 2011, a hospital may qualify to receive an increase in its otherwise applicable FTE resident cap (up to 75 additional FTEs) if the criteria specified in § 413.79(n) of this subchapter are met. The increase shall be made to the hospital's FTE resident cap as reduced under paragraph (f)(1)(E)(iv)(B)(1).

* * * * *

(ix)(A) A hospital may receive a temporary adjustment to its FTE resident cap to reflect residents added because of another hospital's closure if the hospitals meets the criteria specified in §§ 413.79(h)(1) and (h)(2) of this subchapter. If a hospital that closes its residency training program agrees to temporarily reduce its FTE resident cap according to the criteria specified in §§ 413.79(h)(1) and (h)(3)(ii) of this subchapter, another hospital(s) may receive a temporary adjustment to its FTE resident cap to reflect residents added because of the closure of the residency training program if the criteria specified in §§ 413.79(h)(1) and (h)(3)(i) of this subchapter are met.

(B) A hospital may receive a permanent adjustment to its FTE resident cap as a result of slots that were redistributed from a closed hospital, as defined at § 413.79(h)(1)(i) of this subchapter, if the hospital meets the requirements at § 413.79(o) of this subchapter.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

10. The authority citation for Part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Pub. L. 106–133 (113 Stat. 1501A–332).

11. Section 413.75(b) is amended by—

a. Revising paragraph (2) under the definition of "All or substantially all of the costs for the training program in the nonhospital setting".

b. Adding a definition of "Nonprovider setting that is primarily engaged in furnishing patient care".

The revision and addition read as follows:

§ 413.75 Direct GME payments: General requirements.

* * * * *

(b) * * *

All or substantially all of the costs for the training program in the nonhospital setting means—

* * * * *

(2) Effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010, at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to nonpatient care direct GME activities.

* * * * *

Nonprovider setting that is primarily engaged in furnishing patient care

means a nonprovider setting in which the primary activity is the care and treatment of patients.

* * * * *

12. Section 413.78 is amended by—

a. Revising the introductory text of paragraph (f).

b. Revising paragraph (f)(1).

c. Adding a new paragraph (g).

d. Adding a new paragraph (h).

The revisions and additions read as follows:

§ 413.78 Direct GME payments: Determination of the total number of FTE residents.

* * * * *

(f) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time in patient care activities, except that for cost reporting periods beginning on or after July 1, 2009, the time spent training in nonpatient care activities, such as didactic conferences and seminars, but excluding research not associated with the treatment or diagnosis of a particular patient, in a nonprovider setting that is primarily engaged in furnishing patient care activities, as defined at § 413.75(b), also may be counted.

* * * * *

(g) For cost reporting periods beginning on or after July 1, 2010, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time—

(i) In patient care activities, or,

(ii) In nonpatient care activities, such as didactic conferences and seminars, but excluding research not associated with the treatment or diagnosis of a particular patient, in a nonprovider setting that is primarily engaged in furnishing patient care activities, as defined at § 413.75(b).

(2) The hospital or hospitals must incur the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting.

(i) If more than one hospital incurs these costs, either directly or through a third party, the hospitals must count a proportional share of the time that residents train at the nonhospital setting(s) as recorded in a written agreement between the hospitals.

(ii) Hospitals must have a reasonable basis for establishing that proportion of the cost and the FTE time that each will incur and count.

(iii) If hospitals already arrange payment to the nonhospital site via a written agreement as described in § 413.78(g)(3)(ii), the proportion may be recorded in that agreement.

(iv) If hospitals choose to pay the nonhospital site concurrently as described in § 413.78(g)(4)(i), the hospitals must record the proportion of cost and FTE time they are incurring and counting in a written agreement between the hospitals.

(3) For cost reporting periods beginning prior to July 1, 2010, the hospitals must comply with one of the following:

(i) The hospital or hospitals must pay for all or substantially all of the costs for the training program in a nonhospital setting(s) attributable to training that occurs during a month by the end of the third month following the month in which the training in the nonhospital site occurred.

(ii) There is a written agreement between the hospital or hospitals and the outside entity that states that the residents' salaries and fringe benefits (including travel and lodging where applicable) during the time the resident spends in the nonhospital setting is to be paid by the hospital(s). Hospitals may modify the amounts specified in the written agreement by the end of the academic year (that is, June 30) to reflect that the costs of the training program in the nonhospital site have been incurred.

(iii) If the hospital has in place an emergency Medicare GME affiliation agreement in accordance with § 413.79(f)(6), during the period covered by the emergency Medicare GME affiliation agreement—

(A) The hospital must pay all or substantially all of the costs of the training program in a nonhospital setting(s) attributable to training that occurs during a month by the end of the sixth month after the month in which the training in the nonhospital site occurs. For the costs that would otherwise be required to be incurred by the hospital during the period of August 29, 2005 through November 1, 2007, the participating hospital must incur the costs by April 29, 2008; or

(B) There is a written agreement between the hospital and the outside entity that states that the residents' salaries and fringe benefits (including travel and lodging where applicable) during the time the resident spends in the nonhospital setting is to be paid by the hospital. The written agreement must be submitted to the contractor by 180 days after the training at the nonhospital site begins. Hospitals may modify the amounts specified in the written agreement by the end of the academic year (that is, June 30) to reflect that the costs of the training program in the nonhospital site have been incurred. For written agreements that would otherwise be required to be submitted prior to the date the training begins in the nonhospital site during the period of August 29, 2005 through November 1, 2007, the hospital must submit the written agreement to its contractor by April 29, 2008.

(4) For cost reporting periods beginning on or after July 1, 2010, the hospitals must comply with one of the following:

(i) The hospital or hospitals must incur the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting by the end of the third month following the month in which the training in the nonhospital site occurred.

(ii) There is a written agreement between the hospital or hospitals and the outside entity that states that the residents' salaries and fringe benefits (including travel and lodging where applicable) during the time the resident spends in the nonhospital setting is to be paid by the hospital(s). Hospitals may modify the amounts specified in the written agreement by the end of the academic year (that is, June 30) to reflect that the costs of the training program in the nonhospital site have been incurred.

(5) The hospital is subject to the principles of community support and redistribution of costs as specified in § 413.81.

(6) For cost reporting periods beginning on or after July 1, 2010, a hospital must maintain and make available records of the FTE count determined for direct GME purposes under this section that its residents spend in nonprovider sites, in order to compare that time to the time spent by its residents in nonprovider sites in the base year July 1, 2009 through June 30, 2010. The hospital must supply the CMS contractor with the data for each of its primary care programs on a program-specific basis, and with data for its nonprimary care programs on an overall basis.

(h) Effective for cost reporting periods beginning on or after January 1, 1983,

the time spent by a resident in an approved medical residency program on vacation, sick leave, or other approved leave that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program is countable. This provision cannot be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which there is a pending, jurisdictionally proper appeal on direct GME or IME payments as of March 23, 2010.

13. Section 413.79 is amended by—

a. Revising paragraph (c)(1)(ii).

b. Revising the introductory text of paragraph (c)(2).

c. Revising paragraph (c)(2)(iv).

d. Revising the heading of paragraph (c)(3).

e. Revising the heading of paragraph (c)(4).

f. Revising the heading of paragraph (c)(5).

g. Adding a new paragraph (m).

h. Adding a new paragraph (n).

i. Adding a new paragraph (o).

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

* * * * *

(c) * * *

(1) * * *

(ii)(A) For purposes of paragraph (c)(3) of this section, *reference resident level* refers to a hospital's resident level in the applicable reference period specified under paragraph (c)(3) of this section.

(B) For purposes of paragraph (m) of this section, *reference resident level* means with respect to a hospital, the highest resident level for any of the three most recent cost reporting periods ending before March 23, 2010, for which a cost report has been either settled or submitted (subject to audit).

* * * * *

(2) *Determination of the FTE resident cap.* Subject to the provisions of paragraphs (c)(3) through (c)(6) and (m) through (o) of this section and § 413.81, for purposes of determining direct GME payment—

* * * * *

(iv) Hospitals that are part of the same Medicare GME affiliated group or the same emergency Medicare GME affiliated group (as described under § 413.75(b)) may elect to apply the limit on an aggregate basis as described under paragraph (f) of this section.

* * * * *

(3) *Determination of the reduction to the FTE resident cap due to unused FTE resident slots under section 422 of Public Law 108–173.* * * *

(4) *Determination of an increase in the otherwise applicable resident cap under section 422 of Public Law 108–173.* * * *

(5) *Special rules for hospitals that participate in demonstration projects or voluntary resident reduction plans for purposes of section 422 of Public Law 108–173.* * * *

* * * * *

(m) *Determination of the reduction to the FTE resident cap due to unused FTE resident slots under section 5503 of Public Law 111–148.* If a hospital's reference resident level, as defined under paragraph (c)(1)(ii)(B) of this section is less than its otherwise applicable FTE resident cap as determined under paragraph (c)(2) of this section or paragraph (e) of this section in the reference cost reporting period (as described under paragraph (m)(5) of this section), for portions of cost reporting periods beginning on or after July 1, 2011, the hospital's otherwise applicable FTE resident cap is reduced by 65 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level. The reduction shall take into account the hospital's FTE resident cap as reduced under paragraph (c)(3) of this section. Under this provision—

(1) *Exemption for certain rural hospitals.* A rural hospital, as defined at subpart D of paragraph 412 of this subchapter, with fewer than 250 beds (as determined at § 412.105(b)) in its most recent cost reporting period ending on or before March 23, 2010, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(2) *Exemption for certain hospitals that participate in demonstration projects or voluntary residency reduction plans.* A hospital that was participating in a demonstration project under section 402 of Public Law 90–248 or the voluntary reduction plan under § 413.88, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section if by December 1, 2010, it submits a plan to CMS for filling all of its unused FTE resident slots by not later than March 23, 2012.

(3) *Exemption for a hospital described at section 1886(h)(4)(H)(v) of the Act.* A hospital described at section 1886(h)(4)(H)(v) of the Act, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(4) *Exemptions for certain other hospitals.* A hospital training at or above its otherwise applicable FTE resident cap as determined under paragraph (c)(2) of this section for all three most recent cost reporting periods ending prior to March 23, 2010 (as described under section (iv) of this paragraph), is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(5) *Reference cost reporting period.* (i) To determine a hospital's reference resident level, CMS determines, for a hospital's three most recent cost reporting periods ending before March 23, 2010, the cost reporting period with the highest resident level, for which a cost report has been settled or if the cost report has not been settled, the as-submitted cost report (subject to audit).

(ii) If the cost report that is used to determine a hospital's otherwise applicable FTE resident cap in the reference period is not equal to 12 months, the Medicare contractor may make appropriate modifications to apply the provisions of paragraph (m) of this section based on the equivalent of a 12-month cost reporting period.

(iii) If a hospital is a member of a Medicare GME affiliated group during its reference cost reporting period, and its reference resident level is less than its otherwise applicable FTE resident cap as adjusted by the terms of the Medicare GME affiliation agreement, the hospital's FTE resident cap will be reduced as described under paragraph (m) of this section.

(n) *Determination of an increase in the otherwise applicable resident cap under section 5503 of Public Law 111–148.* (1) For portions of cost reporting periods beginning on or after July 1, 2011, a hospital may receive an increase in its otherwise applicable FTE resident cap (as determined by CMS) up to an additional 75 FTEs if the hospital meets the requirements and qualifying criteria of section 1886(h)(8) of the Act and implementing instructions issued by CMS and if the hospital submits an application to CMS within the timeframe specified by CMS.

(2) A hospital that receives an increase in the otherwise applicable resident cap under paragraph (n)(1) of this section must ensure, during the 5-year period beginning on July 1, 2011 and ending on June 30, 2016, that—

(i) The number of FTE primary care residents, as defined in § 413.75(b), excluding any additional positions under this paragraph, is not less than the average number of FTE primary care residents (as so determined) during the three most recent cost reporting periods ending prior to March 23, 2010; and not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency programs.

(ii) CMS may determine whether a hospital has met the requirements under paragraph (n)(1) of this section during the 5-year period of July 1, 2011 through June 30, 2016 in such manner and at such time as CMS determines appropriate, including at the end of such 5-year period.

(iii) In a case where the Medicare contractor determines that a hospital did not meet the requirements in a cost reporting period within the 5-year time period, the Medicare contractor will reduce the otherwise applicable resident cap of the hospital by the amount by which such limit was increased under paragraph (n)(1) of this section.

(o) *Determination of an increase in the FTE resident cap due to slots redistributed from a closed hospital.* (1) Except in the case of the closure of the hospital with Medicare Provider Number 05–0578, in the instance of a hospital closure, as defined at (h)(1)(i) of this section, the FTE resident cap of the closed hospital would be redistributed, and a hospital that meets the requirements and qualifying criteria of section 1886(h)(4)(H)(vi) of the Act and implementing instructions issued by CMS, including submission of a timely application to CMS, may receive an increase in its FTE resident cap, as determined by CMS.

(2)(i) Except in the case of the closure of the hospital with Medicare Provider Number 05–0578, in redistributing the FTE resident cap of a closed hospital, consideration shall be given to ensure that there is no duplication of FTE slots between FTE slots redistributed under this paragraph and temporary adjustments to FTE resident caps provider under paragraph (h)(2) of this section.

(ii) The provisions of this paragraph (o) will not be applied in a manner that will require the reopening of settled cost reports, except where the provider has a pending, jurisdictionally proper appeal on direct GME or IME payments as of March 23, 2010.

PART 416—AMBULATORY SURGICAL SERVICES

14. 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).

15. Section 416.160 is amended by—

a. Revising paragraph (a)(1).

b. Revising paragraph (a)(4).

c. Adding a new paragraph (a)(5).

The revisions and addition read as follows:

§ 416.160 Basis and scope.

(a) * * *

(1) Section 1833(i)(2)(D) of the Act requires the Secretary to implement a revised payment system for payment of surgical services furnished in ASCs. The statute requires that, in the year such system is implemented, the system shall be designed to result in the same amount of aggregate expenditures for such services as would be made if there was no requirement for a revised payment system. The revised payment system shall be implemented no earlier than January 1, 2006, and no later than January 1, 2008. The statute also requires that, for CY 2011 and each subsequent year, any annual update to the ASC payment system be reduced by a productivity adjustment. There shall be no administrative or judicial review under section 1869 of the Act, section 1878 of the Act, or otherwise of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, of the revised payment system.

* * * * *

(4) Section 1834(d) of the Act specifies that, when screening colonoscopies or screening flexible sigmoidoscopies are performed in an ASC or hospital outpatient department, payment shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area. Section 1834(d) of the Act also specifies that, in the case of screening flexible sigmoidoscopy and screening colonoscopy services, the payment amounts must not exceed the payment rates established for the related diagnostic services.

(5) Section 1833(a)(1) of the Act requires 100 percent payment for preventive services described in section 1861(ww)(2) of the Act (excluding electrocardiograms) to which the United States Preventive Services Task Force (USPSTF) has given a grade of A or B for any indication or population. Section 1833(b)(1) of the Act also specifies that the Part B deductible shall not apply with respect to preventive services described in section 1861(ww)(2) of the Act (excluding electrocardiograms) to which the USPSTF has given a grade of A or B for any indication or population.

* * * * *

16. Section 416.171 is amended by adding a new paragraph (a)(2)(iii) to read as follows:

§ 416.171 Determination of payment rates for ASC services.

(a) * * *

(2) * * *

(iii) *Productivity adjustment.*

(A) For calendar year 2011 and subsequent years, the Consumer Price Index for All Urban Consumers determined in paragraph (a)(2)(ii) of this section is reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

(B) The application of the provisions of paragraph (a)(2)(iii)(A) of this section may result in the update being less than 0.0 for a year, and may result in payment rates for a year being less than the payment rates for the preceding year.

* * * * *

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, 1395(t), and 1395hh).

18. Section 419.21 is amended by—

a. Redesignating paragraph (e) as paragraph (e)(1).

b. Revising the newly redesignated paragraph (e)(1).

c. Adding a new paragraph (e)(2).

The revision and addition read as follows:

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

* * * * *

(e)(1) Effective January 1, 2005 through December 31, 2008, an initial preventive physical examination, as defined in § 410.16 of this chapter, if the examination is performed no later than 6 months after the individual's initial Part B coverage date that begins on or after January 1, 2005.

(2) Effective January 1, 2009, an initial preventive physical examination, as defined in § 410.16 of this chapter, if the examination is performed no later than 12 months after the date of the individual's initial enrollment in Part B.

19. Section 419.22 is amended by—

a. Revising paragraph (m).

b. Adding a new paragraph (t).

The revision and addition read as follows:

§ 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

* * * * *

(m)(1) Services provided on or before December 31, 2010, for patients with

ESRD that are paid under the ESRD composite rate and drugs and supplies furnished during dialysis but not included in the composite rate.

(2) Renal dialysis services provided on or after January 1, 2011, for patients with ESRD that are paid under the ESRD benefit, as described in Subpart H of Part 413 of this chapter.

* * * * *

(t) Effective January 1, 2011, annual wellness visit providing personalized prevention plan services as defined in § 410.15 of this chapter.

20. Section 419.32 is amended by revising paragraph (b)(1)(iv) to read as follows:

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

* * * * *

(b) * * *

(1) * * *

(iv)(A) For calendar year 2003 and subsequent years, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act.

(B) The percentage increase determined under paragraph (b)(1)(iv)(A) of this section is reduced by the following for the specific calendar year:

(*i*) For calendar year 2010, 0.25 percentage point; and

(*ii*) For calendar year 2011, 0.25 percentage point.

* * * * *

21. Section 419.43 is amended by—

a. Revising paragraph (c).

b. Adding a new paragraph (i).

The revision and addition read as follows:

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

* * * * *

(c) *Wage index factor.*—(1) CMS uses the hospital inpatient prospective payment system wage index established in accordance with Part 412 of this chapter to make the adjustment specified under paragraph (a) of this section.

(2) For services furnished beginning January 1, 2011, the wage index factor provided for in paragraph (c)(1) of this section applicable to any hospital outpatient department that is located in a frontier State, as defined in § 412.64(m) of this chapter, may not be less than 1.00.

(3) The additional payments made under the provisions of paragraph (c)(2) of this section are not implemented in a budget neutral manner.

* * * * *

(i) *Payment adjustment for certain cancer hospitals.*—(1) *General rule.* CMS provides for an additional payment for covered hospital outpatient services furnished on or after January 1, 2011, by cancer hospitals described in section 1886(d)(1)(B)(v) of the Act.

(2) *Amount of adjustment.* The amount of the additional payment under paragraph (i)(1) of this section is determined by CMS and is based on the difference between costs incurred by hospitals described in section 1886(d)(1)(B)(v) of the Act and costs incurred by other hospitals that are paid under the hospital outpatient prospective payment system, including the costs of drugs and biologicals.

(3) *Budget neutrality.* CMS establishes the payment adjustment under paragraph (i)(2) of this section in a budget neutral manner, excluding services and groups specified in paragraph (i)(4) of this section.

(4) *Excluded services and groups.* The following services or groups are excluded from qualification for the payment adjustment in paragraph (i)(2) of this section:

(i) Devices paid under 419.66; and

(ii) Items and services paid at charges adjusted to cost by application of a hospital specific cost-to-charge ratio.

22. Section 419.70 is amended by—

a. Revising the introductory text of paragraph (d)(2).

b. Adding a new paragraph (d)(6).

The revision and addition read as follows:

§ 419.70 Transitional adjustments to limit decline in payments.

* * * * *

(d) * * *

(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, 2010, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part 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, 2009, and 2010, if the hospital—

* * * * *

(6) *Temporary treatment for sole community hospitals on or after January 1, 2010 and through December 31, 2010.* For covered hospital outpatient services furnished on or after January 1, 2010 through December 31, 2010, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by 85 percent of that difference if the hospital is a sole community hospital as defined in § 412.92 of this chapter or is an essential access community hospital as described under § 412.109 of this chapter.

* * * * *

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

23. The authority citation for Part 482 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

24. Section 482.12 is amended by adding a new paragraph (g) to read as follows:

§ 482.12 Condition of participation: Governing body.

* * * * *

(g) *Standard: Inpatient rights.* A hospital must have the capacity to provide assessment and initial treatment for all patients and the ability to refer and transfer patients to hospitals with capabilities to treat the needs of the patient that the hospital is unable to address.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

25. The authority citation for Part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

26. Section 489.20 is amended by—

a. Republishing the introductory text of paragraph (u).

b. Revising paragraph (u)(1).

c. Revising paragraph (u)(2).

d. Adding a new paragraph (u)(3).

e. Revising paragraph (w).

The revisions and addition read as follows:

§ 489.20 Basic commitments.

* * * * *

(u) Except as provided in paragraph (v) of this section, in the case of a physician-owned hospital as defined at § 489.3—

(1)(i) To furnish written notice to each patient at the beginning of the patient's hospital stay or outpatient visit that the hospital is a physician-owned hospital, in order to assist the patient in making an informed decision regarding his or her care, in accordance with § 482.13(b)(2) of this subchapter. The notice should disclose, in a manner reasonably designed to be understood by all patients, the fact that the hospital meets the Federal definition of a

physician-owned hospital specified in § 489.3 and that the list of the hospital's owners or investors who are physicians or immediate family members (as defined at § 411.351 of this chapter) of physicians is available upon request and must be provided to the patient at the time the request for the list is made by or on behalf of the patient. For purposes of this paragraph (u)(1), the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or an outpatient service; and

(ii) To disclose on any public Web site for the hospital and in any public advertising that the hospital is owned or invested in by physicians.

(2) To require each physician who is a member of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients the physician refers to the hospital any ownership or investment interest in the hospital that is held by the physician or by an immediate family member (as defined at § 411.351 of this chapter) of the physician, and any ownership or investment interest in the hospital by the patient's treating physician(s). Disclosure must be required at the time the referral is made.

(3) To ensure that the hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

* * * * *

(w)(1) In the case of a hospital as defined in § 489.24(b), to furnish written notice to all patients at the beginning of their hospital stay or outpatient visit if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week, in order to assist the patients in making informed decisions regarding their care, in accordance with § 482.13(b)(2) of this subchapter. The notice must indicate how the hospital will meet the medical needs of any patient who develops an emergency medical condition, as defined in § 489.24(b), at a time when there is no physician present in the hospital. For purposes of this paragraph, the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or outpatient service.

(2) Before admitting a patient or providing an outpatient service, the hospital must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during all hours services are furnished to the patient.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; Program No. 93.774, Medicare—Supplementary Medical Insurance Program; andProgram No. 93.778 (Medical Assistance)

Dated: June 24, 2010.

Marilyn Tavenner,

Acting Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services.

Dated: June 30, 2010

Kathleen Sebelius,

Secretary.

BILLING CODE 4120–01–P

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001	Level I Photochemotherapy	S	0.5422	$37.01	.	$7.41
0002	Fine Needle Biopsy/Aspiration	T	1.7752	$121.19	.	$24.24
0003	Bone Marrow Biopsy/Aspiration	T	3.6353	$248.17	.	$49.64
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	4.6624	$318.29	.	$63.66
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	8.1600	$557.06	.	$111.42
0006	Level I Incision & Drainage	T	1.4939	$101.98	.	$20.40
0007	Level II Incision & Drainage	T	13.3268	$909.78	.	$181.96
0008	Level III Incision and Drainage	T	20.2481	$1,382.28	.	$276.46
0012	Level I Debridement & Destruction	T	0.4253	$29.03	.	$5.81
0013	Level II Debridement & Destruction	T	0.8782	$59.95	.	$11.99
0015	Level III Debridement & Destruction	T	1.5303	$104.47	.	$20.90
0016	Level IV Debridement & Destruction	T	2.8176	$192.35	.	$38.47
0017	Level V Debridement & Destruction	T	21.8217	$1,489.70	.	$297.94
0019	Level I Excision/ Biopsy	T	4.9184	$335.76	.	$67.16
0020	Level II Excision/ Biopsy	T	8.7772	$599.19	.	$119.84
0021	Level III Excision/ Biopsy	T	18.2223	$1,243.98	.	$248.80
0022	Level IV Excision/ Biopsy	T	24.1269	$1,647.07	$354.45	$329.42
0028	Level I Breast Surgery	T	25.7651	$1,758.91	.	$351.79
0029	Level II Breast Surgery	T	34.3618	$2,345.78	$581.52	$469.16
0030	Level III Breast Surgery	T	45.1924	$3,085.15	$747.07	$617.03
0031	Smoking Cessation Services	X	0.3066	$20.93	.	$4.19
0034	Mental Health Services Composite	S	3.3838	$231.00	.	$46.20
0035	Vascular Puncture and Minor Diagnostic Procedures	X	0.2446	$16.70	.	$3.34
0037	Level IV Needle Biopsy/Aspiration Except Bone Marrow	T	15.7640	$1,076.16	$228.76	$215.24
0039	Level I Implantation of Neurostimulator Generator	S	210.3341	$14,358.88	.	$2,871.78
0040	Percutaneous Implantation of Neurostimulator Electrodes	S	65.4002	$4,464.68	.	$892.94
0041	Level I Arthroscopy	T	30.3175	$2,069.68	.	$413.94
0042	Level II Arthroscopy	T	48.2063	$3,290.90	$804.74	$658.18
0045	Bone/Joint Manipulation Under Anesthesia	T	15.5647	$1,062.56	$268.44	$212.52
0047	Arthroplasty without Prosthesis	T	39.0731	$2,667.40	$534.09	$533.48
0048	Level I Arthroplasty or Implantation with Prosthesis	T	60.2668	$4,114.23	.	$822.85
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	23.2249	$1,585.49	.	$317.10
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	32.4253	$2,213.58	.	$442.72

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	47.3761	$3,234.22	.	$646.85
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	88.5249	$6,043.33	.	$1,208.67
0053	Level I Hand Musculoskeletal Procedures	T	17.3655	$1,185.49	$253.49	$237.10
0054	Level II Hand Musculoskeletal Procedures	T	29.8184	$2,035.61	.	$407.13
0055	Level I Foot Musculoskeletal Procedures	T	22.6974	$1,549.48	$355.34	$309.90
0056	Level II Foot Musculoskeletal Procedures	T	55.5064	$3,789.26	.	$757.86
0057	Bunion Procedures	T	33.3853	$2,279.11	$475.91	$455.83
0058	Level I Strapping and Cast Application	S	1.1409	$77.89	.	$15.58
0060	Manipulation Therapy	S	0.3636	$24.82	.	$4.97
0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	S	88.8954	$6,068.62	.	$1,213.73
0062	Level I Treatment Fracture/Dislocation	T	26.6924	$1,822.21	$372.87	$364.45
0063	Level II Treatment Fracture/Dislocation	T	48.0827	$3,282.46	.	$656.50
0064	Level III Treatment Fracture/Dislocation	T	66.5750	$4,544.88	.	$908.98
0065	Level I Stereotactic Radiosurgery, MRgFUS, and MEG	S	13.7821	$940.86	.	$188.18
0066	Level II Stereotactic Radiosurgery, MRgFUS, and MEG	S	36.8580	$2,516.19	.	$503.24
0067	Level III Stereotactic Radiosurgery, MRgFUS, and MEG	S	50.0116	$3,414.14	.	$682.83
0069	Thoracoscopy	T	35.4455	$2,419.76	$591.64	$483.96
0070	Thoracentesis/Lavage Procedures	T	5.6491	$385.65	.	$77.13
0071	Level I Endoscopy Upper Airway	T	0.9225	$62.98	.	$12.60
0072	Level II Endoscopy Upper Airway	T	1.8778	$128.19	.	$25.64
0073	Level III Endoscopy Upper Airway	T	4.0416	$275.91	$64.31	$55.19
0074	Level IV Endoscopy Upper Airway	T	21.9959	$1,501.59	.	$300.32
0075	Level V Endoscopy Upper Airway	T	31.4168	$2,144.73	$445.92	$428.95
0076	Level I Endoscopy Lower Airway	T	10.5445	$719.84	$189.82	$143.97
0077	Level I Pulmonary Treatment	S	0.4180	$28.54	$7.74	$5.71
0078	Level III Pulmonary Treatment	S	1.4237	$97.19	.	$19.44
0079	Ventilation Initiation and Management	S	2.8784	$196.50	.	$39.30
0080	Diagnostic Cardiac Catheterization	T	39.8374	$2,719.58	$838.92	$543.92
0082	Coronary or Non-Coronary Atherectomy	T	97.8929	$6,682.85	.	$1,336.57
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty	T	52.1947	$3,563.18	.	$712.64
0084	Level I Electrophysiologic Procedures	S	10.1429	$692.43	.	$138.49
0085	Level II Electrophysiologic Procedures	T	53.4167	$3,646.60	.	$729.32
0086	Level III Electrophysiologic Procedures	T	116.6136	$7,960.86	.	$1,592.18
0088	Thrombectomy	T	41.8116	$2,854.35	$655.22	$570.87
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	112.4202	$7,674.59	$1,615.11	$1,534.92

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	92.6057	$6,321.91	$1,530.07	$1,264.39
0091	Level II Vascular Ligation	T	44.4254	$3,032.79	.	$606.56
0092	Level I Vascular Ligation	T	27.5456	$1,880.46	.	$376.10
0093	Vascular Reconstruction/Fistula Repair without Device	T	36.5266	$2,493.56	.	$498.72
0094	Level I Resuscitation and Cardioversion	S	2.4281	$165.76	$46.29	$33.16
0095	Cardiac Rehabilitation	S	0.5678	$38.76	$13.86	$7.76
0096	Level II Noninvasive Physiologic Studies	S	1.5710	$107.25	$37.13	$21.45
0097	Level I Noninvasive Physiologic Studies	S	0.9646	$65.85	$23.66	$13.17
0099	Electrocardiograms/Cardiography	S	0.3998	$27.29	.	$5.46
0100	Cardiac Stress Tests	X	2.6301	$179.55	$41.44	$35.91
0101	Tilt Table Evaluation	S	4.3590	$297.58	$100.24	$59.52
0102	Level II Pulmonary Treatment	S	0.9754	$66.59	.	$13.32
0103	Miscellaneous Vascular Procedures	T	19.1796	$1,309.33	.	$261.87
0104	Transcatheter Placement of Intracoronary Stents	T	81.9089	$5,591.67	.	$1,118.34
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices	T	23.2281	$1,585.71	.	$317.15
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	T	52.6182	$3,592.09	.	$718.42
0107	Insertion of Cardioverter-Defibrillator	T	335.0724	$22,874.39	.	$4,574.88
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	389.7128	$26,604.52	.	$5,320.91
0110	Transfusion	S	3.4107	$232.84	.	$46.57
0111	Blood Product Exchange	S	12.5247	$855.02	$198.40	$171.01
0112	Apheresis and Stem Cell Procedures	S	33.8904	$2,313.60	.	$462.72
0113	Excision Lymphatic System	T	25.2939	$1,726.74	.	$345.35
0114	Thyroid/Lymphadenectomy Procedures	T	50.9844	$3,480.55	.	$696.11
0115	Cannula/Access Device Procedures	T	33.3074	$2,273.80	.	$454.76
0121	Level I Tube or Catheter Changes or Repositioning	T	6.3264	$431.88	.	$86.38
0126	Level I Urinary and Procedures	T	1.0983	$74.98	$16.21	$15.00
0127	Level IV Stereotactic Radiosurgery, MRgFUS, and MEG	S	105.7702	$7,220.61	.	$1,444.13
0128	Echocardiogram with Contrast	S	7.1663	$489.22	$162.90	$97.85
0129	Level I Closed Treatment Fracture Finger/Toe/Trunk	T	1.6325	$111.45	.	$22.29
0130	Level I Laparoscopy	T	38.7195	$2,643.26	$659.53	$528.66
0131	Level II Laparoscopy	T	48.0382	$3,279.42	$1,001.89	$655.89
0132	Level III Laparoscopy	T	71.1086	$4,854.37	$1,226.23	$970.88
0133	Level I Skin Repair	T	1.3598	$92.83	$25.67	$18.57
0134	Level II Skin Repair	T	3.1890	$217.70	.	$43.54

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0135	Level III Skin Repair	T	4.6616	$318.23	.	$63.65
0136	Level IV Skin Repair	T	17.1353	$1,169.78	.	$233.96
0137	Level V Skin Repair	T	22.1186	$1,509.97	.	$302.00
0138	Level II Closed Treatment Fracture Finger/Toe/Trunk	T	5.2593	$359.04	.	$71.81
0139	Level III Closed Treatment Fracture Finger/Toe/Trunk	T	20.9892	$1,432.87	.	$286.58
0140	Esophageal Dilation without Endoscopy	T	6.4279	$438.81	.	$87.77
0141	Level I Upper GI Procedures	T	8.8811	$606.29	$143.38	$121.26
0142	Small Intestine Endoscopy	T	10.1443	$692.52	$152.78	$138.51
0143	Lower GI Endoscopy	T	9.3206	$636.29	$186.06	$127.26
0146	Level I Sigmoidoscopy and Anoscopy	T	5.7839	$394.85	.	$78.97
0147	Level II Sigmoidoscopy and Anoscopy	T	9.5024	$648.70	.	$129.74
0148	Level I Anal/Rectal Procedures	T	6.2678	$427.88	.	$85.58
0149	Level III Anal/Rectal Procedures	T	24.5978	$1,679.22	.	$335.85
0150	Level IV Anal/Rectal Procedures	T	32.6184	$2,226.76	.	$445.36
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	23.0632	$1,574.46	.	$314.90
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	32.3789	$2,210.41	.	$442.09
0153	Peritoneal and Abdominal Procedures	T	26.2068	$1,789.06	$368.04	$357.82
0154	Hernia/Hydrocele Procedures	T	33.3680	$2,277.93	$464.85	$455.59
0155	Level II Anal/Rectal Procedures	T	16.1014	$1,099.19	.	$219.84
0156	Level III Urinary and Anal Procedures	T	3.0859	$210.67	.	$42.14
0157	Colorectal Cancer Screening: Barium Enema	S	1.3220	$90.25	.	$18.05
0158	Colorectal Cancer Screening: Colonoscopy	T	8.2505	$563.24		
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	5.1653	$352.62		
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	7.2012	$491.60	.	$98.32
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	17.7215	$1,209.79	.	$241.96
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	26.4198	$1,803.60	.	$360.72
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	37.4369	$2,555.70	.	$511.14
0164	Level II Urinary and Anal Procedures	T	2.0672	$141.12	.	$28.23
0165	Level IV Urinary and Anal Procedures	T	20.5471	$1,402.69	.	$280.54
0166	Level I Urethral Procedures	T	21.3781	$1,459.42	.	$291.89
0168	Level II Urethral Procedures	T	32.3809	$2,210.55	.	$442.11
0169	Lithotripsy	T	41.7267	$2,848.56	$997.74	$569.72
0170	Dialysis	S	7.0059	$478.27	.	$95.66
0172	Level I Partial Hospitalization (3 services) for CMHCs	P	1.6977	$115.90	.	$23.18

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	P	1.7718	$120.96	.	$24.20
0174	Level IV Laparoscopy	T	112.2008	$7,659.61	$2,064.24	$1,531.93
0175	Level I Partial Hospitalization (3 services) for Hospital-based PHPs	P	2.6497	$180.89	.	$36.18
0176	Level II Partial Hospitalization (4 or more services) for Hospital-based PHPs	P	3.3838	$231.00	.	$46.20
0181	Level II Male Genital Procedures	T	36.4186	$2,486.19	$620.84	$497.24
0183	Level I Male Genital Procedures	T	23.7895	$1,624.04	.	$324.81
0184	Prostate Biopsy	T	13.3380	$910.55	.	$182.11
0188	Level II Female Reproductive Proc	T	1.5975	$109.06	.	$21.82
0189	Level III Female Reproductive Proc	T	3.5572	$242.84	.	$48.57
0190	Level I Hysteroscopy	T	23.1990	$1,583.73	$424.28	$316.75
0191	Level I Female Reproductive Proc	T	0.1514	$10.34	$2.08	$2.07
0192	Level IV Female Reproductive Proc	T	6.7542	$461.09	.	$92.22
0193	Level V Female Reproductive Proc	T	20.7158	$1,414.21	.	$282.85
0195	Level VI Female Reproductive Procedures	T	35.7350	$2,439.52	.	$487.91
0202	Level VII Female Reproductive Procedures	T	45.2093	$3,086.30	$981.50	$617.26
0203	Level IV Nerve Injections	T	13.3062	$908.37	$225.43	$181.68
0204	Level I Nerve Injections	T	2.6660	$182.00	$40.13	$36.40
0206	Level II Nerve Injections	T	3.8796	$264.85	.	$52.97
0207	Level III Nerve Injections	T	7.7204	$527.05	.	$105.41
0208	Laminotomies and Laminectomies	T	51.7137	$3,530.34	.	$706.07
0209	Level II Extended EEG, Sleep, and Cardiovascular Studies	S	11.4620	$782.48	$268.73	$156.50
0213	Level I Extended EEG, Sleep, and Cardiovascular Studies	S	2.4455	$166.95	$53.58	$33.39
0215	Level I Nerve and Muscle Tests	S	0.6295	$42.97	.	$8.60
0216	Level III Nerve and Muscle Tests	S	2.7192	$185.63	.	$37.13
0218	Level II Nerve and Muscle Tests	S	1.1923	$81.39	.	$16.28
0220	Level I Nerve Procedures	T	19.3535	$1,321.21	.	$264.25
0221	Level II Nerve Procedures	T	37.5345	$2,562.37	.	$512.48
0224	Implantation of Catheter/Reservoir/Shunt	T	41.9698	$2,865.15	.	$573.03
0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	S	212.7796	$14,525.82	.	$2,905.17
0227	Implantation of Drug Infusion Device	T	194.6115	$13,285.54	.	$2,657.11
0229	Transcatherter Placement of Intravascular Shunts	T	96.8443	$6,611.27	.	$1,322.26
0230	Level I Eye Tests & Treatments	S	0.5913	$40.37	.	$8.08
0231	Level III Eye Tests & Treatments	S	2.2924	$156.50	.	$31.30
0232	Level I Anterior Segment Eye Procedures	T	2.4827	$169.49	$40.82	$33.90
0233	Level III Anterior Segment Eye Procedures	T	17.0898	$1,166.67	$263.12	$233.34
0234	Level IV Anterior Segment Eye Procedures	T	24.5236	$1,674.15	$511.31	$334.83

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0235	Level I Posterior Segment Eye Procedures	T	5.2921	$361.28	.	$72.26
0237	Level II Posterior Segment Eye Procedures	T	23.2772	$1,589.06	.	$317.82
0238	Level I Repair and Plastic Eye Procedures	T	3.1607	$215.77	.	$43.16
0239	Level II Repair and Plastic Eye Procedures	T	7.7830	$531.32	.	$106.27
0240	Level III Repair and Plastic Eye Procedures	T	19.9889	$1,364.58	$296.20	$272.92
0241	Level IV Repair and Plastic Eye Procedures	T	26.8719	$1,834.46	$383.45	$366.90
0242	Level V Repair and Plastic Eye Procedures	T	39.3413	$2,685.71	$597.36	$537.15
0243	Strabismus/Muscle Procedures	T	25.3150	$1,728.18	$416.98	$345.64
0244	Corneal and Amniotic Membrane Transplant	T	39.0380	$2,665.01	$803.26	$533.01
0245	Level I Cataract Procedures without IOL Insert	T	14.3198	$977.57	$196.91	$195.52
0246	Cataract Procedures with IOL Insert	T	24.7788	$1,691.57	$495.96	$338.32
0247	Laser Eye Procedures	T	5.5659	$379.97	$104.31	$76.00
0249	Level II Cataract Procedures without IOL Insert	T	31.0191	$2,117.58	$516.99	$423.52
0250	Level I ENT Procedures	T	1.1743	$80.17	$25.10	$16.04
0251	Level II ENT Procedures	T	3.4369	$234.63	.	$46.93
0252	Level III ENT Procedures	T	7.8743	$537.55	$109.16	$107.51
0253	Level IV ENT Procedures	T	17.4151	$1,188.88	$282.29	$237.78
0254	Level V ENT Procedures	T	25.5397	$1,743.52	.	$348.71
0255	Level II Anterior Segment Eye Procedures	T	7.8769	$537.73	$129.50	$107.55
0256	Level VI ENT Procedures	T	44.8441	$3,061.37	.	$612.28
0259	Level VII ENT Procedures	T	454.7997	$31,047.81	$8,543.66	$6,209.57
0260	Level I Plain Film Except Teeth	X	0.6683	$45.62	.	$9.13
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.1314	$77.24	.	$15.45
0262	Plain Film of Teeth	X	0.4853	$33.13	.	$6.63
0263	Level I Miscellaneous Radiology Procedures	X	3.3875	$231.25	.	$46.25
0265	Level I Diagnostic and Screening Ultrasound	S	0.9262	$63.23	$22.28	$12.65
0266	Level II Diagnostic and Screening Ultrasound	S	1.4262	$97.36	$37.53	$19.48
0267	Level III Diagnostic and Screening Ultrasound	S	2.2748	$155.29	$60.50	$31.06
0269	Level II Echocardiogram Without Contrast	S	5.7019	$389.25	.	$77.85
0270	Level III Echocardiogram Without Contrast	S	8.1944	$559.41	$132.96	$111.89
0272	Fluoroscopy	X	1.2472	$85.14	$31.07	$17.03
0274	Myelography	S	7.4103	$505.88	.	$101.18
0275	Arthrography	S	4.0041	$273.35	$68.90	$54.67
0276	Level I Digestive Radiology	S	1.2890	$88.00	$34.66	$17.60
0277	Level II Digestive Radiology	S	2.0916	$142.79	$53.90	$28.56
0278	Diagnostic Urography	S	2.5910	$176.88	$58.44	$35.38
0279	Level II Angiography and Venography	S	29.7399	$2,030.25	.	$406.05
0280	Level III Angiography and Venography	S	48.7134	$3,325.52	.	$665.11
0282	Miscellaneous Computed Axial Tomography	S	1.7637	$120.40	$37.80	$24.08

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0283	Computed Tomography with Contrast	S	4.4120	$301.19	$96.62	$60.24
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast	S	6.4555	$440.70	$146.85	$88.14
0288	Bone Density:Axial Skeleton	S	1.0562	$72.10	$28.51	$14.42
0293	Level VI Anterior Segment Eye Procedures	T	113.4961	$7,748.04	.	$1,549.61
0299	Hyperthermia and Radiation Treatment Procedures	S	5.7142	$390.09	.	$78.02
0300	Level I Radiation Therapy	S	1.4418	$98.43	.	$19.69
0301	Level II Radiation Therapy	S	2.3741	$162.07	.	$32.42
0303	Treatment Device Construction	X	2.9021	$198.12	$66.95	$39.63
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.5401	$105.14	$34.63	$21.03
0305	Level II Therapeutic Radiation Treatment Preparation	X	4.0762	$278.27	$91.38	$55.66
0307	Myocardial Positron Emission Tomography (PET) imaging	S	16.1009	$1,099.16	.	$219.84
0308	Non-Myocardial Positron Emission Tomography (PET) imaging	S	15.3994	$1,051.27	.	$210.26
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.5651	$926.05	$325.27	$185.21
0312	Radioelement Applications	S	5.0976	$348.00	.	$69.60
0313	Brachytherapy	S	10.4062	$710.40	$268.63	$142.08
0315	Level II Implantation of Neurostimulator Generator	S	270.0348	$18,434.47	.	$3,686.90
0317	Level II Miscellaneous Radiology Procedures	X	5.9820	$408.37	.	$81.68
0320	Electroconvulsive Therapy	S	6.0291	$411.59	.	$82.32
0322	Brief Individual Psychotherapy	S	1.1744	$80.17	.	$16.04
0323	Extended Individual Psychotherapy	S	1.6309	$111.34	.	$22.27
0324	Family Psychotherapy	S	1.8392	$125.56	.	$25.12
0325	Group Psychotherapy	S	0.7880	$53.79	$11.47	$10.76
0330	Dental Procedures	S	9.9085	$676.42	.	$135.29
0332	Computed Tomography without Contrast	S	2.8569	$195.03	$75.24	$39.01
0333	Computed Tomography without Contrast followed by Contrast	S	4.8922	$333.98	$116.13	$66.80
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast	S	5.1052	$348.52	$137.34	$69.71
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast	S	7.9271	$541.16	$197.83	$108.24
0340	Minor Ancillary Procedures	X	0.6899	$47.10	.	$9.42
0341	Skin Tests	X	0.0804	$5.49	$2.09	$1.10
0342	Level I Pathology	X	0.1596	$10.90	.	$2.18
0343	Level II Pathology	X	0.5351	$36.53	$10.84	$7.31
0344	Level III Pathology	X	0.8227	$56.16	$15.56	$11.24

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0345	Level I Transfusion Laboratory Procedures	X	0.2168	$14.80	.	$2.96
0346	Level II Transfusion Laboratory Procedures	X	0.3619	$24.71	.	$4.95
0347	Level III Transfusion Laboratory Procedures	X	0.6903	$47.12	$9.43	$9.43
0350	Administration of flu and PPV vaccine	S	0.3853	$26.30		
0360	Level I Alimentary Tests	X	1.7011	$116.13	$33.88	$23.23
0361	Level II Alimentary Tests	X	4.0753	$278.21	$83.23	$55.65
0363	Level I Otorhinolaryngologic Function Tests	X	0.8721	$59.54	$16.71	$11.91
0364	Level I Audiometry	X	0.4612	$31.48	$7.03	$6.30
0365	Level II Audiometry	X	1.2498	$85.32	$18.52	$17.07
0366	Level III Audiometry	X	1.5786	$107.77	$24.61	$21.56
0367	Level I Pulmonary Test	X	0.5872	$40.09	$13.75	$8.02
0368	Level II Pulmonary Tests	X	0.8679	$59.25	$20.93	$11.85
0369	Level III Pulmonary Tests	X	3.0374	$207.35	$42.19	$41.47
0370	Allergy Tests	X	1.4793	$100.99	.	$20.20
0373	Level I Neuropsychological Testing	X	1.1738	$80.13	.	$16.03
0375	Ancillary Outpatient Services When Patient Expires	S	94.3159	$6,438.66	.	$1,287.74
0377	Level II Cardiac Imaging	S	11.2555	$768.38	.	$153.68
0378	Level II Pulmonary Imaging	S	4.7678	$325.48	$124.64	$65.10
0381	Single Allergy Tests	X	0.4215	$28.77	.	$5.76
0382	Level II Neuropsychological Testing	X	2.5561	$174.50	.	$34.90
0383	Cardiac Computed Tomographic Imaging	S	3.7795	$258.02	.	$51.61
0384	GI Procedures with Stents	T	27.4802	$1,875.99	.	$375.20
0385	Level I Prosthetic Urological Procedures	S	102.2894	$6,982.99	.	$1,396.60
0386	Level II Prosthetic Urological Procedures	S	168.1193	$11,477.00	.	$2,295.40
0387	Level II Hysteroscopy	T	38.2775	$2,613.09	$655.55	$522.62
0388	Discography	S	24.9242	$1,701.50	.	$340.30
0389	Level I Non-imaging Nuclear Medicine	S	1.5770	$107.66	$28.71	$21.54
0390	Level I Endocrine Imaging	S	2.0375	$139.09	$49.95	$27.82
0391	Level II Endocrine Imaging	S	3.2886	$224.50	$65.96	$44.90
0392	Level II Non-imaging Nuclear Medicine	S	2.6029	$177.69	$43.31	$35.54
0393	Hematologic Processing & Studies	S	5.8770	$401.21	.	$80.25
0394	Hepatobiliary Imaging	S	4.2112	$287.49	$98.44	$57.50
0395	GI Tract Imaging	S	3.6081	$246.31	$89.56	$49.27
0396	Bone Imaging	S	3.6637	$250.11	$95.02	$50.03
0397	Vascular Imaging	S	3.5928	$245.27	.	$49.06
0398	Level I Cardiac Imaging	S	4.3724	$298.49	$95.61	$59.70
0400	Hematopoietic Imaging	S	3.7861	$258.47	$91.52	$51.70
0401	Level I Pulmonary Imaging	S	2.9903	$204.14	$73.80	$40.83
0402	Level II Nervous System Imaging	S	9.0850	$620.21	.	$124.05
0403	Level I Nervous System Imaging	S	3.4106	$232.83	$72.42	$46.57
0404	Renal and Genitourinary Studies	S	4.7288	$322.82	$82.54	$64.57

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0406	Level I Tumor/Infection Imaging	S	4.2872	$292.67	$88.01	$58.54
0407	Level I Radionuclide Therapy	S	3.2871	$224.40	$78.13	$44.88
0408	Level III Tumor/Infection Imaging	S	12.6011	$860.24	.	$172.05
0409	Red Blood Cell Tests	X	0.1134	$7.74	$2.18	$1.55
0412	IMRT Treatment Delivery	S	6.4458	$440.04	.	$88.01
0413	Level II Radionuclide Therapy	S	5.1912	$354.39	.	$70.88
0414	Level II Tumor/Infection Imaging	S	7.1451	$487.77	.	$97.56
0415	Level II Endoscopy Lower Airway	T	28.5180	$1,946.84	$459.92	$389.37
0418	Insertion of Left Ventricular Pacing Elect.	T	143.1583	$9,772.99	.	$1,954.60
0422	Level II Upper GI Procedures	T	16.3107	$1,113.48	$271.47	$222.70
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	57.2089	$3,905.48	.	$781.10
0425	Level II Arthroplasty or Implantation with Prosthesis	T	122.1766	$8,340.63	.	$1,668.13
0426	Level II Strapping and Cast Application	S	2.4913	$170.07	.	$34.02
0427	Level II Tube or Catheter Changes or Repositioning	T	16.3601	$1,116.85	.	$223.37
0428	Level III Sigmoidoscopy and Anoscopy	T	24.5869	$1,678.47	.	$335.70
0429	Level V Cystourethroscopy and other Genitourinary Procedures	T	46.5713	$3,179.28	.	$635.86
0432	Health and Behavior Services	S	0.4597	$31.38	.	$6.28
0433	Level II Pathology	X	0.2465	$16.83	$5.17	$3.37
0434	Cardiac Defect Repair	T	158.2753	$10,804.98	.	$2,161.00
0436	Level I Drug Administration	S	0.3853	$26.30	.	$5.26
0437	Level II Drug Administration	S	0.5491	$37.49	.	$7.50
0438	Level III Drug Administration	S	1.1156	$76.16	.	$15.24
0439	Level IV Drug Administration	S	1.8498	$126.28	.	$25.26
0440	Level V Drug Administration	S	2.9855	$203.81	.	$40.77
0442	Dosimetric Drug Administration	S	31.9890	$2,183.79	.	$436.76
0604	Level 1 Hospital Clinic Visits	V	0.7431	$50.73	.	$10.15
0605	Level 2 Hospital Clinic Visits	V	1.0573	$72.18	.	$14.44
0606	Level 3 Hospital Clinic Visits	V	1.3650	$93.18	.	$18.64
0607	Level 4 Hospital Clinic Visits	V	1.7939	$122.46	.	$24.50
0608	Level 5 Hospital Clinic Visits	V	2.4657	$168.33	.	$33.67
0609	Level 1 Type A Emergency Visits	V	0.7735	$52.80	$12.64	$10.56
0613	Level 2 Type A Emergency Visits	V	1.3150	$89.77	$21.06	$17.96
0614	Level 3 Type A Emergency Visits	V	2.1031	$143.57	$34.50	$28.72
0615	Level 4 Type A Emergency Visits	V	3.3549	$229.03	$48.49	$45.81
0616	Level 5 Type A Emergency Visits	V	4.9888	$340.57	$72.86	$68.12
0617	Critical Care	S	7.7626	$529.93	$111.59	$105.99
0618	Trauma Response with Critical Care	S	13.9990	$955.67	.	$191.14
0621	Level I Vascular Access Procedures	T	11.4058	$778.64	.	$155.73

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0622	Level II Vascular Access Procedures	T	25.6930	$1,753.98	.	$350.80
0623	Level III Vascular Access Procedures	T	30.8594	$2,106.68	.	$421.34
0624	Phlebotomy and Minor Vascular Access Device Procedures	X	0.6338	$43.27	$12.65	$8.66
0626	Level 1 Type B Emergency Visits	V	0.6250	$42.67	.	$8.54
0627	Level 2 Type B Emergency Visits	V	0.9279	$63.34	.	$12.67
0628	Level 3 Type B Emergency Visits	V	1.4941	$102.00	.	$20.40
0629	Level 4 Type B Emergency Visits	V	2.4251	$165.55	.	$33.11
0630	Level 5 Type B Emergency Visits	V	3.8788	$264.79	.	$52.96
0648	Level IV Breast Surgery	T	62.9000	$4,293.99	.	$858.80
0651	Complex Interstitial Radiation Source Application	S	14.3321	$978.41	.	$195.69
0652	Insertion of Intraperitoneal and Pleural Catheters	T	31.1286	$2,125.06	.	$425.02
0653	Vascular Reconstruction/Fistula Repair with Device	T	44.7437	$3,054.52	.	$610.91
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	108.1716	$7,384.55	.	$1,476.91
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T	138.0708	$9,425.68	.	$1,885.14
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	104.6619	$7,144.95	.	$1,428.99
0659	Hyperbaric Oxygen	S	1.5650	$106.84	.	$21.37
0660	Level II Otorhinolaryngologic Function Tests	X	1.4013	$95.66	$25.67	$19.14
0661	Level IV Pathology	X	2.3687	$161.70	.	$32.34
0662	CT Angiography	S	5.0605	$345.47	$114.75	$69.10
0664	Level I Proton Beam Radiation Therapy	S	13.2159	$902.21	.	$180.45
0665	Bone Density:AppendicularSkeleton	S	0.4667	$31.86	$11.60	$6.38
0667	Level II Proton Beam Radiation Therapy	S	17.2884	$1,180.23	.	$236.05
0668	Level I Angiography and Venography	S	10.6287	$725.59	.	$145.12
0672	Level III Posterior Segment Eye Procedures	T	40.6474	$2,774.88	.	$554.98
0673	Level V Anterior Segment Eye Procedures	T	44.5131	$3,038.78	$649.56	$607.76
0674	Prostate Cryoablation	T	116.8825	$7,979.22	.	$1,595.85
0676	Thrombolysis and Other Device Revisions	T	2.3844	$162.78	.	$32.56
0678	External Counterpulsation	T	1.4509	$99.05	.	$19.81
0679	Level II Resuscitation and Cardioversion	S	5.4877	$374.63	$95.30	$74.93
0680	Insertion of Patient Activated Event Recorders	S	78.5933	$5,365.33	.	$1,073.07
0683	Level II Photochemotherapy	S	2.8503	$194.58	.	$38.92
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.9046	$676.16	.	$135.24
0687	Revision/Removal of Neurostimulator Electrodes	T	21.9323	$1,497.25	$397.37	$299.45
0688	Revision/Removal of Neurostimulator Pulse	T	29.5816	$2,019.45	$768.94	$403.89

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	Generator Receiver					
0690	Level I Electronic Analysis of Devices	S	0.5225	$35.67	$8.67	$7.14
0691	Level III Electronic Analysis of Devices	S	2.4765	$169.06	.	$33.82
0692	Level II Electronic Analysis of Devices	S	1.6175	$110.42	.	$22.09
0694	Mohs Surgery	T	5.0842	$347.08	$91.69	$69.42
0697	Level I Echocardiogram Without Contrast	S	3.1630	$215.93	.	$43.19
0698	Level II Eye Tests & Treatments	S	0.9316	$63.60	.	$12.72
0699	Level IV Eye Tests & Treatments	T	16.6419	$1,136.09	.	$227.22
0701	Sr89 strontium	K		$805.83	.	$161.17
0726	Dexrazoxane HCl injection	K		$261.24	.	$52.25
0728	Filgrastim 300 mcg injection	K		$223.05	.	$44.61
0731	Sargramostim injection	K		$25.25	.	$5.05
0735	Ampho b cholesteryl sulfate	K		$14.00	.	$2.80
0736	Amphotericin b liposome inj	K		$15.78	.	$3.16
0738	Rasburicase	K		$172.53	.	$34.51
0747	Chlorothiazide sodium inj	K		$352.37	.	$70.48
0751	Mechlorethamine hcl inj	K		$154.50	.	$30.90
0752	Dactinomycin injection	K		$570.53	.	$114.11
0759	Naltrexone, depot form	K		$2.43	.	$0.49
0800	Leuprolide acetate	K		$516.09	.	$103.22
0802	Etoposide oral	K		$28.26	.	$5.66
0807	Aldesleukin injection	K		$844.43	.	$168.89
0809	Bcg live intravesical vac	K		$121.25	.	$24.25
0810	Goserelin acetate implant	K		$195.23	.	$39.05
0812	Carmustine injection	K		$176.41	.	$35.29
0814	Asparaginase injection	K		$60.94	.	$12.19
0820	Daunorubicin injection	K		$19.46	.	$3.90
0821	Daunorubicin citrate inj	K		$56.31	.	$11.27
0823	Docetaxel injection	K		$17.86	.	$3.58
0825	Nelarabine injection	K		$105.91	.	$21.19
0827	Floxuridine injection	K		$42.99	.	$8.60
0828	Gemcitabine hcl injection	K		$145.10	.	$29.02
0830	Irinotecan injection	K		$9.15	.	$1.83
0831	Ifosfomide injection	K		$30.76	.	$6.16
0832	Idarubicin hcl injection	K		$63.57	.	$12.72
0835	Cosyntropin injection NOS	K		$73.19	.	$14.64
0836	Interferon alfa-2b inj	K		$15.84	.	$3.17
0838	Interferon gamma 1-b inj	K		$430.93	.	$86.19
0840	Inj melphalan hydrochl	K		$1,500.32	.	$300.07
0842	Fludarabine phosphate inj	K		$205.81	.	$41.17
0843	Pegaspargase injection	K		$2,747.44	.	$549.49

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0844	Pentostatin injection	K		$1,246.38	.	$249.28
0849	Rituximab injection	K		$578.40	.	$115.68
0850	Streptozocin injection	K		$282.86	.	$56.58
0851	Thiotepa injection	K		$113.52	.	$22.71
0852	Topotecan injection	K		$1,058.90	.	$211.78
0856	Porfimer sodium injection	K		$2,934.28	.	$586.86
0858	Inj cladribine	K		$28.22	.	$5.65
0861	Leuprolide acetate injeciton	K		$4.27	.	$0.86
0864	Mitoxantrone hydrochl	K		$45.26	.	$9.06
0865	Interferon alfa-n3 inj	K		$18.23	.	$3.65
0868	Oral aprepitant	K		$5.67	.	$1.14
0873	Hyalgan/supartz inj per dose	K		$91.96	.	$18.40
0874	Synvisc or synvisc-one	K		$11.78	.	$2.36
0875	Euflexxa inj per dose	K		$113.79	.	$22.76
0877	Orthovisc inj per dose	K		$176.70	.	$35.34
0878	Gallium nitrate injection	K		$2.03	.	$0.41
0884	Rho d immune globulin inj	K		$77.47	.	$15.50
0887	Azathioprine parenteral	K		$96.29	.	$19.26
0890	Lymphocyte immune globulin	K		$487.88	.	$97.58
0900	Alglucerase injection	K		$41.98	.	$8.40
0901	Alpha 1 proteinase inhibitor	K		$3.77	.	$0.76
0902	Injection,onabotulinumtoxinA	K		$5.49	.	$1.10
0903	Cytomegalovirus imm IV /vial	K		$878.82	.	$175.77
0904	Gamma globulin 4 CC inj	K		$64.13	.	$12.83
0910	Interferon beta-1b / .25 MG	K		$176.67	.	$35.34
0913	Ganciclovir long act implant	K		$16,960.00	.	$3,392.00
0916	Injection imiglucerase /unit	K		$4.20	.	$0.84
0917	Adenosine injection	K		$82.72	.	$16.55
0920	Gamma globulin 6 CC inj	K		$96.23	.	$19.25
0921	Gamma globulin 7 CC inj	K		$112.17	.	$22.44
0922	Gamma globulin 8 CC inj	K		$128.27	.	$25.66
0923	Gamma globulin 9 CC inj	K		$160.34	.	$32.07
0924	Gamma globulin 10 CC inj	K		$160.34	.	$32.07
0925	Factor viii	K		$0.87	.	$0.18
0927	Factor viii recombinant	K		$1.09	.	$0.22
0928	Factor ix complex	K		$0.88	.	$0.18
0929	Anti-inhibitor	K		$1.55	.	$0.31
0931	Factor IX non-recombinant	K		$0.91	.	$0.19
0932	Factor IX recombinant	K		$1.11	.	$0.23
0933	Gamma globulin > 10 CC inj	K		$160.34	.	$32.07
0934	Capecitabine, oral	K		$20.66	.	$4.14

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0935	Clonidine hydrochloride	K		$98.64	.	$19.73
0943	Octagam injection	K		$37.69	.	$7.54
0944	Gammagard liquid injection	K		$38.53	.	$7.71
0945	Rhophylac injection	K		$5.21	.	$1.05
0946	Hepagam b im injection	K		$50.63	.	$10.13
0947	Flebogamma injection	K		$37.01	.	$7.41
0948	Gamunex injection	K		$37.63	.	$7.53
0949	Frozen plasma, pooled, sd	R	0.8126	$55.47	.	$11.10
0950	Whole blood for transfusion	R	2.9637	$202.32	.	$40.47
0951	Reclast injection	K		$222.92	.	$44.59
0952	Cryoprecipitate each unit	R	0.7391	$50.46	.	$10.10
0954	RBC leukocytes reduced	R	2.7694	$189.06	.	$37.82
0955	Plasma, frz between 8-24hour	R	1.0672	$72.85	.	$14.57
0956	Plasma protein fract,5%,50ml	R	0.3751	$25.61	.	$5.13
0957	Platelets, each unit	R	1.0506	$71.72	.	$14.35
0958	Plaelet rich plasma unit	R	2.0520	$140.08	.	$28.02
0959	Red blood cells unit	R	2.1860	$149.23	.	$29.85
0960	Washed red blood cells unit	R	4.3079	$294.09	.	$58.82
0961	Albumin (human),5%, 50ml	K		$16.89	.	$3.38
0963	Albumin (human), 5%, 250 ml	K		$60.58	.	$12.12
0964	Albumin (human), 25%, 20 ml	K		$25.67	.	$5.14
0965	Albumin (human), 25%, 50ml	K		$62.05	.	$12.41
0966	Plasmaprotein fract,5%,250ml	R	1.6989	$115.98	.	$23.20
0967	Blood split unit	R	2.9552	$201.74	.	$40.35
0968	Platelets leukoreduced irrad	R	2.0209	$137.96	.	$27.60
0969	RBC leukoreduced irradiated	R	3.6796	$251.20	.	$50.24
1009	Cryoprecipitatereducedplasma	R	1.1663	$79.62	.	$15.93
1010	Blood, l/r, cmv-neg	R	2.7600	$188.42	.	$37.69
1011	Platelets, hla-m, l/r, unit	R	10.5854	$722.63	.	$144.53
1013	Platelets leukocytes reduced	R	1.5839	$108.13	.	$21.63
1015	Injection glatiramer acetate	K		$82.34	.	$16.47
1016	Blood, l/r, froz/degly/wash	R	1.4749	$100.69	.	$20.14
1017	Plt, aph/pher, l/r, cmv-neg	R	6.2876	$429.24	.	$85.85
1018	Blood, l/r, irradiated	R	2.4465	$167.02	.	$33.41
1019	Plate pheres leukoredu irrad	R	9.6439	$658.36	.	$131.68
1020	Plt, pher, l/r cmv-neg, irr	R	8.5688	$584.97	.	$117.00
1021	RBC, frz/deg/wsh, l/r, irrad	R	4.1093	$280.53	.	$56.11
1022	RBC, l/r, cmv-neg, irrad	R	4.3870	$299.49	.	$59.90
1023	Pralidoxime chloride inj	K		$90.79	.	$18.16
1052	Injection, voriconazole	K		$5.82	.	$1.17
1064	I131 iodide cap, rx	K		$18.20	.	$3.64

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1083	Adalimumab injection	K		$374.48	.	$74.90
1084	Denileukin diftitox inj	K		$1,494.82	.	$298.97
1086	Temozolomide	K		$8.83	.	$1.77
1138	Hepagam b intravenous, inj	K		$50.63	.	$10.13
1139	Protein c concentrate	K		$12.19	.	$2.44
1142	Supprelin LA implant	K		$14,990.44	.	$2,998.09
1150	I131 iodide sol, rx	K		$13.72	.	$2.75
1166	Cytarabine liposome inj	K		$488.90	.	$97.78
1167	Inj, epirubicin hcl	K		$2.48	.	$0.50
1168	Inj, temsirolimus	K		$49.83	.	$9.97
1178	Busulfan injection	K		$14.45	.	$2.89
1203	Verteporfin injection	K		$9.50	.	$1.90
1207	Octreotide injection, depot	K		$109.01	.	$21.81
1213	Antihemophilic viii/vwf comp	K		$0.92	.	$0.19
1214	Inj IVIG privigen 500 mg	K		$35.10	.	$7.02
1220	Calcitonin salmon injection	K		$49.26	.	$9.86
1221	Dimethyl sulfoxide 50%	K		$69.98	.	$14.00
1222	Pentastarch 10% solution	K		$161.82	.	$32.37
1226	Inj streptokinase /250000 IU	K		$32.12	.	$6.43
1232	Mitomycin 5 MG inj	K		$20.35	.	$4.07
1233	Mitomycin 20 MG inj	K		$81.44	.	$16.29
1234	Mitomycin 40 MG inj	K		$162.86	.	$32.58
1235	Valrubicin injection	K		$960.22	.	$192.05
1236	Levoleucovorin injection	G		$0.78	.	$0.16
1237	Inj iron dextran	K		$12.63	.	$2.53
1238	Topotecan oral	G		$74.66	.	$14.94
1239	Rotavirus vacc 2 dose oral	K		$102.50	.	$20.50
1240	Apligraf skin sub	K		$32.71	.	$6.55
1241	Oasis wound matrix skin sub	K		$4.62	.	$0.93
1242	Oasis burn matrix skin sub	K		$4.62	.	$0.93
1243	Integra BMWD skin sub	K		$14.84	.	$2.97
1244	Integra DRT skin sub	K		$10.00	.	$2.00
1245	Dermagraft skin sub	K		$40.10	.	$8.02
1246	Graftjacket skin sub	K		$92.04	.	$18.41
1247	Integra matrix skin sub	K		$17.99	.	$3.60
1248	Primatrix skin sub	K		$34.35	.	$6.87
1249	Cymetra allograft	K		$342.34	.	$68.47
1250	Graftjacket express allograf	K		$342.34	.	$68.47
1251	Integra flowable wound matri	K		$914.43	.	$182.89
1252	Gammagraft skin sub	K		$7.40	.	$1.48
1253	Triamcinolone A inj PRS-free	K		$3.21	.	$0.65

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1254	Adenovirus vaccine, type 4	K		$173.84	.	$34.77
1255	Rotovirus vacc 3 dose, oral	K		$73.76	.	$14.76
1256	Brompheniramine maleate inj	K		$9.24	.	$1.85
1260	Nandrolone decanoate 100 MG	K		$71.34	.	$14.27
1263	Antithrombin iii injection	K		$2.31	.	$0.47
1266	Interferon alfacon-1 inj	K		$4.80	.	$0.96
1268	Xyntha inj	K		$1.08	.	$0.22
1270	Alloderm skin sub	K		$32.57	.	$6.52
1271	Cholera vaccine, injectable	K		$103.90	.	$20.78
1272	Acetylcysteine injection	K		$2.45	.	$0.49
1274	Edetate calcium disodium inj	K		$197.37	.	$39.48
1275	Vivaglobin, inj	K		$7.20	.	$1.44
1279	Factor VIII (porcine)	K		$8.21	.	$1.65
1280	Corticotropin injection	K		$2,441.70	.	$488.34
1281	Bevacizumab injection	K		$1.44	.	$0.29
1282	Gamma globulin 2 CC inj	K		$32.07	.	$6.42
1283	Gamma globulin 3 CC inj	K		$48.10	.	$9.62
1284	Gamma globulin 5 CC inj	K		$80.16	.	$16.04
1285	Nandrolone decanoate 50 MG	K		$7.08	.	$1.42
1286	Nandrolone decanoate 200 MG	K		$43.59	.	$8.72
1287	Alloskin skin sub	K		$7.34	.	$1.47
1288	Visualization adjunct	K		$1.82	.	$0.37
1289	AbobotulinumtoxinA	K		$7.71	.	$1.55
1290	Human fibrinogen conc inj	G		$72.89	.	$14.58
1291	Rilonacept injection	K		$24.09	.	$4.82
1295	Sm 153 lexidronam	K		$5,613.99	.	$1,122.80
1296	Degarelix injection	G		$2.60	.	$0.52
1297	Ferumoxytol, non-esrd	G		$0.82	.	$0.17
1298	Cosyntropin cortrosyn inj	K		$90.95	.	$18.19
1299	Gadofosveset trisodium inj	G		$12.89		
1302	Inj benztropine mesylate	K		$42.16	.	$8.44
1303	Itraconazole injection	K		$42.28	.	$8.46
1304	Perphenazine injeciton	K		$29.11	.	$5.83
1306	Urea injection	K		$83.87	.	$16.78
1307	Oral busulfan	K		$3.65	.	$0.73
1308	Mecasermin injection	K		$125.21	.	$25.05
1309	Paclitaxel injection	K		$11.46	.	$2.30
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

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1495	New Technology - Level IE ($40-$50)	S		$45.00	.	$9.00
1496	New Technology - Level IA ($0-$10)	T		$5.00	.	$1.00
1497	New Technology - Level IB($10-$20)	T		$15.00	.	$3.00
1498	New Technology - Level IC ($20-$30)	T		$25.00	.	$5.00
1499	New Technology - Level ID($30-$40)	T		$35.00	.	$7.00
1500	New Technology - Level IE ($40-$50)	T		$45.00	.	$9.00
1502	New Technology - Level II ($50 - $100)	S		$75.00	.	$15.00
1503	New Technology - Level III ($100 - $200)	S		$150.00	.	$30.00
1504	New Technology - Level IV ($200 - $300)	S		$250.00	.	$50.00
1505	New Technology - Level V ($300 - $400)	S		$350.00	.	$70.00
1506	New Technology - Level VI ($400 - $500)	S		$450.00	.	$90.00
1507	New Technology - Level VII ($500 - $600)	S		$550.00	.	$110.00
1508	New Technology - Level VIII ($600 - $700)	S		$650.00	.	$130.00
1509	New Technology - Level IX ($700 - $800)	S		$750.00	.	$150.00
1510	New Technology - Level X ($800 - $900)	S		$850.00	.	$170.00
1511	New Technology - Level XI ($900 - $1000)	S		$950.00	.	$190.00
1512	New Technology - Level XII ($1000 - $1100)	S		$1,050.00	.	$210.00
1513	New Technology - Level XIII ($1100 - $1200)	S		$1,150.00	.	$230.00
1514	New Technology - Level XIV ($1200- $1300)	S		$1,250.00	.	$250.00
1515	New Technology - Level XV ($1300 - $1400)	S		$1,350.00	.	$270.00
1516	New Technology - Level XVI ($1400 - $1500)	S		$1,450.00	.	$290.00
1517	New Technology - Level XVII ($1500-$1600)	S		$1,550.00	.	$310.00
1518	New Technology - Level XVIII ($1600-$1700)	S		$1,650.00	.	$330.00
1519	New Technology - Level IXX ($1700-$1800)	S		$1,750.00	.	$350.00
1520	New Technology - Level XX ($1800-$1900)	S		$1,850.00	.	$370.00
1521	New Technology - Level XXI ($1900-$2000)	S		$1,950.00	.	$390.00
1522	New Technology - Level XXII ($2000-$2500)	S		$2,250.00	.	$450.00
1523	New Technology - Level XXIII ($2500-$3000)	S		$2,750.00	.	$550.00
1524	New Technology - Level XXIV ($3000-$3500)	S		$3,250.00	.	$650.00
1525	New Technology - Level XXV ($3500-$4000)	S		$3,750.00	.	$750.00
1526	New Technology - Level XXVI ($4000-$4500)	S		$4,250.00	.	$850.00
1527	New Technology - Level XXVII ($4500-$5000)	S		$4,750.00	.	$950.00
1528	New Technology - Level XXVIII ($5000-$5500)	S		$5,250.00	.	$1,050.00
1529	New Technology - Level XXIX ($5500-$6000)	S		$5,750.00	.	$1,150.00
1530	New Technology - Level XXX ($6000-$6500)	S		$6,250.00	.	$1,250.00
1531	New Technology - Level XXXI ($6500-$7000)	S		$6,750.00	.	$1,350.00
1532	New Technology - Level XXXII ($7000-$7500)	S		$7,250.00	.	$1,450.00
1533	New Technology - Level XXXIII ($7500-$8000)	S		$7,750.00	.	$1,550.00
1534	New Technology - Level XXXIV ($8000-$8500)	S		$8,250.00	.	$1,650.00

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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-	T		$8,750.00	.	$1,750.00

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	$9000)					
1573	New Technology - Level XXXVI ($9000-$9500)	T		$9,250.00	.	$1,850.00
1574	New Technology - Level XXXVII ($9500-$10000)	T		$9,750.00	.	$1,950.00
1605	Abciximab injection	K		$462.83	.	$92.57
1607	Eptifibatide injection	K		$19.00	.	$3.80
1608	Etanercept injection	K		$191.55	.	$38.31
1609	Rho(D) immune globulin h, sd	K		$18.55	.	$3.71
1612	Daclizumab, parenteral	K		$351.10	.	$70.22
1613	Trastuzumab injection	K		$66.41	.	$13.29
1630	Hep b ig, im	K		$115.97	.	$23.20
1631	Baclofen intrathecal trial	K		$73.50	.	$14.70
1633	Alefacept	K		$30.63	.	$6.13
1643	Y90 ibritumomab, rx	K		$31,434.63	.	$6,286.93
1645	I131 tositumomab, rx	K		$23,132.09	.	$4,626.42
1670	Tetanus immune globulin inj	K		$136.81	.	$27.37
1675	P32 Na phosphate	K		$196.49	.	$39.30
1676	P32 chromic phosphate	K		$113.44	.	$22.69
1683	Basiliximab	K		$1,755.73	.	$351.15
1684	Corticorelin ovine triflutal	K		$4.48	.	$0.90
1685	Darbepoetin alfa, non-esrd	K		$2.88	.	$0.58
1686	Epoetin alfa, non-esrd	K		$9.44	.	$1.89
1687	Digoxin immune fab (ovine)	K		$487.78	.	$97.56
1688	Ethanolamine oleate	K		$149.97	.	$30.00
1689	Fomepizole	K		$7.64	.	$1.53
1690	Hemin	K		$8.18	.	$1.64
1693	Lepirudin	K		$234.37	.	$46.88
1694	Ziconotide injection	K		$6.50	.	$1.30
1695	Nesiritide injection	K		$38.37	.	$7.68
1696	Palifermin injection	K		$11.34	.	$2.27
1697	Pegaptanib sodium injection	K		$1,030.34	.	$206.07
1700	Inj secretin synthetic human	K		$20.31	.	$4.07
1701	Treprostinil injection	K		$55.88	.	$11.18
1704	Humate-P, inj	K		$0.88	.	$0.18
1705	Factor viia	K		$1.36	.	$0.28
1709	Azacitidine injection	K		$4.99	.	$1.00
1710	Clofarabine injection	K		$116.49	.	$23.30
1711	Vantas implant	K		$1,515.25	.	$303.05
1712	Paclitaxel protein bound	K		$9.43	.	$1.89
1716	Brachytx, non-str, Gold-198	U	2.7019	$184.45	.	$36.89
1717	Brachytx, non-str, HDR Ir-192	U	3.2259	$220.22	.	$44.05

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1719	Brachytx, NS, Non-HDRIr-192	U	0.3366	$22.98	.	$4.60
1738	Oxaliplatin	K		$6.83	.	$1.37
1739	Pegademase bovine, 25 iu	K		$247.34	.	$49.47
1740	Diazoxide injection	K		$114.32	.	$22.87
1741	Urofollitropin, 75 iu	K		$60.01	.	$12.01
2210	Methyldopate hcl injection	K		$36.34	.	$7.27
2616	Brachytx, non-str,Yttrium-90	U	245.7374	$16,775.76	.	$3,355.16
2632	Iodine I-125 sodium iodide	U	0.3077	$21.01	.	$4.21
2634	Brachytx, non-str, HA, I-125	U	0.7596	$51.86	.	$10.38
2635	Brachytx, non-str, HA, P-103	U	0.4337	$29.61	.	$5.93
2636	Brachy linear, non-str,P-103	U	0.5280	$36.04	.	$7.21
2638	Brachytx, stranded, I-125	U	0.5662	$38.65	.	$7.73
2639	Brachytx, non-stranded,I-125	U	0.5292	$36.13	.	$7.23
2640	Brachytx, stranded, P-103	U	0.9334	$63.72	.	$12.75
2641	Brachytx, non-stranded,P-103	U	0.9135	$62.36	.	$12.48
2642	Brachytx, stranded, C-131	U	1.6774	$114.51	.	$22.91
2643	Brachytx, non-stranded,C-131	U	0.9143	$62.42	.	$12.49
2698	Brachytx, stranded, NOS	U	0.5662	$38.65	.	$7.73
2699	Brachytx, non-stranded, NOS	U	0.3366	$22.98	.	$4.60
2731	Immune globulin, powder	K		$30.86	.	$6.18
2770	Quinupristin/dalfopristin	K		$147.06	.	$29.42
3041	Bivalirudin	K		$2.41	.	$0.49
3043	Gamma globulin 1 CC inj	K		$16.03	.	$3.21
3050	Sermorelin acetate injection	K		$1.80	.	$0.36
7000	Amifostine	K		$327.97	.	$65.60
7011	Oprelvekin injection	K		$245.08	.	$49.02
7034	Somatropin injection	K		$55.46	.	$11.10
7035	Teniposide	K		$324.55	.	$64.91
7036	Urokinase 250,000 IU inj	K		$457.73	.	$91.55
7038	Monoclonal antibodies	K		$1,133.50	.	$226.70
7041	Tirofiban HCl	K		$7.39	.	$1.48
7042	Capecitabine, oral	K		$6.28	.	$1.26
7043	Infliximab injection	K		$58.74	.	$11.75
7046	Doxorubicin hcl liposome inj	K		$472.01	.	$94.41
7048	Alteplase recombinant	K		$37.35	.	$7.47
7049	Filgrastim 480 mcg injection	K		$348.68	.	$69.74
7051	Leuprolide acetate implant	K		$4,819.82	.	$963.97
7308	Aminolevulinic acid hcl top	K		$134.54	.	$26.91
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	T	155.6137	$10,623.28	.	$2,124.66
8001	LDR Prostate Brachytherapy Composite	T	46.9015	$3,201.82	.	$640.37
8002	Level I Extended Assessment & Management	V	5.7633	$393.44	.	$78.69

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	Composite					
8003	Level II Extended Assessment & Management Composite	V	10.6788	$729.01	.	$145.81
8004	Ultrasound Composite	S	2.8299	$193.19	.	$38.64
8005	CT and CTA without Contrast Composite	S	6.1855	$422.27	.	$84.46
8006	CT and CTA with Contrast Composite	S	9.3145	$635.87	.	$127.18
8007	MRI and MRA without Contrast Composite	S	10.5169	$717.96	.	$143.60
8008	MRI and MRA with Contrast Composite	S	14.7671	$1,008.11	.	$201.63
9001	Linezolid injection	K		$32.57	.	$6.52
9002	Tenecteplase injection	K		$46.74	.	$9.35
9003	Palivizumab	K		$510.69	.	$102.14
9004	Gemtuzumab ozogamicin inj	K		$2,687.21	.	$537.45
9005	Reteplase injection	K		$1,555.98	.	$311.20
9006	Tacrolimus injection	K		$139.41	.	$27.89
9012	Arsenic trioxide injection	K		$37.43	.	$7.49
9018	Inj, rimabotulinumtoxinB	K		$10.58	.	$2.12
9019	Caspofungin acetate	K		$11.59	.	$2.32
9022	IM inj interferon beta 1-a	K		$193.93	.	$38.79
9023	Rho d immune globulin	K		$25.14	.	$5.03
9024	Amphotericin b lipid complex	K		$9.84	.	$1.97
9032	Baclofen 10 MG injection	K		$203.89	.	$40.78
9033	Cidofovir injection	K		$761.10	.	$152.22
9038	Inj estrogen conjugate	K		$88.68	.	$17.74
9042	Glucagon hydrochloride	K		$81.41	.	$16.29
9044	Ibutilide fumarate injection	K		$416.61	.	$83.33
9046	Iron sucrose injection	K		$0.37	.	$0.08
9104	Antithymocyte globuln rabbit	K		$386.48	.	$77.30
9108	Thyrotropin injection	K		$1,053.42	.	$210.69
9110	Alemtuzumab injection	K		$578.02	.	$115.61
9115	Zoledronic acid	K		$221.12	.	$44.23
9119	Injection, pegfilgrastim 6mg	K		$2,432.50	.	$486.50
9120	Injection, Fulvestrant	K		$82.22	.	$16.45
9121	Injection, argatroban	K		$18.39	.	$3.68
9122	Triptorelin pamoate	K		$164.10	.	$32.82
9124	Daptomycin injection	K		$0.43	.	$0.09
9125	Risperidone, long acting	K		$5.06	.	$1.02
9126	Natalizumab injection	K		$7.97	.	$1.60
9133	Rabies ig, im/sc	K		$139.75	.	$27.95
9134	Rabies ig, heat treated	K		$152.38	.	$30.48
9135	Varicella-zoster ig, im	K		$147.58	.	$29.52
9137	Bcg vaccine, percut	K		$109.47	.	$21.90
9139	Rabies vaccine, im	K		$181.27	.	$36.26

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9140	Rabies vaccine, id	K		$98.12	.	$19.63
9143	Meningococcal vaccine, sc	K		$103.41	.	$20.69
9144	Encephalitis vaccine, sc	K		$102.08	.	$20.42
9145	Meningococcal vaccine, im	K		$103.41	.	$20.69
9207	Bortezomib injection	K		$38.24	.	$7.65
9208	Agalsidase beta injection	K		$136.24	.	$27.25
9209	Laronidase injection	K		$25.56	.	$5.12
9210	Palonosetron hcl	K		$17.62	.	$3.53
9213	Pemetrexed injection	K		$50.63	.	$10.13
9214	Bevacizumab injection	K		$57.57	.	$11.52
9215	Cetuximab injection	K		$49.73	.	$9.95
9217	Leuprolide acetate suspnsion	K		$220.41	.	$44.09
9224	Galsulfase injection	K		$339.90	.	$67.98
9225	Fluocinolone acetonide implt	K		$19,345.00	.	$3,869.00
9227	Micafungin sodium injection	K		$1.10	.	$0.22
9228	Tigecycline injection	K		$1.16	.	$0.24
9229	Ibandronate sodium injection	K		$141.39	.	$28.28
9230	Abatacept injection	K		$19.96	.	$4.00
9231	Decitabine injection	K		$29.65	.	$5.93
9232	Idursulfase injection	K		$455.03	.	$91.01
9233	Ranibizumab injection	K		$404.70	.	$80.94
9234	Alglucosidase alfa injection	K		$127.08	.	$25.42
9235	Panitumumab injection	K		$87.24	.	$17.45
9236	Eculizumab injection	K		$182.61	.	$36.53
9237	Inj, lanreotide acetate	K		$29.30	.	$5.86
9240	Injection, ixabepilone	K		$63.74	.	$12.75
9242	Injection, fosaprepitant	K		$1.62	.	$0.33
9243	Bendamustine injection	K		$18.47	.	$3.70
9244	Regadenoson injection	K		$50.73	.	$10.15
9245	Romiplostim injection	K		$44.18	.	$8.84
9247	Inj, iobenguane, I-123, dx	G		$2,282.67		
9248	Inj, clevidipine butyrate	K		$2.98	.	$0.60
9249	Certolizumab pegol inj	G		$3.78	.	$0.76
9250	Artiss fibrin sealant	G		$136.64	.	$27.33
9251	C1 esterase inhibitor inj	G		$42.75	.	$8.55
9252	Plerixafor injection	G		$268.58	.	$53.72
9253	Temozolomide injection	G		$4.90	.	$0.98
9254	Injection, lacosamide	K		$0.18	.	$0.04
9255	Paliperidone palmitate inj	G		$6.54	.	$1.31
9256	Dexamethasone intravitreal	G		$196.10	.	$39.22
9258	Telavancin injection	G		$0.21	.	$0.05

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9259	Pralatrexate injection	G		$165.63	.	$33.13
9260	Ofatumumab injection	G		$46.64	.	$9.33
9261	Ustekinumab injection	G		$107.43	.	$21.49
9262	Fludarabine phosphate, oral	G		$81.77	.	$16.36
9263	Ecallantide injection	G		$280.90	.	$56.18
9300	Omalizumab injection	K		$19.77	.	$3.96
9358	SurgiMend, fetal	K		$10.67	.	$2.14
9360	SurgiMend, neonatal	G		$11.24	.	$2.25
9361	NeuroMend nerve wrap	G		$265.18		
9362	Implnt,bon void filler-strip	G		$50.88		
9363	Integra Meshed Bil Wound Mat	G		$17.88	.	$3.58
9364	Porcine implant, Permacol	G		$17.67		
9500	Platelets, irradiated	R	2.2804	$155.68	.	$31.14
9501	Platelet pheres leukoreduced	R	7.7397	$528.37	.	$105.68
9502	Platelet pheresis irradiated	R	6.8837	$469.93	.	$93.99
9503	Fr frz plasma donor retested	R	0.9734	$66.45	.	$13.29
9504	RBC deglycerolized	R	5.1865	$354.07	.	$70.82
9505	RBC irradiated	R	3.1620	$215.86	.	$43.18
9506	Granulocytes, pheresis unit	R	23.7666	$1,622.47	.	$324.50
9507	Platelets, pheresis	R	6.5766	$448.96	.	$89.80
9508	Plasma 1 donor frz w/in 8 hr	R	1.1671	$79.67	.	$15.94

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
0016T	Thermotx choroid vasc lesion	Y		R2	4.8105	$201.55
0017T	Photocoagulat macular drusen	Y		R2	4.8105	$201.55
0099T*	Implant corneal ring	Y		R2	15.5346	$650.87
0100T	Prosth retina receive&gen	Y		G2	36.9485	$1,548.07
0101T	Extracorp shockwv tx,hi enrg	Y		G2	29.4746	$1,234.93
0102T	Extracorp shockwv tx,anesth	Y		G2	29.4746	$1,234.93
0123T	Scleral fistulization	Y		G2	22.292	$933.99
0124T*	Conjunctival drug placement	Y		R2	2.2568	$94.56
0176T	Aqu canal dilat w/o retent	Y		A2	40.4623	$1,695.29
0177T	Aqu canal dilat w retent	Y		A2	40.4623	$1,695.29
0186T	Suprachoroidal drug delivery	Y		G2	21.159	$886.52
0190T	Place intraoc radiation src	Y		G2	21.159	$886.52
0191T	Insert ant segment drain int	Y		G2	22.292	$933.99
0192T	Insert ant segment drain ext	Y		G2	40.4624	$1,695.29
0193T	Rf bladder neck microremodel	Y		G2	18.6773	$782.54
0200T	Perq sacral augmt unilat inj	Y		G2	21.1114	$884.53
0201T	Perq sacral augmt bilat inj	Y		G2	29.4746	$1,234.93
0213T	Us facet jt inj cerv/t 1 lev	Y		G2	7.0178	$294.03
0214T	Us facet jt inj cerv/t 2 lev	Y		G2	2.4234	$101.54
0215T	Us facet jt inj cerv/t 3 lev	Y		G2	2.4234	$101.54
0216T	Us facet jt inj ls 1 level	Y		G2	7.0178	$294.03
0217T	Us facet jt inj ls 2 level	Y		G2	2.4234	$101.54
0218T	Us facet jt inj ls 3 level	Y		G2	2.4234	$101.54
10021	Fna w/o image	Y	CH	P3		$64.82
10022	Fna w/image	Y		G2	4.2381	$177.57
10040	Acne surgery	Y		P2	0.7983	$33.45
10060	Drainage of skin abscess	Y		P3		$44.93
10061	Drainage of skin abscess	Y		P2	1.358	$56.90
10080	Drainage of pilonidal cyst	Y		P2	1.358	$56.90
10081	Drainage of pilonidal cyst	Y		P3		$110.98
10120	Remove foreign body	Y		P3		$61.13
10121	Remove foreign body	Y		A2	16.564	$694.00
10140	Drainage of hematoma/fluid	Y		P3		$66.29
10160	Puncture drainage of lesion	Y	CH	P3		$54.26
10180	Complex drainage, wound	Y		A2	18.4054	$771.15
11000	Debride infected skin	Y		P3		$21.11

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
11001	Debride infected skin add-on	Y		P3		$6.87
11010	Debride skin, fx	Y		A2	4.4709	$187.32
11011	Debride skin/muscle, fx	Y		A2	4.4709	$187.32
11012	Debride skin/muscle/bone, fx	Y		A2	4.4709	$187.32
11040	Debride skin, partial	Y		P3		$19.40
11041	Debride skin, full	Y		P3		$21.36
11042	Debride skin/tissue	Y		A2	2.5612	$107.31
11043	Debride tissue/muscle	Y		A2	2.5612	$107.31
11044	Debride tissue/muscle/bone	Y		A2	7.9784	$334.28
11055	Trim skin lesion	Y		P3		$22.83
11056	Trim skin lesions, 2 to 4	Y		P3		$25.04
11057	Trim skin lesions, over 4	Y		P3		$28.23
11100	Biopsy, skin lesion	Y	CH	P3		$50.33
11101	Biopsy, skin add-on	Y		P3		$12.03
11200	Removal of skin tags	Y		P2	0.7983	$33.45
11201	Remove skin tags add-on	Y		P3		$5.16
11300	Shave skin lesion	Y		P2	0.7983	$33.45
11301	Shave skin lesion	Y		P2	0.7983	$33.45
11302	Shave skin lesion	Y		P2	0.7983	$33.45
11303	Shave skin lesion	Y	CH	P3		$57.45
11305	Shave skin lesion	Y	CH	P3		$30.69
11306	Shave skin lesion	Y		P2	0.7983	$33.45
11307	Shave skin lesion	Y		P2	0.7983	$33.45
11308	Shave skin lesion	Y		P2	0.7983	$33.45
11310	Shave skin lesion	Y		P2	0.7983	$33.45
11311	Shave skin lesion	Y		P2	0.7983	$33.45
11312	Shave skin lesion	Y		P2	0.7983	$33.45
11313	Shave skin lesion	Y		P2	0.7983	$33.45
11400	Exc tr-ext b9+marg 0.5 < cm	Y		P3		$58.19
11401	Exc tr-ext b9+marg 0.6-1 cm	Y		P3		$65.80
11402	Exc tr-ext b9+marg 1.1-2 cm	Y		P3		$72.18
11403	Exc tr-ext b9+marg 2.1-3 cm	Y		P3		$78.08
11404	Exc tr-ext b9+marg 3.1-4 cm	Y		A2	16.564	$694.00
11406	Exc tr-ext b9+marg > 4.0 cm	Y		A2	16.564	$694.00
11420	Exc h-f-nk-sp b9+marg 0.5 <	Y		P3		$55.00
11421	Exc h-f-nk-sp b9+marg 0.6-1	Y		P3		$66.78
11422	Exc h-f-nk-sp b9+marg 1.1-2	Y		P3		$72.92
11423	Exc h-f-nk-sp b9+marg 2.1-3	Y		P3		$81.27
11424	Exc h-f-nk-sp b9+marg 3.1-4	Y		A2	16.564	$694.00

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
11426	Exc h-f-nk-sp b9+marg > 4 cm	Y		A2	21.9314	$918.88
11440	Exc face-mm b9+marg 0.5 < cm	Y		P3		$62.36
11441	Exc face-mm b9+marg 0.6-1 cm	Y		P3		$72.43
11442	Exc face-mm b9+marg 1.1-2 cm	Y		P3		$80.04
11443	Exc face-mm b9+marg 2.1-3 cm	Y		P3		$89.12
11444	Exc face-mm b9+marg 3.1-4 cm	Y		A2	7.9784	$334.28
11446	Exc face-mm b9+marg > 4 cm	Y		A2	21.9314	$918.88
11450	Removal, sweat gland lesion	Y		A2	21.9314	$918.88
11451	Removal, sweat gland lesion	Y		A2	21.9314	$918.88
11462	Removal, sweat gland lesion	Y		A2	21.9314	$918.88
11463	Removal, sweat gland lesion	Y		A2	21.9314	$918.88
11470	Removal, sweat gland lesion	Y		A2	21.9314	$918.88
11471	Removal, sweat gland lesion	Y		A2	21.9314	$918.88
11600	Exc tr-ext mlg+marg 0.5 < cm	Y		P3		$83.48
11601	Exc tr-ext mlg+marg 0.6-1 cm	Y		P3		$99.44
11602	Exc tr-ext mlg+marg 1.1-2 cm	Y		P3		$108.77
11603	Exc tr-ext mlg+marg 2.1-3 cm	Y		P3		$117.11
11604	Exc tr-ext mlg+marg 3.1-4 cm	Y		A2	7.9784	$334.28
11606	Exc tr-ext mlg+marg > 4 cm	Y		A2	16.564	$694.00
11620	Exc h-f-nk-sp mlg+marg 0.5 <	Y		P3		$85.69
11621	Exc h-f-nk-sp mlg+marg 0.6-1	Y		P3		$100.66
11622	Exc h-f-nk-sp mlg+marg 1.1-2	Y		P3		$111.22
11623	Exc h-f-nk-sp mlg+marg 2.1-3	Y		P3		$121.53
11624	Exc h-f-nk-sp mlg+marg 3.1-4	Y		A2	16.564	$694.00
11626	Exc h-f-nk-sp mlg+mar > 4 cm	Y		A2	21.9314	$918.88
11640	Exc face-mm malig+marg 0.5 <	Y		P3		$90.11
11641	Exc face-mm malig+marg 0.6-1	Y		P3		$104.84
11642	Exc face-mm malig+marg 1.1-2	Y		P3		$116.87
11643	Exc face-mm malig+marg 2.1-3	Y		P3		$127.67
11644	Exc face-mm malig+marg 3.1-4	Y		A2	16.564	$694.00
11646	Exc face-mm mlg+marg > 4 cm	Y		A2	21.9314	$918.88
11719	Trim nail(s)	Y		P3		$10.80
11720	Debride nail, 1-5	Y		P3		$13.26
11721	Debride nail, 6 or more	Y		P3		$15.71
11730	Removal of nail plate	Y		P2	0.7983	$33.45
11732	Remove nail plate, add-on	Y		P3		$15.71
11740	Drain blood from under nail	Y		P2	0.3866	$16.20
11750	Removal of nail bed	Y		P3		$85.20
11752	Remove nail bed/finger tip	Y		P3		$120.30

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
11755	Biopsy, nail unit	Y		P3		$57.70
11760	Repair of nail bed	Y		G2	1.2361	$51.79
11762	Reconstruction of nail bed	Y		P3		$109.75
11765	Excision of nail fold, toe	Y		P2	0.7983	$33.45
11770	Removal of pilonidal lesion	Y		A2	21.9314	$918.88
11771	Removal of pilonidal lesion	Y		A2	21.9314	$918.88
11772	Removal of pilonidal lesion	Y		A2	21.9314	$918.88
11900	Injection into skin lesions	Y		P3		$25.29
11901	Added skin lesions injection	Y	CH	P3		$28.23
11920	Correct skin color defects	Y		P3		$77.34
11921	Correct skin color defects	Y		P3		$86.91
11922	Correct skin color defects	Y		P3		$28.97
11950	Therapy for contour defects	Y		P3		$27.01
11951	Therapy for contour defects	Y		P3		$36.09
11952	Therapy for contour defects	Y	CH	P3		$44.44
11954	Therapy for contour defects	Y		P2	1.2361	$51.79
11960	Insert tissue expander(s)	Y		A2	20.106	$842.39
11970	Replace tissue expander	Y		A2	43.0648	$1,804.33
11971	Remove tissue expander(s)	Y		A2	21.9314	$918.88
11976	Removal of contraceptive cap	Y		P3		$51.80
11980	Implant hormone pellet(s)	N		P2	0.6271	$26.27
11981	Insert drug implant device	N		P2	0.6271	$26.27
11982	Remove drug implant device	N		P2	0.6271	$26.27
11983	Remove/insert drug implant	N		P2	0.6271	$26.27
12001	Repair superficial wound(s)	Y		P2	1.2361	$51.79
12002	Repair superficial wound(s)	Y		P2	1.2361	$51.79
12004	Repair superficial wound(s)	Y		P2	1.2361	$51.79
12005	Repair superficial wound(s)	Y		A2	1.2361	$51.79
12006	Repair superficial wound(s)	Y		A2	1.2361	$51.79
12007	Repair superficial wound(s)	Y		A2	1.2361	$51.79
12011	Repair superficial wound(s)	Y		P2	1.2361	$51.79
12013	Repair superficial wound(s)	Y		P2	1.2361	$51.79
12014	Repair superficial wound(s)	Y		P2	1.2361	$51.79
12015	Repair superficial wound(s)	Y		G2	1.2361	$51.79
12016	Repair superficial wound(s)	Y		A2	1.2361	$51.79
12017	Repair superficial wound(s)	Y		A2	1.2361	$51.79
12018	Repair superficial wound(s)	Y		A2	1.2361	$51.79
12020	Closure of split wound	Y		A2	4.2374	$177.54
12021	Closure of split wound	Y		A2	2.8987	$121.45

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
12031	Intmd wnd repair s/tr/ext	Y		P2	1.2361	$51.79
12032	Intmd wnd repair s/tr/ext	Y		P2	2.8988	$121.45
12034	Intmd wnd repair s/tr/ext	Y		A2	1.2361	$51.79
12035	Intmd wnd repair s/tr/ext	Y		A2	1.2361	$51.79
12036	Intmd wnd repair s/tr/ext	Y		A2	2.8987	$121.45
12037	Intmd wnd repair s/tr/ext	Y		A2	2.8987	$121.45
12041	Intmd wnd repair n-hf/genit	Y		P2	1.2361	$51.79
12042	Intmd wnd repair n-hg/genit	Y		P2	1.2361	$51.79
12044	Intmd wnd repair n-hg/genit	Y		A2	1.2361	$51.79
12045	Intmd wnd repair n-hg/genit	Y		A2	2.8987	$121.45
12046	Intmd wnd repair n-hg/genit	Y		A2	2.8987	$121.45
12047	Intmd wnd repair n-hg/genit	Y		A2	2.8987	$121.45
12051	Intmd wnd repair face/mm	Y	CH	P3		$117.60
12052	Intmd wnd repair face/mm	Y		P2	1.2361	$51.79
12053	Intmd wnd repair face/mm	Y		P2	1.2361	$51.79
12054	Intmd wnd repair, face/mm	Y		A2	1.2361	$51.79
12055	Intmd wnd repair face/mm	Y		A2	2.8987	$121.45
12056	Intmd wnd repair face/mm	Y		A2	2.8987	$121.45
12057	Intmd wnd repair face/mm	Y		A2	2.8987	$121.45
13100	Repair of wound or lesion	Y		A2	4.2374	$177.54
13101	Repair of wound or lesion	Y		A2	4.2374	$177.54
13102	Repair wound/lesion add-on	Y		A2	4.2374	$177.54
13120	Repair of wound or lesion	Y		A2	2.8987	$121.45
13121	Repair of wound or lesion	Y		A2	2.8987	$121.45
13122	Repair wound/lesion add-on	Y		A2	1.2361	$51.79
13131	Repair of wound or lesion	Y		A2	2.8987	$121.45
13132	Repair of wound or lesion	Y		A2	4.2374	$177.54
13133	Repair wound/lesion add-on	Y		A2	2.8987	$121.45
13150	Repair of wound or lesion	Y		A2	4.2374	$177.54
13151	Repair of wound or lesion	Y		A2	4.2374	$177.54
13152	Repair of wound or lesion	Y		A2	4.2374	$177.54
13153	Repair wound/lesion add-on	Y		A2	2.8987	$121.45
13160	Late closure of wound	Y		A2	20.106	$842.39
14000	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14001	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14020	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14021	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14040	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14041	Skin tissue rearrangement	Y		A2	15.5759	$652.60

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
14060	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14061	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14301	Skin tissue rearrangement	Y		G2	20.1058	$842.39
14302	Skin tissue rearrange add-on	Y		G2	20.1058	$842.39
14350	Skin tissue rearrangement	Y		A2	20.106	$842.39
15002	Wound prep, trk/arm/leg	Y		A2	4.2374	$177.54
15003	Wound prep, addl 100 cm	Y		A2	4.2374	$177.54
15004	Wound prep, f/n/hf/g	Y		A2	4.2374	$177.54
15005	Wnd prep, f/n/hf/g, addl cm	Y		A2	4.2374	$177.54
15040	Harvest cultured skin graft	Y		A2	2.8987	$121.45
15050	Skin pinch graft	Y		A2	4.2374	$177.54
15100	Skin splt grft, trnk/arm/leg	Y		A2	20.106	$842.39
15101	Skin splt grft t/a/l, add-on	Y		A2	20.106	$842.39
15110	Epidrm autogrft trnk/arm/leg	Y		A2	4.2374	$177.54
15111	Epidrm autogrft t/a/l add-on	Y		A2	4.2374	$177.54
15115	Epidrm a-grft face/nck/hf/g	Y		A2	4.2374	$177.54
15116	Epidrm a-grft f/n/hf/g addl	Y		A2	4.2374	$177.54
15120	Skn splt a-grft fac/nck/hf/g	Y		A2	20.106	$842.39
15121	Skn splt a-grft f/n/hf/g add	Y		A2	20.106	$842.39
15130	Derm autograft, trnk/arm/leg	Y		A2	15.5759	$652.60
15131	Derm autograft t/a/l add-on	Y		A2	15.5759	$652.60
15135	Derm autograft face/nck/hf/g	Y		A2	15.5759	$652.60
15136	Derm autograft, f/n/hf/g add	Y		A2	15.5759	$652.60
15150	Cult epiderm grft t/arm/leg	Y		A2	4.2374	$177.54
15151	Cult epiderm grft t/a/l addl	Y		A2	4.2374	$177.54
15152	Cult epiderm graft t/a/l +%	Y		A2	4.2374	$177.54
15155	Cult epiderm graft, f/n/hf/g	Y		A2	4.2374	$177.54
15156	Cult epidrm grft f/n/hfg add	Y		A2	4.2374	$177.54
15157	Cult epiderm grft f/n/hfg +%	Y		A2	4.2374	$177.54
15170	Acell graft trunk/arms/legs	Y		G2	4.2374	$177.54
15171	Acell graft t/arm/leg add-on	Y		G2	2.8988	$121.45
15175	Acellular graft, f/n/hf/g	Y		G2	4.2374	$177.54
15176	Acell graft, f/n/hf/g add-on	Y		G2	4.2374	$177.54
15200	Skin full graft, trunk	Y		A2	15.5759	$652.60
15201	Skin full graft trunk add-on	Y		A2	15.5759	$652.60
15220	Skin full graft sclp/arm/leg	Y		A2	15.5759	$652.60
15221	Skin full graft add-on	Y		A2	4.2374	$177.54
15240	Skin full grft face/genit/hf	Y		A2	15.5759	$652.60
15241	Skin full graft add-on	Y		A2	4.2374	$177.54

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
15260	Skin full graft een & lips	Y		A2	15.5759	$652.60
15261	Skin full graft add-on	Y		A2	15.5759	$652.60
15300	Apply skinallogrft, t/arm/lg	Y		A2	4.2374	$177.54
15301	Apply sknallogrft t/a/l addl	Y		A2	4.2374	$177.54
15320	Apply skin allogrft f/n/hf/g	Y		A2	4.2374	$177.54
15321	Aply sknallogrft f/n/hfg add	Y		A2	4.2374	$177.54
15330	Aply acell alogrft t/arm/leg	Y		A2	4.2374	$177.54
15331	Aply acell grft t/a/l add-on	Y		A2	4.2374	$177.54
15335	Apply acell graft, f/n/hf/g	Y		A2	4.2374	$177.54
15336	Aply acell grft f/n/hf/g add	Y		A2	4.2374	$177.54
15340	Apply cult skin substitute	Y		G2	2.8988	$121.45
15341	Apply cult skin sub add-on	Y		G2	2.8988	$121.45
15360	Apply cult derm sub, t/a/l	Y		G2	2.8988	$121.45
15361	Aply cult derm sub t/a/l add	Y		G2	2.8988	$121.45
15365	Apply cult derm sub f/n/hf/g	Y		G2	2.8988	$121.45
15366	Apply cult derm f/hf/g add	Y		G2	2.8988	$121.45
15400	Apply skin xenograft, t/a/l	Y		A2	4.2374	$177.54
15401	Apply skn xenogrft t/a/l add	Y		A2	4.2374	$177.54
15420	Apply skin xgraft, f/n/hf/g	Y		A2	4.2374	$177.54
15421	Apply skn xgrft f/n/hf/g add	Y		A2	4.2374	$177.54
15430	Apply acellular xenograft	Y		A2	4.2374	$177.54
15431	Apply acellular xgraft add	Y		A2	4.2374	$177.54
15570	Form skin pedicle flap	Y		A2	20.106	$842.39
15572	Form skin pedicle flap	Y		A2	20.106	$842.39
15574	Form skin pedicle flap	Y		A2	20.106	$842.39
15576	Form skin pedicle flap	Y		A2	20.106	$842.39
15600	Skin graft	Y		A2	20.106	$842.39
15610	Skin graft	Y		A2	20.106	$842.39
15620	Skin graft	Y		A2	20.106	$842.39
15630	Skin graft	Y		A2	20.106	$842.39
15650	Transfer skin pedicle flap	Y		A2	20.106	$842.39
15731	Forehead flap w/vasc pedicle	Y		A2	20.106	$842.39
15732	Muscle-skin graft, head/neck	Y		A2	20.106	$842.39
15734	Muscle-skin graft, trunk	Y		A2	20.106	$842.39
15736	Muscle-skin graft, arm	Y		A2	20.106	$842.39
15738	Muscle-skin graft, leg	Y		A2	20.106	$842.39
15740	Island pedicle flap graft	Y		A2	15.5759	$652.60
15750	Neurovascular pedicle graft	Y		A2	20.106	$842.39
15760	Composite skin graft	Y		A2	20.106	$842.39

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
15770	Derma-fat-fascia graft	Y		A2	20.106	$842.39
15775	Hair transplant punch grafts	Y		A2	1.2361	$51.79
15776	Hair transplant punch grafts	Y		A2	1.2361	$51.79
15780	Abrasion treatment of skin	Y		P3		$337.84
15781	Abrasion treatment of skin	Y		P2	4.4708	$187.32
15782	Abrasion treatment of skin	Y		P2	4.4708	$187.32
15783	Abrasion treatment of skin	Y		P2	2.5612	$107.31
15786	Abrasion, lesion, single	Y		P2	0.7983	$33.45
15787	Abrasion, lesions, add-on	Y		P3		$24.55
15788	Chemical peel, face, epiderm	Y		P2	0.7983	$33.45
15789	Chemical peel, face, dermal	Y		P2	1.391	$58.28
15792	Chemical peel, nonfacial	Y		P2	1.391	$58.28
15793	Chemical peel, nonfacial	Y		P2	0.7983	$33.45
15819	Plastic surgery, neck	Y		G2	2.8988	$121.45
15820	Revision of lower eyelid	Y		A2	20.106	$842.39
15821	Revision of lower eyelid	Y		A2	20.106	$842.39
15822	Revision of upper eyelid	Y		A2	20.106	$842.39
15823	Revision of upper eyelid	Y		A2	20.106	$842.39
15824	Removal of forehead wrinkles	Y		A2	20.106	$842.39
15825	Removal of neck wrinkles	Y		A2	20.106	$842.39
15826	Removal of brow wrinkles	Y		A2	20.106	$842.39
15828	Removal of face wrinkles	Y		A2	20.106	$842.39
15829	Removal of skin wrinkles	Y		A2	20.106	$842.39
15830	Exc skin abd	Y		A2	21.9314	$918.88
15832	Excise excessive skin tissue	Y		A2	21.9314	$918.88
15833	Excise excessive skin tissue	Y		A2	21.9314	$918.88
15834	Excise excessive skin tissue	Y		A2	21.9314	$918.88
15835	Excise excessive skin tissue	Y		A2	21.9314	$918.88
15836	Excise excessive skin tissue	Y		A2	16.564	$694.00
15837	Excise excessive skin tissue	Y		G2	16.5641	$694.00
15838	Excise excessive skin tissue	Y		G2	16.5641	$694.00
15839	Excise excessive skin tissue	Y		A2	16.564	$694.00
15840	Graft for face nerve palsy	Y		A2	20.106	$842.39
15841	Graft for face nerve palsy	Y		A2	20.106	$842.39
15842	Flap for face nerve palsy	Y		G2	20.1058	$842.39
15845	Skin and muscle repair, face	Y		A2	20.106	$842.39
15847	Exc skin abd add-on	Y		A2	21.9314	$918.88
15850	Removal of sutures	Y		G2	2.5612	$107.31
15851	Removal of sutures	Y		P3		$42.72

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
15852	Dressing change not for burn	N		R2	0.6271	$26.27
15860	Test for blood flow in graft	N		G2	0.6271	$26.27
15876	Suction assisted lipectomy	Y		A2	20.106	$842.39
15877	Suction assisted lipectomy	Y		A2	20.106	$842.39
15878	Suction assisted lipectomy	Y		A2	20.106	$842.39
15879	Suction assisted lipectomy	Y		A2	20.106	$842.39
15920	Removal of tail bone ulcer	Y		A2	4.4709	$187.32
15922	Removal of tail bone ulcer	Y		A2	20.106	$842.39
15931	Remove sacrum pressure sore	Y		A2	21.9314	$918.88
15933	Remove sacrum pressure sore	Y		A2	21.9314	$918.88
15934	Remove sacrum pressure sore	Y		A2	20.106	$842.39
15935	Remove sacrum pressure sore	Y		A2	20.106	$842.39
15936	Remove sacrum pressure sore	Y		A2	15.5759	$652.60
15937	Remove sacrum pressure sore	Y		A2	20.106	$842.39
15940	Remove hip pressure sore	Y		A2	21.9314	$918.88
15941	Remove hip pressure sore	Y		A2	21.9314	$918.88
15944	Remove hip pressure sore	Y		A2	20.106	$842.39
15945	Remove hip pressure sore	Y		A2	20.106	$842.39
15946	Remove hip pressure sore	Y		A2	20.106	$842.39
15950	Remove thigh pressure sore	Y		A2	21.9314	$918.88
15951	Remove thigh pressure sore	Y		A2	21.9314	$918.88
15952	Remove thigh pressure sore	Y		A2	15.5759	$652.60
15953	Remove thigh pressure sore	Y		A2	15.5759	$652.60
15956	Remove thigh pressure sore	Y		A2	15.5759	$652.60
15958	Remove thigh pressure sore	Y		A2	15.5759	$652.60
16000	Initial treatment of burn(s)	Y		P3		$23.32
16020	Dress/debrid p-thick burn, s	Y		P3		$35.60
16025	Dress/debrid p-thick burn, m	Y		A2	1.3912	$58.28
16030	Dress/debrid p-thick burn, l	Y		A2	1.3912	$58.28
16035	Incision of burn scab, initi	Y		G2	1.391	$58.28
17000	Destruct premalg lesion	Y		P2	0.7983	$33.45
17003	Destruct premalg les, 2-14	Y		P3		$3.19
17004	Destroy premlg lesions 15+	Y		P3		$70.71
17106	Destruction of skin lesions	Y		P2	2.5612	$107.31
17107	Destruction of skin lesions	Y		P2	2.5612	$107.31
17108	Destruction of skin lesions	Y		P2	2.5612	$107.31
17110	Destruct b9 lesion, 1-14	Y		P2	0.7983	$33.45
17111	Destruct lesion, 15 or more	Y		P2	1.391	$58.28
17250	Chemical cautery, tissue	Y		P3		$39.28

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
17260	Destruction of skin lesions	Y		P3		$40.51
17261	Destruction of skin lesions	Y		P2	1.391	$58.28
17262	Destruction of skin lesions	Y		P2	1.391	$58.28
17263	Destruction of skin lesions	Y		P2	1.391	$58.28
17264	Destruction of skin lesions	Y		P2	1.391	$58.28
17266	Destruction of skin lesions	Y	CH	P3		$97.23
17270	Destruction of skin lesions	Y		P2	1.391	$58.28
17271	Destruction of skin lesions	Y		P2	1.391	$58.28
17272	Destruction of skin lesions	Y		P2	1.391	$58.28
17273	Destruction of skin lesions	Y	CH	P3		$88.39
17274	Destruction of skin lesions	Y	CH	P3		$99.93
17276	Destruction of skin lesions	Y		P2	2.5612	$107.31
17280	Destruction of skin lesions	Y		P2	1.391	$58.28
17281	Destruction of skin lesions	Y		P3		$75.62
17282	Destruction of skin lesions	Y		P3		$86.42
17283	Destruction of skin lesions	Y	CH	P3		$99.44
17284	Destruction of skin lesions	Y		P2	2.5612	$107.31
17286	Destruction of skin lesions	Y		P2	2.5612	$107.31
17311	Mohs, 1 stage, h/n/hf/g	Y		P2	4.6215	$193.63
17312	Mohs addl stage	Y	CH	P3		$192.24
17313	Mohs, 1 stage, t/a/l	Y		P2	4.6215	$193.63
17314	Mohs, addl stage, t/a/l	Y	CH	P3		$178.00
17315	Mohs surg, addl block	Y		P3		$33.15
17340	Cryotherapy of skin	Y		P3		$13.99
17360	Skin peel therapy	Y		P2	0.7983	$33.45
17380	Hair removal by electrolysis	Y		R2	0.7983	$33.45
19000	Drainage of breast lesion	Y		P3		$53.77
19001	Drain breast lesion add-on	Y		P3		$7.37
19020	Incision of breast lesion	Y		A2	18.4054	$771.15
19030	Injection for breast x-ray	N		N1		
19100	Bx breast percut w/o image	Y		A2	4.2381	$177.57
19101	Biopsy of breast, open	Y		A2	23.4204	$981.27
19102	Bx breast percut w/image	Y		A2	7.4175	$310.77
19103	Bx breast percut w/device	Y		A2	14.3296	$600.38
19105	Cryosurg ablate fa, each	Y		P2	31.2349	$1,308.68
19110	Nipple exploration	Y		A2	23.4204	$981.27
19112	Excise breast duct fistula	Y		A2	23.4204	$981.27
19120	Removal of breast lesion	Y		A2	23.4204	$981.27
19125	Excision, breast lesion	Y		A2	23.4204	$981.27

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
19126	Excision, addl breast lesion	Y		A2	23.4204	$981.27
19290	Place needle wire, breast	N		N1		
19291	Place needle wire, breast	N		N1		
19295	Place breast clip, percut	N		N1		
19296	Place po breast cath for rad	Y		A2	57.176	$2,395.56
19297	Place breast cath for rad	Y		A2	57.176	$2,395.56
19298	Place breast rad tube/caths	Y		A2	57.176	$2,395.56
19300	Removal of breast tissue	Y		A2	23.4204	$981.27
19301	Partical mastectomy	Y		A2	23.4204	$981.27
19302	P-mastectomy w/ln removal	Y		A2	41.0798	$1,721.17
19303	Mast, simple, complete	Y		A2	31.2349	$1,308.68
19304	Mast, subq	Y		A2	31.2349	$1,308.68
19316	Suspension of breast	Y		A2	31.2349	$1,308.68
19318	Reduction of large breast	Y		A2	41.0798	$1,721.17
19324	Enlarge breast	Y		A2	41.0798	$1,721.17
19325	Enlarge breast with implant	Y		A2	57.176	$2,395.56
19328	Removal of breast implant	Y		A2	31.2349	$1,308.68
19330	Removal of implant material	Y		A2	31.2349	$1,308.68
19340	Immediate breast prosthesis	Y		A2	41.0798	$1,721.17
19342	Delayed breast prosthesis	Y		A2	57.176	$2,395.56
19350	Breast reconstruction	Y		A2	23.4204	$981.27
19355	Correct inverted nipple(s)	Y		A2	31.2349	$1,308.68
19357	Breast reconstruction	Y		A2	57.176	$2,395.56
19366	Breast reconstruction	Y		A2	31.2349	$1,308.68
19370	Surgery of breast capsule	Y		A2	31.2349	$1,308.68
19371	Removal of breast capsule	Y		A2	31.2349	$1,308.68
19380	Revise breast reconstruction	Y		A2	41.0798	$1,721.17
19396	Design custom breast implant	Y		G2	31.2349	$1,308.68
20000	Incision of abscess	Y		P2	1.358	$56.90
20005	Incision of deep abscess	Y		A2	21.1115	$884.53
20103	Explore wound, extremity	Y		G2	12.1141	$507.56
20150	Excise epiphyseal bar	Y		G2	43.0649	$1,804.33
20200	Muscle biopsy	Y		A2	16.564	$694.00
20205	Deep muscle biopsy	Y		A2	16.564	$694.00
20206	Needle biopsy, muscle	Y		A2	7.4175	$310.77
20220	Bone biopsy, trocar/needle	Y		A2	7.9784	$334.28
20225	Bone biopsy, trocar/needle	Y		A2	16.564	$694.00
20240	Bone biopsy, excisional	Y		A2	21.9314	$918.88
20245	Bone biopsy, excisional	Y		A2	21.9314	$918.88

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
20250	Open bone biopsy	Y		A2	21.1115	$884.53
20251	Open bone biopsy	Y		A2	21.1115	$884.53
20500	Injection of sinus tract	Y		P3		$43.21
20501	Inject sinus tract for x-ray	N		N1		
20520	Removal of foreign body	Y		P3		$82.74
20525	Removal of foreign body	Y		A2	21.9314	$918.88
20526	Ther injection, carp tunnel	Y		P3		$26.27
20550	Inj tendon sheath/ligament	Y		P3		$19.89
20551	Inj tendon origin/insertion	Y		P3		$20.38
20552	Inj trigger point, 1/2 muscl	Y		P3		$19.40
20553	Inject trigger points, =/> 3	Y		P3		$22.34
20555	Place ndl musc/tis for rt	Y		R2	29.4746	$1,234.93
20600	Drain/inject, joint/bursa	Y		P3		$20.13
20605	Drain/inject, joint/bursa	Y		P3		$22.59
20610	Drain/inject, joint/bursa	Y		P3		$32.41
20612	Aspirate/inj ganglion cyst	Y		P3		$21.85
20615	Treatment of bone cyst	Y		P3		$88.39
20650	Insert and remove bone pin	Y		A2	21.1115	$884.53
20662	Application of pelvis brace	Y		R2	21.1114	$884.53
20663	Application of thigh brace	Y		R2	21.1114	$884.53
20665	Removal of fixation device	N		G2	0.6271	$26.27
20670	Removal of support implant	Y		A2	16.564	$694.00
20680	Removal of support implant	Y		A2	21.9314	$918.88
20690	Apply bone fixation device	Y		A2	29.4747	$1,234.93
20692	Apply bone fixation device	Y		A2	29.4747	$1,234.93
20693	Adjust bone fixation device	Y		A2	21.1115	$884.53
20694	Remove bone fixation device	Y		A2	21.1115	$884.53
20696	Comp multiplane ext fixation	Y		G2	29.4746	$1,234.93
20697	Comp ext fixate strut change	Y	CH	P2	19.0792	$799.38
20822	Replantation digit, complete	Y		G2	27.1049	$1,135.64
20900	Removal of bone for graft	Y		A2	29.4747	$1,234.93
20902	Removal of bone for graft	Y		A2	29.4747	$1,234.93
20910	Remove cartilage for graft	Y		A2	20.106	$842.39
20912	Remove cartilage for graft	Y		A2	20.106	$842.39
20920	Removal of fascia for graft	Y		A2	15.5759	$652.60
20922	Removal of fascia for graft	Y		A2	15.5759	$652.60
20924	Removal of tendon for graft	Y		A2	29.4747	$1,234.93
20926	Removal of tissue for graft	Y		A2	4.2374	$177.54
20950	Fluid pressure, muscle	Y		G2	1.358	$56.90

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
20972	Bone/skin graft, metatarsal	Y		G2	50.4553	$2,113.98
20973	Bone/skin graft, great toe	Y		R2	50.4553	$2,113.98
20975	Electrical bone stimulation	N		N1		
20979	Us bone stimulation	N		P3		$19.64
20982	Ablate, bone tumor(s) perq	Y		G2	43.0649	$1,804.33
20985	Cptr-asst dir ms px	N		N1		
21010	Incision of jaw joint	Y		A2	23.2154	$972.69
21011	Exc face les sc < 2 cm	Y		P3		$149.77
21012	Exc face les sc = 2 cm	Y		R2	7.9785	$334.28
21013	Exc face tum deep < 2 cm	Y		P3		$209.18
21014	Exc face tum deep = 2 cm	Y		R2	7.9785	$334.28
21015*	Resect face tum < 2 cm	Y		R2	16.5641	$694.00
21016	Resect face tum = 2 cm	Y		G2	21.9314	$918.88
21025	Excision of bone, lower jaw	Y		A2	40.7633	$1,707.90
21026	Excision of facial bone(s)	Y		A2	40.7633	$1,707.90
21029	Contour of face bone lesion	Y		A2	40.7633	$1,707.90
21030	Excise max/zygoma b9 tumor	Y		P3		$219.49
21031	Remove exostosis, mandible	Y		P3		$178.98
21032	Remove exostosis, maxilla	Y		P3		$182.67
21034	Excise max/zygoma mlg tumor	Y		A2	40.7633	$1,707.90
21040	Excise mandible lesion	Y		A2	23.2154	$972.69
21044	Removal of jaw bone lesion	Y		A2	40.7633	$1,707.90
21046	Remove mandible cyst complex	Y		A2	40.7633	$1,707.90
21047	Excise lwr jaw cyst w/repair	Y		A2	40.7633	$1,707.90
21048	Remove maxilla cyst complex	Y		R2	40.7633	$1,707.90
21050	Removal of jaw joint	Y		A2	40.7633	$1,707.90
21060	Remove jaw joint cartilage	Y		A2	40.7633	$1,707.90
21070	Remove coronoid process	Y		A2	40.7633	$1,707.90
21073	Mnpj of tmj w/anesth	Y		P3		$172.11
21076	Prepare face/oral prosthesis	Y		P3		$309.36
21077	Prepare face/oral prosthesis	Y		P3		$742.21
21079	Prepare face/oral prosthesis	Y		P3		$531.80
21080	Prepare face/oral prosthesis	Y		P3		$606.19
21081	Prepare face/oral prosthesis	Y		P3		$558.56
21082	Prepare face/oral prosthesis	Y		P3		$539.65
21083	Prepare face/oral prosthesis	Y		P3		$528.36
21084	Prepare face/oral prosthesis	Y		P3		$602.02
21085	Prepare face/oral prosthesis	Y		P3		$241.59
21086	Prepare face/oral prosthesis	Y		P3		$529.10

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
21087	Prepare face/oral prosthesis	Y		P3		$525.66
21088	Prepare face/oral prosthesis	Y		R2	40.7633	$1,707.90
21100	Maxillofacial fixation	Y		A2	40.7633	$1,707.90
21110	Interdental fixation	Y		P2	7.1577	$299.89
21116	Injection, jaw joint x-ray	N		N1		
21120	Reconstruction of chin	Y		A2	23.2154	$972.69
21121	Reconstruction of chin	Y		A2	23.2154	$972.69
21122	Reconstruction of chin	Y		A2	23.2154	$972.69
21123	Reconstruction of chin	Y		A2	23.2154	$972.69
21125	Augmentation, lower jaw bone	Y		A2	23.2154	$972.69
21127	Augmentation, lower jaw bone	Y		A2	40.7633	$1,707.90
21137	Reduction of forehead	Y		G2	23.2156	$972.69
21138	Reduction of forehead	Y		G2	40.7633	$1,707.90
21139	Reduction of forehead	Y		G2	40.7633	$1,707.90
21150	Reconstruct midface, lefort	Y		G2	40.7633	$1,707.90
21181	Contour cranial bone lesion	Y		A2	23.2154	$972.69
21198	Reconstr lwr jaw segment	Y		G2	40.7633	$1,707.90
21199	Reconstr lwr jaw w/advance	Y		G2	40.7633	$1,707.90
21206	Reconstruct upper jaw bone	Y		A2	40.7633	$1,707.90
21208	Augmentation of facial bones	Y		A2	40.7633	$1,707.90
21209	Reduction of facial bones	Y		A2	40.7633	$1,707.90
21210	Face bone graft	Y		A2	40.7633	$1,707.90
21215	Lower jaw bone graft	Y		A2	40.7633	$1,707.90
21230	Rib cartilage graft	Y		A2	40.7633	$1,707.90
21235	Ear cartilage graft	Y		A2	23.2154	$972.69
21240	Reconstruction of jaw joint	Y		A2	40.7633	$1,707.90
21242	Reconstruction of jaw joint	Y		A2	40.7633	$1,707.90
21243	Reconstruction of jaw joint	Y		A2	40.7633	$1,707.90
21244	Reconstruction of lower jaw	Y		A2	40.7633	$1,707.90
21245	Reconstruction of jaw	Y		A2	40.7633	$1,707.90
21246	Reconstruction of jaw	Y		A2	40.7633	$1,707.90
21248	Reconstruction of jaw	Y		A2	40.7633	$1,707.90
21249	Reconstruction of jaw	Y		A2	40.7633	$1,707.90
21260	Revise eye sockets	Y		G2	40.7633	$1,707.90
21267	Revise eye sockets	Y		A2	40.7633	$1,707.90
21270	Augmentation, cheek bone	Y		A2	40.7633	$1,707.90
21275	Revision, orbitofacial bones	Y		A2	40.7633	$1,707.90
21280	Revision of eyelid	Y		A2	40.7633	$1,707.90
21282	Revision of eyelid	Y		A2	15.8303	$663.26

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
21295	Revision of jaw muscle/bone	Y		A2	7.1579	$299.89
21296	Revision of jaw muscle/bone	Y		A2	23.2154	$972.69
21310	Treatment of nose fracture	Y		A2	1.0674	$44.72
21315	Treatment of nose fracture	Y		A2	15.8303	$663.26
21320	Treatment of nose fracture	Y		A2	15.8303	$663.26
21325	Treatment of nose fracture	Y		A2	23.2154	$972.69
21330	Treatment of nose fracture	Y		A2	23.2154	$972.69
21335	Treatment of nose fracture	Y		A2	23.2154	$972.69
21336	Treat nasal septal fracture	Y		A2	24.2634	$1,016.59
21337	Treat nasal septal fracture	Y		A2	15.8303	$663.26
21338	Treat nasoethmoid fracture	Y		A2	23.2154	$972.69
21339	Treat nasoethmoid fracture	Y		A2	23.2154	$972.69
21340	Treatment of nose fracture	Y		A2	40.7633	$1,707.90
21345	Treat nose/jaw fracture	Y		A2	23.2154	$972.69
21355	Treat cheek bone fracture	Y		A2	40.7633	$1,707.90
21356	Treat cheek bone fracture	Y		A2	23.2154	$972.69
21360	Treat cheek bone fracture	Y		G2	23.2156	$972.69
21390	Treat eye socket fracture	Y		G2	40.7633	$1,707.90
21400	Treat eye socket fracture	Y		A2	7.1579	$299.89
21401	Treat eye socket fracture	Y		A2	15.8303	$663.26
21406	Treat eye socket fracture	Y		G2	40.7633	$1,707.90
21407	Treat eye socket fracture	Y		G2	40.7633	$1,707.90
21421	Treat mouth roof fracture	Y		A2	23.2154	$972.69
21440	Treat dental ridge fracture	Y		P3		$290.20
21445	Treat dental ridge fracture	Y		A2	23.2154	$972.69
21450	Treat lower jaw fracture	Y		A2	3.1243	$130.89
21451	Treat lower jaw fracture	Y		A2	7.1579	$299.89
21452	Treat lower jaw fracture	Y		A2	15.8303	$663.26
21453	Treat lower jaw fracture	Y		A2	40.7633	$1,707.90
21454	Treat lower jaw fracture	Y		A2	23.2154	$972.69
21461	Treat lower jaw fracture	Y		A2	40.7633	$1,707.90
21462	Treat lower jaw fracture	Y		A2	40.7633	$1,707.90
21465	Treat lower jaw fracture	Y		A2	40.7633	$1,707.90
21480	Reset dislocated jaw	Y		A2	1.0674	$44.72
21485	Reset dislocated jaw	Y		A2	15.8303	$663.26
21490	Repair dislocated jaw	Y		A2	40.7633	$1,707.90
21495	Treat hyoid bone fracture	Y		G2	15.8303	$663.26
21497	Interdental wiring	Y		A2	15.8303	$663.26
21501	Drain neck/chest lesion	Y		A2	18.4054	$771.15

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
21502	Drain chest lesion	Y		A2	21.1115	$884.53
21550	Biopsy of neck/chest	Y		G2	16.5641	$694.00
21552	Exc neck les sc = 3 cm	Y		G2	21.9314	$918.88
21554	Exc neck tum deep = 5 cm	Y		G2	21.9314	$918.88
21555*	Exc neck les sc < 3 cm	Y		P3		$174.32
21556	Exc neck tum deep < 5 cm	Y		G2	21.9314	$918.88
21557	Resect neck tum < 5 cm	Y		G2	16.5641	$694.00
21558	Resect neck tum = 5 cm	Y		G2	21.9314	$918.88
21600	Partial removal of rib	Y		A2	29.4747	$1,234.93
21610	Partial removal of rib	Y		A2	29.4747	$1,234.93
21685	Hyoid myotomy & suspension	Y		G2	7.1577	$299.89
21700	Revision of neck muscle	Y		A2	21.1115	$884.53
21720	Revision of neck muscle	Y		A2	21.1115	$884.53
21725	Revision of neck muscle	Y		A2	1.3578	$56.90
21800	Treatment of rib fracture	Y		A2	1.4841	$62.17
21805	Treatment of rib fracture	Y		A2	24.2634	$1,016.59
21820	Treat sternum fracture	Y		A2	1.4841	$62.17
21920	Biopsy soft tissue of back	Y		P3		$121.78
21925	Biopsy soft tissue of back	Y		A2	21.9314	$918.88
21930*	Exc back les sc < 3 cm	Y		P3		$181.93
21931	Exc back les sc = 3 cm	Y		G2	21.9314	$918.88
21932	Exc back tum deep < 5 cm	Y		G2	16.5641	$694.00
21933	Exc back tum deep = 5 cm	Y		G2	21.9314	$918.88
21935	Resect back tum < 5 cm	Y		G2	16.5641	$694.00
21936	Resect back tum = 5 cm	Y		G2	21.9314	$918.88
22102	Remove part, lumbar vertebra	Y		G2	47.0078	$1,969.53
22103	Remove extra spine segment	Y		G2	47.0078	$1,969.53
22305	Treat spine process fracture	Y		A2	1.4841	$62.17
22310	Treat spine fracture	Y		A2	4.7807	$200.30
22315	Treat spine fracture	Y		A2	19.0792	$799.38
22505	Manipulation of spine	Y		A2	14.1484	$592.79
22520	Percut vertebroplasty thor	Y		A2	29.4747	$1,234.93
22521	Percut vertebroplasty lumb	Y		A2	29.4747	$1,234.93
22522	Percut vertebroplasty addl	Y		A2	29.4747	$1,234.93
22523	Percut kyphoplasty, thor	Y		G2	80.4691	$3,371.49
22524	Percut kyphoplasty, lumbar	Y		G2	80.4691	$3,371.49
22525	Percut kyphoplasty, add-on	Y		G2	80.4691	$3,371.49
22900	Exc back tum deep < 5 cm	Y		G2	21.9314	$918.88
22901	Exc back tum deep = 5 cm	Y		G2	21.9314	$918.88

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
22902	Exc abd les sc < 3 cm	Y		G2	16.5641	$694.00
22903	Exc abd les sc > 3 cm	Y		G2	21.9314	$918.88
22904	Resect abd tum < 5 cm	Y		G2	16.5641	$694.00
22905	Resect abd tum > 5 cm	Y		G2	21.9314	$918.88
23000	Removal of calcium deposits	Y		A2	16.564	$694.00
23020	Release shoulder joint	Y		A2	43.0648	$1,804.33
23030	Drain shoulder lesion	Y		A2	18.4054	$771.15
23031	Drain shoulder bursa	Y		A2	18.4054	$771.15
23035	Drain shoulder bone lesion	Y		A2	21.1115	$884.53
23040	Exploratory shoulder surgery	Y		A2	29.4747	$1,234.93
23044	Exploratory shoulder surgery	Y		A2	29.4747	$1,234.93
23065	Biopsy shoulder tissues	Y		P3		$86.18
23066	Biopsy shoulder tissues	Y		A2	21.9314	$918.88
23071	Exc shoulder les sc > 3 cm	Y		G2	21.9314	$918.88
23073	Exc shoulder tum deep > 5 cm	Y		G2	21.9314	$918.88
23075*	Exc shoulder les sc < 3 cm	Y		P3		$156.64
23076	Exc shoulder tum deep < 5 cm	Y		G2	16.5641	$694.00
23077	Resect shoulder tum < 5 cm	Y		G2	16.5641	$694.00
23078	Resect shoulder tum > 5 cm	Y		G2	21.9314	$918.88
23100	Biopsy of shoulder joint	Y		A2	21.1115	$884.53
23101	Shoulder joint surgery	Y		A2	29.4747	$1,234.93
23105	Remove shoulder joint lining	Y		A2	29.4747	$1,234.93
23106	Incision of collarbone joint	Y		A2	29.4747	$1,234.93
23107	Explore treat shoulder joint	Y		A2	29.4747	$1,234.93
23120	Partial removal, collar bone	Y		A2	29.4747	$1,234.93
23125	Removal of collar bone	Y		A2	29.4747	$1,234.93
23130	Remove shoulder bone, part	Y		A2	43.0648	$1,804.33
23140	Removal of bone lesion	Y		A2	21.1115	$884.53
23145	Removal of bone lesion	Y		A2	29.4747	$1,234.93
23146	Removal of bone lesion	Y		A2	29.4747	$1,234.93
23150	Removal of humerus lesion	Y		A2	29.4747	$1,234.93
23155	Removal of humerus lesion	Y		A2	29.4747	$1,234.93
23156	Removal of humerus lesion	Y		A2	29.4747	$1,234.93
23170	Remove collar bone lesion	Y		A2	29.4747	$1,234.93
23172	Remove shoulder blade lesion	Y		A2	29.4747	$1,234.93
23174	Remove humerus lesion	Y		A2	29.4747	$1,234.93
23180	Remove collar bone lesion	Y		A2	29.4747	$1,234.93
23182	Remove shoulder blade lesion	Y		A2	29.4747	$1,234.93
23184	Remove humerus lesion	Y		A2	29.4747	$1,234.93

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
23190	Partial removal of scapula	Y		A2	29.4747	$1,234.93
23195	Removal of head of humerus	Y		A2	29.4747	$1,234.93
23330	Remove shoulder foreign body	Y		A2	7.9784	$334.28
23331	Remove shoulder foreign body	Y		A2	21.9314	$918.88
23350	Injection for shoulder x-ray	N		N1		
23395	Muscle transfer,shoulder/arm	Y		A2	43.0648	$1,804.33
23397	Muscle transfers	Y		A2	80.4692	$3,371.49
23400	Fixation of shoulder blade	Y		A2	29.4747	$1,234.93
23405	Incision of tendon & muscle	Y		A2	29.4747	$1,234.93
23406	Incise tendon(s) & muscle(s)	Y		A2	29.4747	$1,234.93
23410	Repair rotator cuff, acute	Y		A2	43.0648	$1,804.33
23412	Repair rotator cuff, chronic	Y		A2	43.0648	$1,804.33
23415	Release of shoulder ligament	Y		A2	43.0648	$1,804.33
23420	Repair of shoulder	Y		A2	43.0648	$1,804.33
23430	Repair biceps tendon	Y		A2	43.0648	$1,804.33
23440	Remove/transplant tendon	Y		A2	43.0648	$1,804.33
23450	Repair shoulder capsule	Y		A2	80.4692	$3,371.49
23455	Repair shoulder capsule	Y		A2	80.4692	$3,371.49
23460	Repair shoulder capsule	Y		A2	80.4692	$3,371.49
23462	Repair shoulder capsule	Y		A2	43.0648	$1,804.33
23465	Repair shoulder capsule	Y		A2	80.4692	$3,371.49
23466	Repair shoulder capsule	Y		A2	43.0648	$1,804.33
23480	Revision of collar bone	Y		A2	43.0648	$1,804.33
23485	Revision of collar bone	Y		A2	80.4692	$3,371.49
23490	Reinforce clavicle	Y		A2	80.4692	$3,371.49
23491	Reinforce shoulder bones	Y		A2	80.4692	$3,371.49
23500	Treat clavicle fracture	Y		A2	1.4841	$62.17
23505	Treat clavicle fracture	Y		A2	19.0792	$799.38
23515	Treat clavicle fracture	Y		A2	60.5167	$2,535.53
23520	Treat clavicle dislocation	Y		A2	4.7807	$200.30
23525	Treat clavicle dislocation	Y		A2	4.7807	$200.30
23530	Treat clavicle dislocation	Y		A2	43.7071	$1,831.24
23532	Treat clavicle dislocation	Y		A2	24.2634	$1,016.59
23540	Treat clavicle dislocation	Y		A2	1.4841	$62.17
23545	Treat clavicle dislocation	Y		A2	4.7807	$200.30
23550	Treat clavicle dislocation	Y		A2	43.7071	$1,831.24
23552	Treat clavicle dislocation	Y		A2	43.7071	$1,831.24
23570	Treat shoulder blade fx	Y		A2	1.4841	$62.17
23575	Treat shoulder blade fx	Y		A2	4.7807	$200.30

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
23585	Treat scapula fracture	Y		A2	60.5167	$2,535.53
23600	Treat humerus fracture	Y		P2	1.4839	$62.17
23605	Treat humerus fracture	Y		A2	19.0792	$799.38
23615	Treat humerus fracture	Y		A2	60.5167	$2,535.53
23616	Treat humerus fracture	Y		A2	60.5167	$2,535.53
23620	Treat humerus fracture	Y		P2	1.4839	$62.17
23625	Treat humerus fracture	Y		A2	19.0792	$799.38
23630	Treat humerus fracture	Y		A2	60.5167	$2,535.53
23650	Treat shoulder dislocation	Y		A2	1.4841	$62.17
23655	Treat shoulder dislocation	Y		A2	14.1484	$592.79
23660	Treat shoulder dislocation	Y		A2	43.7071	$1,831.24
23665	Treat dislocation/fracture	Y		A2	4.7807	$200.30
23670	Treat dislocation/fracture	Y		A2	60.5167	$2,535.53
23675	Treat dislocation/fracture	Y		A2	1.4841	$62.17
23680	Treat dislocation/fracture	Y		A2	43.7071	$1,831.24
23700	Fixation of shoulder	Y		A2	14.1484	$592.79
23800	Fusion of shoulder joint	Y		A2	80.4692	$3,371.49
23802	Fusion of shoulder joint	Y		A2	80.4692	$3,371.49
23921	Amputation follow-up surgery	Y		A2	15.5759	$652.60
23930	Drainage of arm lesion	Y		A2	18.4054	$771.15
23931	Drainage of arm bursa	Y		A2	18.4054	$771.15
23935	Drain arm/elbow bone lesion	Y		A2	21.1115	$884.53
24000	Exploratory elbow surgery	Y		A2	29.4747	$1,234.93
24006	Release elbow joint	Y		A2	29.4747	$1,234.93
24065	Biopsy arm/elbow soft tissue	Y		P3		$118.34
24066	Biopsy arm/elbow soft tissue	Y		A2	16.564	$694.00
24071	Exc arm/elbow les sc = 3 cm	Y		G2	21.9314	$918.88
24073	Ex arm/elbow tum deep > 5 cm	Y		G2	21.9314	$918.88
24075*	Exc arm/elbow les sc < 3 cm	Y		P3		$216.06
24076	Ex arm/elbow tum deep < 5 cm	Y		G2	16.5641	$694.00
24077	Resect arm/elbow tum < 5 cm	Y		G2	16.5641	$694.00
24079	Resect arm/elbow tum > 5 cm	Y		G2	21.9314	$918.88
24100	Biopsy elbow joint lining	Y		A2	21.1115	$884.53
24101	Explore/treat elbow joint	Y		A2	29.4747	$1,234.93
24102	Remove elbow joint lining	Y		A2	29.4747	$1,234.93
24105	Removal of elbow bursa	Y		A2	21.1115	$884.53
24110	Remove humerus lesion	Y		A2	21.1115	$884.53
24115	Remove/graft bone lesion	Y		A2	29.4747	$1,234.93
24116	Remove/graft bone lesion	Y		A2	29.4747	$1,234.93

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
24120	Remove elbow lesion	Y		A2	21.1115	$884.53
24125	Remove/graft bone lesion	Y		A2	29.4747	$1,234.93
24126	Remove/graft bone lesion	Y		A2	29.4747	$1,234.93
24130	Removal of head of radius	Y		A2	29.4747	$1,234.93
24134	Removal of arm bone lesion	Y		A2	29.4747	$1,234.93
24136	Remove radius bone lesion	Y		A2	29.4747	$1,234.93
24138	Remove elbow bone lesion	Y		A2	29.4747	$1,234.93
24140	Partial removal of arm bone	Y		A2	29.4747	$1,234.93
24145	Partial removal of radius	Y		A2	29.4747	$1,234.93
24147	Partial removal of elbow	Y		A2	29.4747	$1,234.93
24149	Radical resection of elbow	Y		G2	29.4746	$1,234.93
24152	Resect radius tumor	Y		G2	43.0649	$1,804.33
24155	Removal of elbow joint	Y		A2	43.0648	$1,804.33
24160	Remove elbow joint implant	Y		A2	29.4747	$1,234.93
24164	Remove radius head implant	Y		A2	29.4747	$1,234.93
24200	Removal of arm foreign body	Y		P3		$88.63
24201	Removal of arm foreign body	Y		A2	16.564	$694.00
24220	Injection for elbow x-ray	N		N1		
24300	Manipulate elbow w/anesth	Y		G2	14.1483	$592.79
24301	Muscle/tendon transfer	Y		A2	29.4747	$1,234.93
24305	Arm tendon lengthening	Y		A2	29.4747	$1,234.93
24310	Revision of arm tendon	Y		A2	21.1115	$884.53
24320	Repair of arm tendon	Y		A2	43.0648	$1,804.33
24330	Revision of arm muscles	Y		A2	80.4692	$3,371.49
24331	Revision of arm muscles	Y		A2	43.0648	$1,804.33
24332	Tenolysis, triceps	Y		G2	21.1114	$884.53
24340	Repair of biceps tendon	Y		A2	43.0648	$1,804.33
24341	Repair arm tendon/muscle	Y		A2	43.0648	$1,804.33
24342	Repair of ruptured tendon	Y		A2	43.0648	$1,804.33
24343	Repr elbow lat ligmnt w/tiss	Y		G2	29.4746	$1,234.93
24344	Reconstruct elbow lat ligmnt	Y		G2	80.4691	$3,371.49
24345	Repr elbw med ligmnt w/tissu	Y		A2	29.4747	$1,234.93
24346	Reconstruct elbow med ligmnt	Y		G2	80.4691	$3,371.49
24357	Repair elbow, perc	Y		G2	29.4746	$1,234.93
24358	Repair elbow w/deb, open	Y		G2	29.4746	$1,234.93
24359	Repair elbow deb/attch open	Y		G2	29.4746	$1,234.93
24360	Reconstruct elbow joint	Y		A2	35.5174	$1,488.11
24361	Reconstruct elbow joint	Y		H8	162.8173	$6,821.72
24362	Reconstruct elbow joint	Y		A2	54.7826	$2,295.28

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
24363	Replace elbow joint	Y		H8	162.8173	$6,821.72
24365	Reconstruct head of radius	Y		A2	35.5174	$1,488.11
24366	Reconstruct head of radius	Y		H8	162.8173	$6,821.72
24400	Revision of humerus	Y		A2	80.4692	$3,371.49
24410	Revision of humerus	Y		A2	43.0648	$1,804.33
24420	Revision of humerus	Y		A2	43.0648	$1,804.33
24430	Repair of humerus	Y		A2	80.4692	$3,371.49
24435	Repair humerus with graft	Y		A2	80.4692	$3,371.49
24470	Revision of elbow joint	Y		A2	43.0648	$1,804.33
24495	Decompression of forearm	Y		A2	29.4747	$1,234.93
24498	Reinforce humerus	Y		A2	80.4692	$3,371.49
24500	Treat humerus fracture	Y		A2	1.4841	$62.17
24505	Treat humerus fracture	Y		A2	1.4841	$62.17
24515	Treat humerus fracture	Y		A2	60.5167	$2,535.53
24516	Treat humerus fracture	Y		A2	60.5167	$2,535.53
24530	Treat humerus fracture	Y		A2	1.4841	$62.17
24535	Treat humerus fracture	Y		A2	4.7807	$200.30
24538	Treat humerus fracture	Y		A2	24.2634	$1,016.59
24545	Treat humerus fracture	Y		A2	60.5167	$2,535.53
24546	Treat humerus fracture	Y		A2	60.5167	$2,535.53
24560	Treat humerus fracture	Y		A2	1.4841	$62.17
24565	Treat humerus fracture	Y		A2	1.4841	$62.17
24566	Treat humerus fracture	Y		A2	24.2634	$1,016.59
24575	Treat humerus fracture	Y		A2	60.5167	$2,535.53
24576	Treat humerus fracture	Y		A2	1.4841	$62.17
24577	Treat humerus fracture	Y		A2	4.7807	$200.30
24579	Treat humerus fracture	Y		A2	60.5167	$2,535.53
24582	Treat humerus fracture	Y		A2	24.2634	$1,016.59
24586	Treat elbow fracture	Y		A2	60.5167	$2,535.53
24587	Treat elbow fracture	Y		A2	60.5167	$2,535.53
24600	Treat elbow dislocation	Y		A2	1.4841	$62.17
24605	Treat elbow dislocation	Y		A2	14.1484	$592.79
24615	Treat elbow dislocation	Y		A2	60.5167	$2,535.53
24620	Treat elbow fracture	Y		A2	19.0792	$799.38
24635	Treat elbow fracture	Y		A2	60.5167	$2,535.53
24640	Treat elbow dislocation	Y		P3		$51.07
24650	Treat radius fracture	Y		P2	1.4839	$62.17
24655	Treat radius fracture	Y		A2	4.7807	$200.30
24665	Treat radius fracture	Y		A2	43.7071	$1,831.24

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
24666	Treat radius fracture	Y		A2	60.5167	$2,535.53
24670	Treat ulnar fracture	Y		A2	1.4841	$62.17
24675	Treat ulnar fracture	Y		A2	1.4841	$62.17
24685	Treat ulnar fracture	Y		A2	43.7071	$1,831.24
24800	Fusion of elbow joint	Y		A2	43.0648	$1,804.33
24802	Fusion/graft of elbow joint	Y		A2	80.4692	$3,371.49
24925	Amputation follow-up surgery	Y		A2	21.1115	$884.53
25000	Incision of tendon sheath	Y		A2	21.1115	$884.53
25001	Incise flexor carpi radialis	Y		G2	21.1114	$884.53
25020	Decompress forearm 1 space	Y		A2	29.4747	$1,234.93
25023	Decompress forearm 1 space	Y		A2	29.4747	$1,234.93
25024	Decompress forearm 2 spaces	Y		A2	29.4747	$1,234.93
25025	Decompress forearm 2 spaces	Y		A2	29.4747	$1,234.93
25028	Drainage of forearm lesion	Y		A2	21.1115	$884.53
25031	Drainage of forearm bursa	Y		A2	21.1115	$884.53
25035	Treat forearm bone lesion	Y		A2	21.1115	$884.53
25040	Explore/treat wrist joint	Y		A2	29.4747	$1,234.93
25065	Biopsy forearm soft tissues	Y		P3		$119.81
25066	Biopsy forearm soft tissues	Y		A2	21.9314	$918.88
25071	Exc forearm les sc > 3 cm	Y		G2	21.9314	$918.88
25073	Exc forearm tum deep = 3 cm	Y		G2	21.9314	$918.88
25075*	Exc forearm les sc < 3 cm	Y		P3		$169.65
25076	Exc forearm tum deep < 3 cm	Y		G2	16.5641	$694.00
25077	Resect forearm/wrist tum<3cm	Y		G2	16.5641	$694.00
25078	Resect forearm/wrist tum=3cm	Y		G2	21.9314	$918.88
25085	Incision of wrist capsule	Y		A2	21.1115	$884.53
25100	Biopsy of wrist joint	Y		A2	21.1115	$884.53
25101	Explore/treat wrist joint	Y		A2	29.4747	$1,234.93
25105	Remove wrist joint lining	Y		A2	29.4747	$1,234.93
25107	Remove wrist joint cartilage	Y		A2	29.4747	$1,234.93
25109	Excise tendon forearm/wrist	Y		G2	21.1114	$884.53
25110	Remove wrist tendon lesion	Y		A2	21.1115	$884.53
25111	Remove wrist tendon lesion	Y		A2	21.1115	$884.53
25112	Reremove wrist tendon lesion	Y		A2	21.1115	$884.53
25115	Remove wrist/forearm lesion	Y		A2	21.1115	$884.53
25116	Remove wrist/forearm lesion	Y		A2	21.1115	$884.53
25118	Excise wrist tendon sheath	Y		A2	29.4747	$1,234.93
25119	Partial removal of ulna	Y		A2	29.4747	$1,234.93
25120	Removal of forearm lesion	Y		A2	29.4747	$1,234.93

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
25125	Remove/graft forearm lesion	Y		A2	29.4747	$1,234.93
25126	Remove/graft forearm lesion	Y		A2	29.4747	$1,234.93
25130	Removal of wrist lesion	Y		A2	29.4747	$1,234.93
25135	Remove & graft wrist lesion	Y		A2	29.4747	$1,234.93
25136	Remove & graft wrist lesion	Y		A2	29.4747	$1,234.93
25145	Remove forearm bone lesion	Y		A2	29.4747	$1,234.93
25150	Partial removal of ulna	Y		A2	29.4747	$1,234.93
25151	Partial removal of radius	Y		A2	29.4747	$1,234.93
25210	Removal of wrist bone	Y		A2	29.4747	$1,234.93
25215	Removal of wrist bones	Y		A2	29.4747	$1,234.93
25230	Partial removal of radius	Y		A2	29.4747	$1,234.93
25240	Partial removal of ulna	Y		A2	29.4747	$1,234.93
25246	Injection for wrist x-ray	N		N1		
25248	Remove forearm foreign body	Y		A2	21.1115	$884.53
25250	Removal of wrist prosthesis	Y		A2	29.4747	$1,234.93
25251	Removal of wrist prosthesis	Y		A2	29.4747	$1,234.93
25259	Manipulate wrist w/anesthes	Y		G2	19.0792	$799.38
25260	Repair forearm tendon/muscle	Y		A2	29.4747	$1,234.93
25263	Repair forearm tendon/muscle	Y		A2	29.4747	$1,234.93
25265	Repair forearm tendon/muscle	Y		A2	29.4747	$1,234.93
25270	Repair forearm tendon/muscle	Y		A2	29.4747	$1,234.93
25272	Repair forearm tendon/muscle	Y		A2	29.4747	$1,234.93
25274	Repair forearm tendon/muscle	Y		A2	29.4747	$1,234.93
25275	Repair forearm tendon sheath	Y		A2	29.4747	$1,234.93
25280	Revise wrist/forearm tendon	Y		A2	29.4747	$1,234.93
25290	Incise wrist/forearm tendon	Y		A2	29.4747	$1,234.93
25295	Release wrist/forearm tendon	Y		A2	21.1115	$884.53
25300	Fusion of tendons at wrist	Y		A2	29.4747	$1,234.93
25301	Fusion of tendons at wrist	Y		A2	29.4747	$1,234.93
25310	Transplant forearm tendon	Y		A2	43.0648	$1,804.33
25312	Transplant forearm tendon	Y		A2	43.0648	$1,804.33
25315	Revise palsy hand tendon(s)	Y		A2	43.0648	$1,804.33
25316	Revise palsy hand tendon(s)	Y		A2	80.4692	$3,371.49
25320	Repair/revise wrist joint	Y		A2	43.0648	$1,804.33
25332	Revise wrist joint	Y		A2	35.5174	$1,488.11
25335	Realignment of hand	Y		A2	43.0648	$1,804.33
25337	Reconstruct ulna/radioulnar	Y		A2	43.0648	$1,804.33
25350	Revision of radius	Y		A2	43.0648	$1,804.33
25355	Revision of radius	Y		A2	43.0648	$1,804.33

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
25360	Revision of ulna	Y		A2	43.0648	$1,804.33
25365	Revise radius & ulna	Y		A2	80.4692	$3,371.49
25370	Revise radius or ulna	Y		A2	43.0648	$1,804.33
25375	Revise radius & ulna	Y		A2	43.0648	$1,804.33
25390	Shorten radius or ulna	Y		A2	43.0648	$1,804.33
25391	Lengthen radius or ulna	Y		A2	80.4692	$3,371.49
25392	Shorten radius & ulna	Y		A2	29.4747	$1,234.93
25393	Lengthen radius & ulna	Y		A2	43.0648	$1,804.33
25394	Repair carpal bone, shorten	Y		G2	43.0649	$1,804.33
25400	Repair radius or ulna	Y		A2	80.4692	$3,371.49
25405	Repair/graft radius or ulna	Y		A2	80.4692	$3,371.49
25415	Repair radius & ulna	Y		A2	80.4692	$3,371.49
25420	Repair/graft radius & ulna	Y		A2	80.4692	$3,371.49
25425	Repair/graft radius or ulna	Y		A2	80.4692	$3,371.49
25426	Repair/graft radius & ulna	Y		A2	43.0648	$1,804.33
25430	Vasc graft into carpal bone	Y		G2	43.0649	$1,804.33
25431	Repair nonunion carpal bone	Y		G2	43.0649	$1,804.33
25440	Repair/graft wrist bone	Y		A2	80.4692	$3,371.49
25441	Reconstruct wrist joint	Y		H8	162.8173	$6,821.72
25442	Reconstruct wrist joint	Y		H8	162.8173	$6,821.72
25443	Reconstruct wrist joint	Y		A2	54.7826	$2,295.28
25444	Reconstruct wrist joint	Y		A2	54.7826	$2,295.28
25445	Reconstruct wrist joint	Y		A2	54.7826	$2,295.28
25446	Wrist replacement	Y		H8	162.8173	$6,821.72
25447	Repair wrist joint(s)	Y		A2	35.5174	$1,488.11
25449	Remove wrist joint implant	Y		A2	35.5174	$1,488.11
25450	Revision of wrist joint	Y		A2	43.0648	$1,804.33
25455	Revision of wrist joint	Y		A2	43.0648	$1,804.33
25490	Reinforce radius	Y		A2	43.0648	$1,804.33
25491	Reinforce ulna	Y		A2	43.0648	$1,804.33
25492	Reinforce radius and ulna	Y		A2	43.0648	$1,804.33
25500	Treat fracture of radius	Y		P2	1.4839	$62.17
25505	Treat fracture of radius	Y		A2	4.7807	$200.30
25515	Treat fracture of radius	Y		A2	43.7071	$1,831.24
25520	Treat fracture of radius	Y		A2	4.7807	$200.30
25525	Treat fracture of radius	Y		A2	43.7071	$1,831.24
25526	Treat fracture of radius	Y		A2	43.7071	$1,831.24
25530	Treat fracture of ulna	Y		P2	1.4839	$62.17
25535	Treat fracture of ulna	Y		A2	1.4841	$62.17

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
25545	Treat fracture of ulna	Y		A2	43.7071	$1,831.24
25560	Treat fracture radius & ulna	Y		P2	1.4839	$62.17
25565	Treat fracture radius & ulna	Y		A2	4.7807	$200.30
25574	Treat fracture radius & ulna	Y		A2	60.5167	$2,535.53
25575	Treat fracture radius/ulna	Y		A2	60.5167	$2,535.53
25600	Treat fracture radius/ulna	Y		P2	1.4839	$62.17
25605	Treat fracture radius/ulna	Y		A2	4.7807	$200.30
25606	Treat fx distal radial	Y		A2	24.2634	$1,016.59
25607	Treat fx rad extra-articul	Y		A2	60.5167	$2,535.53
25608	Treat fx rad intra-articul	Y		A2	60.5167	$2,535.53
25609	Treat fx radial 3+ frag	Y		A2	60.5167	$2,535.53
25622	Treat wrist bone fracture	Y		P2	1.4839	$62.17
25624	Treat wrist bone fracture	Y		A2	4.7807	$200.30
25628	Treat wrist bone fracture	Y		A2	43.7071	$1,831.24
25630	Treat wrist bone fracture	Y		P2	1.4839	$62.17
25635	Treat wrist bone fracture	Y		A2	4.7807	$200.30
25645	Treat wrist bone fracture	Y		A2	43.7071	$1,831.24
25650	Treat wrist bone fracture	Y		P2	1.4839	$62.17
25651	Pin ulnar styloid fracture	Y		G2	24.2634	$1,016.59
25652	Treat fracture ulnar styloid	Y		G2	43.7072	$1,831.24
25660	Treat wrist dislocation	Y		A2	1.4841	$62.17
25670	Treat wrist dislocation	Y		A2	24.2634	$1,016.59
25671	Pin radioulnar dislocation	Y		A2	24.2634	$1,016.59
25675	Treat wrist dislocation	Y		A2	1.4841	$62.17
25676	Treat wrist dislocation	Y		A2	24.2634	$1,016.59
25680	Treat wrist fracture	Y		A2	1.4841	$62.17
25685	Treat wrist fracture	Y		A2	24.2634	$1,016.59
25690	Treat wrist dislocation	Y		A2	19.0792	$799.38
25695	Treat wrist dislocation	Y		A2	24.2634	$1,016.59
25800	Fusion of wrist joint	Y		A2	80.4692	$3,371.49
25805	Fusion/graft of wrist joint	Y		A2	80.4692	$3,371.49
25810	Fusion/graft of wrist joint	Y		A2	80.4692	$3,371.49
25820	Fusion of hand bones	Y		A2	43.0648	$1,804.33
25825	Fuse hand bones with graft	Y		A2	80.4692	$3,371.49
25830	Fusion, radioulnar jnt/ulna	Y		A2	80.4692	$3,371.49
25907	Amputation follow-up surgery	Y		A2	21.1115	$884.53
25922	Amputate hand at wrist	Y		A2	21.1115	$884.53
25929	Amputation follow-up surgery	Y		A2	15.5759	$652.60
25931	Amputation follow-up surgery	Y		G2	21.1114	$884.53

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
26010	Drainage of finger abscess	Y		P2	1.358	$56.90
26011	Drainage of finger abscess	Y		A2	12.1142	$507.56
26020	Drain hand tendon sheath	Y		A2	15.7852	$661.37
26025	Drainage of palm bursa	Y		A2	15.7852	$661.37
26030	Drainage of palm bursa(s)	Y		A2	15.7852	$661.37
26034	Treat hand bone lesion	Y		A2	15.7852	$661.37
26035	Decompress fingers/hand	Y		G2	15.7852	$661.37
26037	Decompress fingers/hand	Y		G2	15.7852	$661.37
26040	Release palm contracture	Y		A2	15.7852	$661.37
26045	Release palm contracture	Y		A2	27.1049	$1,135.64
26055	Incise finger tendon sheath	Y		A2	15.7852	$661.37
26060	Incision of finger tendon	Y		A2	15.7852	$661.37
26070	Explore/treat hand joint	Y		A2	15.7852	$661.37
26075	Explore/treat finger joint	Y		A2	15.7852	$661.37
26080	Explore/treat finger joint	Y		A2	15.7852	$661.37
26100	Biopsy hand joint lining	Y		A2	15.7852	$661.37
26105	Biopsy finger joint lining	Y		A2	15.7852	$661.37
26110	Biopsy finger joint lining	Y		A2	15.7852	$661.37
26111	Exc hand les sc > 1.5 cm	Y		G2	21.9314	$918.88
26113	Exc hand tum deep > 1.5 cm	Y		G2	21.9314	$918.88
26115*	Exc hand les sc < 1.5 cm	Y		P3		$274.74
26116	Exc hand tum deep < 1.5 cm	Y		G2	16.5641	$694.00
26117	Exc hand tum ra < 3 cm	Y		G2	16.5641	$694.00
26118	Exc hand tum ra > 3 cm	Y		G2	21.9314	$918.88
26121	Release palm contracture	Y		A2	27.1049	$1,135.64
26123	Release palm contracture	Y		A2	27.1049	$1,135.64
26125	Release palm contracture	Y		A2	15.7852	$661.37
26130	Remove wrist joint lining	Y		A2	15.7852	$661.37
26135	Revise finger joint, each	Y		A2	27.1049	$1,135.64
26140	Revise finger joint, each	Y		A2	15.7852	$661.37
26145	Tendon excision, palm/finger	Y		A2	15.7852	$661.37
26160	Remove tendon sheath lesion	Y		A2	15.7852	$661.37
26170	Removal of palm tendon, each	Y		A2	15.7852	$661.37
26180	Removal of finger tendon	Y		A2	15.7852	$661.37
26185	Remove finger bone	Y		A2	15.7852	$661.37
26200	Remove hand bone lesion	Y		A2	15.7852	$661.37
26205	Remove/graft bone lesion	Y		A2	27.1049	$1,135.64
26210	Removal of finger lesion	Y		A2	15.7852	$661.37
26215	Remove/graft finger lesion	Y		A2	15.7852	$661.37

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
26230	Partial removal of hand bone	Y		A2	15.7852	$661.37
26235	Partial removal, finger bone	Y		A2	15.7852	$661.37
26236	Partial removal, finger bone	Y		A2	15.7852	$661.37
26250	Extensive hand surgery	Y		A2	15.7852	$661.37
26260	Resect prox finger tumor	Y		A2	15.7852	$661.37
26262	Resect distal finger tumor	Y		A2	15.7852	$661.37
26320	Removal of implant from hand	Y		A2	16.564	$694.00
26340	Manipulate finger w/anesth	Y		G2	4.7807	$200.30
26350	Repair finger/hand tendon	Y		A2	27.1049	$1,135.64
26352	Repair/graft hand tendon	Y		A2	27.1049	$1,135.64
26356	Repair finger/hand tendon	Y		A2	27.1049	$1,135.64
26357	Repair finger/hand tendon	Y		A2	27.1049	$1,135.64
26358	Repair/graft hand tendon	Y		A2	27.1049	$1,135.64
26370	Repair finger/hand tendon	Y		A2	27.1049	$1,135.64
26372	Repair/graft hand tendon	Y		A2	27.1049	$1,135.64
26373	Repair finger/hand tendon	Y		A2	27.1049	$1,135.64
26390	Revise hand/finger tendon	Y		A2	27.1049	$1,135.64
26392	Repair/graft hand tendon	Y		A2	27.1049	$1,135.64
26410	Repair hand tendon	Y		A2	15.7852	$661.37
26412	Repair/graft hand tendon	Y		A2	27.1049	$1,135.64
26415	Excision, hand/finger tendon	Y		A2	27.1049	$1,135.64
26416	Graft hand or finger tendon	Y		A2	27.1049	$1,135.64
26418	Repair finger tendon	Y		A2	15.7852	$661.37
26420	Repair/graft finger tendon	Y		A2	27.1049	$1,135.64
26426	Repair finger/hand tendon	Y		A2	27.1049	$1,135.64
26428	Repair/graft finger tendon	Y		A2	27.1049	$1,135.64
26432	Repair finger tendon	Y		A2	15.7852	$661.37
26433	Repair finger tendon	Y		A2	15.7852	$661.37
26434	Repair/graft finger tendon	Y		A2	27.1049	$1,135.64
26437	Realignment of tendons	Y		A2	15.7852	$661.37
26440	Release palm/finger tendon	Y		A2	15.7852	$661.37
26442	Release palm & finger tendon	Y		A2	27.1049	$1,135.64
26445	Release hand/finger tendon	Y		A2	15.7852	$661.37
26449	Release forearm/hand tendon	Y		A2	27.1049	$1,135.64
26450	Incision of palm tendon	Y		A2	15.7852	$661.37
26455	Incision of finger tendon	Y		A2	15.7852	$661.37
26460	Incise hand/finger tendon	Y		A2	15.7852	$661.37
26471	Fusion of finger tendons	Y		A2	15.7852	$661.37
26474	Fusion of finger tendons	Y		A2	15.7852	$661.37

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
26476	Tendon lengthening	Y		A2	15.7852	$661.37
26477	Tendon shortening	Y		A2	15.7852	$661.37
26478	Lengthening of hand tendon	Y		A2	15.7852	$661.37
26479	Shortening of hand tendon	Y		A2	15.7852	$661.37
26480	Transplant hand tendon	Y		A2	27.1049	$1,135.64
26483	Transplant/graft hand tendon	Y		A2	27.1049	$1,135.64
26485	Transplant palm tendon	Y		A2	27.1049	$1,135.64
26489	Transplant/graft palm tendon	Y		A2	27.1049	$1,135.64
26490	Revise thumb tendon	Y		A2	27.1049	$1,135.64
26492	Tendon transfer with graft	Y		A2	27.1049	$1,135.64
26494	Hand tendon/muscle transfer	Y		A2	27.1049	$1,135.64
26496	Revise thumb tendon	Y		A2	27.1049	$1,135.64
26497	Finger tendon transfer	Y		A2	27.1049	$1,135.64
26498	Finger tendon transfer	Y		A2	27.1049	$1,135.64
26499	Revision of finger	Y		A2	27.1049	$1,135.64
26500	Hand tendon reconstruction	Y		A2	15.7852	$661.37
26502	Hand tendon reconstruction	Y		A2	27.1049	$1,135.64
26508	Release thumb contracture	Y		A2	15.7852	$661.37
26510	Thumb tendon transfer	Y		A2	27.1049	$1,135.64
26516	Fusion of knuckle joint	Y		A2	27.1049	$1,135.64
26517	Fusion of knuckle joints	Y		A2	27.1049	$1,135.64
26518	Fusion of knuckle joints	Y		A2	27.1049	$1,135.64
26520	Release knuckle contracture	Y		A2	15.7852	$661.37
26525	Release finger contracture	Y		A2	15.7852	$661.37
26530	Revise knuckle joint	Y		A2	35.5174	$1,488.11
26531	Revise knuckle with implant	Y		A2	54.7826	$2,295.28
26535	Revise finger joint	Y		A2	35.5174	$1,488.11
26536	Revise/implant finger joint	Y		A2	54.7826	$2,295.28
26540	Repair hand joint	Y		A2	15.7852	$661.37
26541	Repair hand joint with graft	Y		A2	27.1049	$1,135.64
26542	Repair hand joint with graft	Y		A2	15.7852	$661.37
26545	Reconstruct finger joint	Y		A2	27.1049	$1,135.64
26546	Repair nonunion hand	Y		A2	27.1049	$1,135.64
26548	Reconstruct finger joint	Y		A2	27.1049	$1,135.64
26550	Construct thumb replacement	Y		A2	27.1049	$1,135.64
26555	Positional change of finger	Y		A2	27.1049	$1,135.64
26560	Repair of web finger	Y		A2	15.7852	$661.37
26561	Repair of web finger	Y		A2	27.1049	$1,135.64
26562	Repair of web finger	Y		A2	27.1049	$1,135.64

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
26565	Correct metacarpal flaw	Y		A2	27.1049	$1,135.64
26567	Correct finger deformity	Y		A2	27.1049	$1,135.64
26568	Lengthen metacarpal/finger	Y		A2	27.1049	$1,135.64
26580	Repair hand deformity	Y		A2	15.7852	$661.37
26587	Reconstruct extra finger	Y		A2	15.7852	$661.37
26590	Repair finger deformity	Y		A2	15.7852	$661.37
26591	Repair muscles of hand	Y		A2	27.1049	$1,135.64
26593	Release muscles of hand	Y		A2	15.7852	$661.37
26596	Excision constricting tissue	Y		A2	15.7852	$661.37
26600	Treat metacarpal fracture	Y		P2	1.4839	$62.17
26605	Treat metacarpal fracture	Y		A2	1.4841	$62.17
26607	Treat metacarpal fracture	Y		A2	19.0792	$799.38
26608	Treat metacarpal fracture	Y		A2	24.2634	$1,016.59
26615	Treat metacarpal fracture	Y		A2	43.7071	$1,831.24
26641	Treat thumb dislocation	Y		P2	1.4839	$62.17
26645	Treat thumb fracture	Y		A2	4.7807	$200.30
26650	Treat thumb fracture	Y		A2	24.2634	$1,016.59
26665	Treat thumb fracture	Y		A2	43.7071	$1,831.24
26670	Treat hand dislocation	Y		P2	1.4839	$62.17
26675	Treat hand dislocation	Y		A2	4.7807	$200.30
26676	Pin hand dislocation	Y		A2	24.2634	$1,016.59
26685	Treat hand dislocation	Y		A2	24.2634	$1,016.59
26686	Treat hand dislocation	Y		A2	60.5167	$2,535.53
26700	Treat knuckle dislocation	Y		P2	1.4839	$62.17
26705	Treat knuckle dislocation	Y		A2	1.4841	$62.17
26706	Pin knuckle dislocation	Y		A2	19.0792	$799.38
26715	Treat knuckle dislocation	Y		A2	24.2634	$1,016.59
26720	Treat finger fracture, each	Y		P2	1.4839	$62.17
26725	Treat finger fracture, each	Y		P2	1.4839	$62.17
26727	Treat finger fracture, each	Y		A2	24.2634	$1,016.59
26735	Treat finger fracture, each	Y		A2	24.2634	$1,016.59
26740	Treat finger fracture, each	Y		P2	1.4839	$62.17
26742	Treat finger fracture, each	Y		A2	1.4841	$62.17
26746	Treat finger fracture, each	Y		A2	24.2634	$1,016.59
26750	Treat finger fracture, each	Y		P2	1.4839	$62.17
26755	Treat finger fracture, each	Y		G2	1.4839	$62.17
26756	Pin finger fracture, each	Y		A2	24.2634	$1,016.59
26765	Treat finger fracture, each	Y		A2	24.2634	$1,016.59
26770	Treat finger dislocation	Y		G2	1.4839	$62.17

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
26775	Treat finger dislocation	Y		P3		$148.29
26776	Pin finger dislocation	Y		A2	24.2634	$1,016.59
26785	Treat finger dislocation	Y		A2	24.2634	$1,016.59
26820	Thumb fusion with graft	Y		A2	27.1049	$1,135.64
26841	Fusion of thumb	Y		A2	27.1049	$1,135.64
26842	Thumb fusion with graft	Y		A2	27.1049	$1,135.64
26843	Fusion of hand joint	Y		A2	27.1049	$1,135.64
26844	Fusion/graft of hand joint	Y		A2	27.1049	$1,135.64
26850	Fusion of knuckle	Y		A2	27.1049	$1,135.64
26852	Fusion of knuckle with graft	Y		A2	27.1049	$1,135.64
26860	Fusion of finger joint	Y		A2	27.1049	$1,135.64
26861	Fusion of finger jnt, add-on	Y		A2	27.1049	$1,135.64
26862	Fusion/graft of finger joint	Y		A2	27.1049	$1,135.64
26863	Fuse/graft added joint	Y		A2	27.1049	$1,135.64
26910	Amputate metacarpal bone	Y		A2	27.1049	$1,135.64
26951	Amputation of finger/thumb	Y		A2	15.7852	$661.37
26952	Amputation of finger/thumb	Y		A2	15.7852	$661.37
26990	Drainage of pelvis lesion	Y		A2	21.1115	$884.53
26991	Drainage of pelvis bursa	Y		A2	21.1115	$884.53
27000	Incision of hip tendon	Y		A2	21.1115	$884.53
27001	Incision of hip tendon	Y		A2	29.4747	$1,234.93
27003	Incision of hip tendon	Y		A2	29.4747	$1,234.93
27033	Exploration of hip joint	Y		A2	43.0648	$1,804.33
27035	Denervation of hip joint	Y		A2	43.0648	$1,804.33
27040	Biopsy of soft tissues	Y		A2	7.9784	$334.28
27041	Biopsy of soft tissues	Y		A2	7.9784	$334.28
27043	Exc hip pelvis les sc > 3 cm	Y		G2	21.9314	$918.88
27045	Exc hip/pelv tum deep > 5 cm	Y		G2	21.9314	$918.88
27047*	Exc hip/pelvis les sc < 3 cm	Y		P3		$197.15
27048	Exc hip/pelv tum deep < 5 cm	Y		G2	16.5641	$694.00
27049	Resect hip/pelv tum < 5 cm	Y		G2	16.5641	$694.00
27050	Biopsy of sacroiliac joint	Y		A2	21.1115	$884.53
27052	Biopsy of hip joint	Y		A2	21.1115	$884.53
27059	Resect hip/pelv tum > 5 cm	Y		G2	21.9314	$918.88
27060	Removal of ischial bursa	Y		A2	21.1115	$884.53
27062	Remove femur lesion/bursa	Y		A2	21.1115	$884.53
27065	Removal of hip bone lesion	Y		A2	21.1115	$884.53
27066	Removal of hip bone lesion	Y		A2	29.4747	$1,234.93
27067	Remove/graft hip bone lesion	Y		A2	29.4747	$1,234.93

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
27080	Removal of tail bone	Y		A2	29.4747	$1,234.93
27086	Remove hip foreign body	Y		A2	7.9784	$334.28
27087	Remove hip foreign body	Y		A2	21.1115	$884.53
27093	Injection for hip x-ray	N		N1		
27095	Injection for hip x-ray	N		N1		
27097	Revision of hip tendon	Y		A2	29.4747	$1,234.93
27098	Transfer tendon to pelvis	Y		A2	29.4747	$1,234.93
27100	Transfer of abdominal muscle	Y		A2	43.0648	$1,804.33
27105	Transfer of spinal muscle	Y		A2	43.0648	$1,804.33
27110	Transfer of iliopsoas muscle	Y		A2	43.0648	$1,804.33
27111	Transfer of iliopsoas muscle	Y		A2	43.0648	$1,804.33
27193	Treat pelvic ring fracture	Y		A2	1.4841	$62.17
27194	Treat pelvic ring fracture	Y		A2	14.1484	$592.79
27200	Treat tail bone fracture	Y		P2	1.4839	$62.17
27202	Treat tail bone fracture	Y		A2	43.7071	$1,831.24
27220	Treat hip socket fracture	Y		G2	1.4839	$62.17
27230	Treat thigh fracture	Y		A2	1.4841	$62.17
27238	Treat thigh fracture	Y		A2	4.7807	$200.30
27246	Treat thigh fracture	Y		A2	4.7807	$200.30
27250	Treat hip dislocation	Y		A2	1.4841	$62.17
27252	Treat hip dislocation	Y		A2	14.1484	$592.79
27256	Treat hip dislocation	Y		G2	1.4839	$62.17
27257	Treat hip dislocation	Y		A2	14.1484	$592.79
27265	Treat hip dislocation	Y		A2	1.4841	$62.17
27266	Treat hip dislocation	Y		A2	14.1484	$592.79
27267	Cltx thigh fx	Y		G2	1.4839	$62.17
27275	Manipulation of hip joint	Y		A2	14.1484	$592.79
27301	Drain thigh/knee lesion	Y		A2	18.4054	$771.15
27305	Incise thigh tendon & fascia	Y		A2	21.1115	$884.53
27306	Incision of thigh tendon	Y		A2	21.1115	$884.53
27307	Incision of thigh tendons	Y		A2	21.1115	$884.53
27310	Exploration of knee joint	Y		A2	29.4747	$1,234.93
27323	Biopsy, thigh soft tissues	Y		A2	7.9784	$334.28
27324	Biopsy, thigh soft tissues	Y		A2	21.9314	$918.88
27325	Neurectomy, hamstring	Y		A2	17.5922	$737.08
27326	Neurectomy, popliteal	Y		A2	17.5922	$737.08
27327*	Exc thigh/knee les sc < 3 cm	Y		P3		$191.01
27328	Exc thigh/knee tum deep <5cm	Y		G2	16.5641	$694.00
27329	Resect thigh/knee tum < 5 cm	Y		G2	16.5641	$694.00

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
27330	Biopsy, knee joint lining	Y		A2	29.4747	$1,234.93
27331	Explore/treat knee joint	Y		A2	29.4747	$1,234.93
27332	Removal of knee cartilage	Y		A2	29.4747	$1,234.93
27333	Removal of knee cartilage	Y		A2	29.4747	$1,234.93
27334	Remove knee joint lining	Y		A2	29.4747	$1,234.93
27335	Remove knee joint lining	Y		A2	29.4747	$1,234.93
27337	Exc thigh/knee les sc > 3 cm	Y		G2	21.9314	$918.88
27339	Exc thigh/knee tum deep >5cm	Y		G2	21.9314	$918.88
27340	Removal of kneecap bursa	Y		A2	21.1115	$884.53
27345	Removal of knee cyst	Y		A2	21.1115	$884.53
27347	Remove knee cyst	Y		A2	21.1115	$884.53
27350	Removal of kneecap	Y		A2	29.4747	$1,234.93
27355	Remove femur lesion	Y		A2	29.4747	$1,234.93
27356	Remove femur lesion/graft	Y		A2	29.4747	$1,234.93
27357	Remove femur lesion/graft	Y		A2	29.4747	$1,234.93
27358	Remove femur lesion/fixation	Y		A2	29.4747	$1,234.93
27360	Partial removal, leg bone(s)	Y		A2	29.4747	$1,234.93
27364	Resect thigh/knee tum >5 cm	Y		G2	21.9314	$918.88
27370	Injection for knee x-ray	N		N1		
27372	Removal of foreign body	Y		A2	21.9314	$918.88
27380	Repair of kneecap tendon	Y		A2	21.1115	$884.53
27381	Repair/graft kneecap tendon	Y		A2	21.1115	$884.53
27385	Repair of thigh muscle	Y		A2	21.1115	$884.53
27386	Repair/graft of thigh muscle	Y		A2	21.1115	$884.53
27390	Incision of thigh tendon	Y		A2	21.1115	$884.53
27391	Incision of thigh tendons	Y		A2	21.1115	$884.53
27392	Incision of thigh tendons	Y		A2	21.1115	$884.53
27393	Lengthening of thigh tendon	Y		A2	29.4747	$1,234.93
27394	Lengthening of thigh tendons	Y		A2	29.4747	$1,234.93
27395	Lengthening of thigh tendons	Y		A2	43.0648	$1,804.33
27396	Transplant of thigh tendon	Y		A2	29.4747	$1,234.93
27397	Transplants of thigh tendons	Y		A2	43.0648	$1,804.33
27400	Revise thigh muscles/tendons	Y		A2	43.0648	$1,804.33
27403	Repair of knee cartilage	Y		A2	29.4747	$1,234.93
27405	Repair of knee ligament	Y		A2	43.0648	$1,804.33
27407	Repair of knee ligament	Y		A2	80.4692	$3,371.49
27409	Repair of knee ligaments	Y		A2	80.4692	$3,371.49
27416	Osteochondral knee autograft	Y		G2	43.0649	$1,804.33
27418	Repair degenerated kneecap	Y		A2	43.0648	$1,804.33

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
27420	Revision of unstable kneecap	Y		A2	43.0648	$1,804.33
27422	Revision of unstable kneecap	Y		A2	43.0648	$1,804.33
27424	Revision/removal of kneecap	Y		A2	43.0648	$1,804.33
27425	Lat retinacular release open	Y		A2	29.4747	$1,234.93
27427	Reconstruction, knee	Y		A2	80.4692	$3,371.49
27428	Reconstruction, knee	Y		A2	80.4692	$3,371.49
27429	Reconstruction, knee	Y		A2	80.4692	$3,371.49
27430	Revision of thigh muscles	Y		A2	43.0648	$1,804.33
27435	Incision of knee joint	Y		A2	43.0648	$1,804.33
27437	Revise kneecap	Y		A2	35.5174	$1,488.11
27438	Revise kneecap with implant	Y		A2	54.7826	$2,295.28
27440	Revision of knee joint	Y		G2	35.5174	$1,488.11
27441	Revision of knee joint	Y		A2	35.5174	$1,488.11
27442	Revision of knee joint	Y		A2	35.5174	$1,488.11
27443	Revision of knee joint	Y		A2	35.5174	$1,488.11
27446	Revision of knee joint	Y		J8	162.8173	$6,821.72
27475	Surgery to stop leg growth	Y		G2	29.4746	$1,234.93
27479	Surgery to stop leg growth	Y		G2	29.4746	$1,234.93
27496	Decompression of thigh/knee	Y		A2	29.4747	$1,234.93
27497	Decompression of thigh/knee	Y		A2	21.1115	$884.53
27498	Decompression of thigh/knee	Y		A2	29.4747	$1,234.93
27499	Decompression of thigh/knee	Y		A2	29.4747	$1,234.93
27500	Treatment of thigh fracture	Y		A2	4.7807	$200.30
27501	Treatment of thigh fracture	Y		A2	1.4841	$62.17
27502	Treatment of thigh fracture	Y		A2	19.0792	$799.38
27503	Treatment of thigh fracture	Y		A2	1.4841	$62.17
27508	Treatment of thigh fracture	Y		A2	1.4841	$62.17
27509	Treatment of thigh fracture	Y		A2	24.2634	$1,016.59
27510	Treatment of thigh fracture	Y		A2	4.7807	$200.30
27516	Treat thigh fx growth plate	Y		A2	1.4841	$62.17
27517	Treat thigh fx growth plate	Y		A2	1.4841	$62.17
27520	Treat kneecap fracture	Y		A2	1.4841	$62.17
27530	Treat knee fracture	Y		A2	1.4841	$62.17
27532	Treat knee fracture	Y		A2	19.0792	$799.38
27538	Treat knee fracture(s)	Y		A2	1.4841	$62.17
27550	Treat knee dislocation	Y		A2	1.4841	$62.17
27552	Treat knee dislocation	Y		A2	14.1484	$592.79
27560	Treat kneecap dislocation	Y		A2	1.4841	$62.17
27562	Treat kneecap dislocation	Y		A2	14.1484	$592.79

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
27566	Treat kneecap dislocation	Y		A2	43.7071	$1,831.24
27570	Fixation of knee joint	Y		A2	14.1484	$592.79
27594	Amputation follow-up surgery	Y		A2	21.1115	$884.53
27600	Decompression of lower leg	Y		A2	21.1115	$884.53
27601	Decompression of lower leg	Y		A2	21.1115	$884.53
27602	Decompression of lower leg	Y		A2	21.1115	$884.53
27603	Drain lower leg lesion	Y		A2	18.4054	$771.15
27604	Drain lower leg bursa	Y		A2	21.1115	$884.53
27605	Incision of achilles tendon	Y		A2	20.632	$864.44
27606	Incision of achilles tendon	Y		A2	21.1115	$884.53
27607	Treat lower leg bone lesion	Y		A2	21.1115	$884.53
27610	Explore/treat ankle joint	Y		A2	29.4747	$1,234.93
27612	Exploration of ankle joint	Y		A2	29.4747	$1,234.93
27613	Biopsy lower leg soft tissue	Y		P3		$114.41
27614	Biopsy lower leg soft tissue	Y		A2	21.9314	$918.88
27615	Resect leg/ankle tum < 5 cm	Y		G2	16.5641	$694.00
27616	Resect leg/ankle tum > 5 cm	Y		G2	21.9314	$918.88
27618*	Exc leg/ankle tum < 3 cm	Y		P3		$193.96
27619	Exc leg/ankle tum deep <5 cm	Y		G2	16.5641	$694.00
27620	Explore/treat ankle joint	Y		A2	29.4747	$1,234.93
27625	Remove ankle joint lining	Y		A2	29.4747	$1,234.93
27626	Remove ankle joint lining	Y		A2	29.4747	$1,234.93
27630	Removal of tendon lesion	Y		A2	21.1115	$884.53
27632	Exc leg/ankle les sc > 3 cm	Y		G2	21.9314	$918.88
27634	Exc leg/ankle tum deep >5 cm	Y		G2	21.9314	$918.88
27635	Remove lower leg bone lesion	Y		A2	29.4747	$1,234.93
27637	Remove/graft leg bone lesion	Y		A2	29.4747	$1,234.93
27638	Remove/graft leg bone lesion	Y		A2	29.4747	$1,234.93
27640	Partial removal of tibia	Y		A2	43.0648	$1,804.33
27641	Partial removal of fibula	Y		A2	29.4747	$1,234.93
27647	Resect talus/calcaneus tum	Y		A2	43.0648	$1,804.33
27648	Injection for ankle x-ray	N		N1		
27650	Repair achilles tendon	Y		A2	43.0648	$1,804.33
27652	Repair/graft achilles tendon	Y		A2	80.4692	$3,371.49
27654	Repair of achilles tendon	Y		A2	43.0648	$1,804.33
27656	Repair leg fascia defect	Y		A2	21.1115	$884.53
27658	Repair of leg tendon, each	Y		A2	21.1115	$884.53
27659	Repair of leg tendon, each	Y		A2	21.1115	$884.53
27664	Repair of leg tendon, each	Y		A2	29.4747	$1,234.93

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
27665	Repair of leg tendon, each	Y		A2	29.4747	$1,234.93
27675	Repair lower leg tendons	Y		A2	21.1115	$884.53
27676	Repair lower leg tendons	Y		A2	29.4747	$1,234.93
27680	Release of lower leg tendon	Y		A2	29.4747	$1,234.93
27681	Release of lower leg tendons	Y		A2	29.4747	$1,234.93
27685	Revision of lower leg tendon	Y		A2	29.4747	$1,234.93
27686	Revise lower leg tendons	Y		A2	29.4747	$1,234.93
27687	Revision of calf tendon	Y		A2	29.4747	$1,234.93
27690	Revise lower leg tendon	Y		A2	43.0648	$1,804.33
27691	Revise lower leg tendon	Y		A2	43.0648	$1,804.33
27692	Revise additional leg tendon	Y		A2	43.0648	$1,804.33
27695	Repair of ankle ligament	Y		A2	29.4747	$1,234.93
27696	Repair of ankle ligaments	Y		A2	29.4747	$1,234.93
27698	Repair of ankle ligament	Y		A2	29.4747	$1,234.93
27700	Revision of ankle joint	Y		A2	35.5174	$1,488.11
27704	Removal of ankle implant	Y		A2	21.1115	$884.53
27705	Incision of tibia	Y		A2	43.0648	$1,804.33
27707	Incision of fibula	Y		A2	21.1115	$884.53
27709	Incision of tibia & fibula	Y		A2	29.4747	$1,234.93
27720	Repair of tibia	Y		G2	43.7072	$1,831.24
27726	Repair fibula nonunion	Y		G2	43.7072	$1,831.24
27730	Repair of tibia epiphysis	Y		A2	29.4747	$1,234.93
27732	Repair of fibula epiphysis	Y		A2	29.4747	$1,234.93
27734	Repair lower leg epiphyses	Y		A2	29.4747	$1,234.93
27740	Repair of leg epiphyses	Y		A2	29.4747	$1,234.93
27742	Repair of leg epiphyses	Y		A2	43.0648	$1,804.33
27745	Reinforce tibia	Y		A2	80.4692	$3,371.49
27750	Treatment of tibia fracture	Y		A2	1.4841	$62.17
27752	Treatment of tibia fracture	Y		A2	19.0792	$799.38
27756	Treatment of tibia fracture	Y		A2	24.2634	$1,016.59
27758	Treatment of tibia fracture	Y		A2	43.7071	$1,831.24
27759	Treatment of tibia fracture	Y		A2	60.5167	$2,535.53
27760	Cltx medial ankle fx	Y		A2	1.4841	$62.17
27762	Cltx med ankle fx w/mnpj	Y		A2	19.0792	$799.38
27766	Optx medial ankle fx	Y		A2	43.7071	$1,831.24
27767	Cltx post ankle fx	Y	CH	P2	1.4839	$62.17
27768	Cltx post ankle fx w/mnpj	Y		G2	1.4839	$62.17
27769	Optx post ankle fx	Y		G2	43.7072	$1,831.24
27780	Treatment of fibula fracture	Y		A2	1.4841	$62.17

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
27781	Treatment of fibula fracture	Y		A2	19.0792	$799.38
27784	Treatment of fibula fracture	Y		A2	43.7071	$1,831.24
27786	Treatment of ankle fracture	Y		A2	1.4841	$62.17
27788	Treatment of ankle fracture	Y		A2	1.4841	$62.17
27792	Treatment of ankle fracture	Y		A2	43.7071	$1,831.24
27808	Treatment of ankle fracture	Y		A2	1.4841	$62.17
27810	Treatment of ankle fracture	Y		A2	4.7807	$200.30
27814	Treatment of ankle fracture	Y		A2	43.7071	$1,831.24
27816	Treatment of ankle fracture	Y		A2	1.4841	$62.17
27818	Treatment of ankle fracture	Y		A2	4.7807	$200.30
27822	Treatment of ankle fracture	Y		A2	43.7071	$1,831.24
27823	Treatment of ankle fracture	Y		A2	60.5167	$2,535.53
27824	Treat lower leg fracture	Y		A2	1.4841	$62.17
27825	Treat lower leg fracture	Y		A2	19.0792	$799.38
27826	Treat lower leg fracture	Y		A2	43.7071	$1,831.24
27827	Treat lower leg fracture	Y		A2	60.5167	$2,535.53
27828	Treat lower leg fracture	Y		A2	60.5167	$2,535.53
27829	Treat lower leg joint	Y		A2	43.7071	$1,831.24
27830	Treat lower leg dislocation	Y		A2	1.4841	$62.17
27831	Treat lower leg dislocation	Y		A2	19.0792	$799.38
27832	Treat lower leg dislocation	Y		A2	43.7071	$1,831.24
27840	Treat ankle dislocation	Y		A2	4.7807	$200.30
27842	Treat ankle dislocation	Y		A2	14.1484	$592.79
27846	Treat ankle dislocation	Y		A2	43.7071	$1,831.24
27848	Treat ankle dislocation	Y		A2	43.7071	$1,831.24
27860	Fixation of ankle joint	Y		A2	14.1484	$592.79
27870	Fusion of ankle joint, open	Y		A2	80.4692	$3,371.49
27871	Fusion of tibiofibular joint	Y		A2	80.4692	$3,371.49
27884	Amputation follow-up surgery	Y		A2	21.1115	$884.53
27889	Amputation of foot at ankle	Y		A2	29.4747	$1,234.93
27892	Decompression of leg	Y		A2	29.4747	$1,234.93
27893	Decompression of leg	Y		A2	29.4747	$1,234.93
27894	Decompression of leg	Y		A2	29.4747	$1,234.93
28001	Drainage of bursa of foot	Y		P3		$114.41
28002	Treatment of foot infection	Y		A2	21.1115	$884.53
28003	Treatment of foot infection	Y		A2	21.1115	$884.53
28005	Treat foot bone lesion	Y		A2	20.632	$864.44
28008	Incision of foot fascia	Y		A2	20.632	$864.44
28010	Incision of toe tendon	Y		P3		$83.72

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
28011	Incision of toe tendons	Y		A2	20.632	$864.44
28020	Exploration of foot joint	Y		A2	20.632	$864.44
28022	Exploration of foot joint	Y		A2	20.632	$864.44
28024	Exploration of toe joint	Y		A2	20.632	$864.44
28035	Decompression of tibia nerve	Y		A2	17.5922	$737.08
28039*	Exc foot/toe tum sc > 1.5 cm	Y		P3		$201.57
28041*	Exc foot/toe tum deep >1.5cm	Y		R2	21.9314	$918.88
28043*	Exc foot/toe tum sc < 1.5 cm	Y		P3		$156.64
28045*	Exc foot/toe tum deep <1.5cm	Y		P3		$203.29
28046*	Resect foot/toe tumor < 3 cm	Y		R2	16.5641	$694.00
28047	Resect foot/toe tumor > 3 cm	Y		G2	21.9314	$918.88
28050	Biopsy of foot joint lining	Y		A2	20.632	$864.44
28052	Biopsy of foot joint lining	Y		A2	20.632	$864.44
28054	Biopsy of toe joint lining	Y		A2	20.632	$864.44
28055	Neurectomy, foot	Y		A2	17.5922	$737.08
28060	Partial removal, foot fascia	Y		A2	20.632	$864.44
28062	Removal of foot fascia	Y		A2	20.632	$864.44
28070	Removal of foot joint lining	Y		A2	20.632	$864.44
28072	Removal of foot joint lining	Y		A2	20.632	$864.44
28080	Removal of foot lesion	Y		A2	20.632	$864.44
28086	Excise foot tendon sheath	Y		A2	20.632	$864.44
28088	Excise foot tendon sheath	Y		A2	20.632	$864.44
28090	Removal of foot lesion	Y		A2	20.632	$864.44
28092	Removal of toe lesions	Y		A2	20.632	$864.44
28100	Removal of ankle/heel lesion	Y		A2	20.632	$864.44
28102	Remove/graft foot lesion	Y		A2	50.4554	$2,113.98
28103	Remove/graft foot lesion	Y		A2	50.4554	$2,113.98
28104	Removal of foot lesion	Y		A2	20.632	$864.44
28106	Remove/graft foot lesion	Y		A2	50.4554	$2,113.98
28107	Remove/graft foot lesion	Y		A2	50.4554	$2,113.98
28108	Removal of toe lesions	Y		A2	20.632	$864.44
28110	Part removal of metatarsal	Y		A2	20.632	$864.44
28111	Part removal of metatarsal	Y		A2	20.632	$864.44
28112	Part removal of metatarsal	Y		A2	20.632	$864.44
28113	Part removal of metatarsal	Y		A2	20.632	$864.44
28114	Removal of metatarsal heads	Y		A2	20.632	$864.44
28116	Revision of foot	Y		A2	20.632	$864.44
28118	Removal of heel bone	Y		A2	20.632	$864.44
28119	Removal of heel spur	Y		A2	20.632	$864.44

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
28120	Part removal of ankle/heel	Y		A2	20.632	$864.44
28122	Partial removal of foot bone	Y		A2	20.632	$864.44
28124	Partial removal of toe	Y		P3		$194.94
28126	Partial removal of toe	Y		A2	20.632	$864.44
28130	Removal of ankle bone	Y		A2	20.632	$864.44
28140	Removal of metatarsal	Y		A2	20.632	$864.44
28150	Removal of toe	Y		A2	20.632	$864.44
28153	Partial removal of toe	Y		A2	20.632	$864.44
28160	Partial removal of toe	Y		A2	20.632	$864.44
28171	Resect tarsal tumor	Y		A2	20.632	$864.44
28173	Resect metatarsal tumor	Y		A2	20.632	$864.44
28175	Resect phalanx of toe tumor	Y		A2	20.632	$864.44
28190	Removal of foot foreign body	Y		P3		$118.83
28192	Removal of foot foreign body	Y		A2	16.564	$694.00
28193	Removal of foot foreign body	Y		A2	7.9784	$334.28
28200	Repair of foot tendon	Y		A2	20.632	$864.44
28202	Repair/graft of foot tendon	Y		A2	20.632	$864.44
28208	Repair of foot tendon	Y		A2	20.632	$864.44
28210	Repair/graft of foot tendon	Y		A2	50.4554	$2,113.98
28220	Release of foot tendon	Y		P3		$183.65
28222	Release of foot tendons	Y		A2	20.632	$864.44
28225	Release of foot tendon	Y		A2	20.632	$864.44
28226	Release of foot tendons	Y		A2	20.632	$864.44
28230	Incision of foot tendon(s)	Y		P3		$179.72
28232	Incision of toe tendon	Y		P3		$172.85
28234	Incision of foot tendon	Y		A2	20.632	$864.44
28238	Revision of foot tendon	Y		A2	50.4554	$2,113.98
28240	Release of big toe	Y		A2	20.632	$864.44
28250	Revision of foot fascia	Y		A2	20.632	$864.44
28260	Release of midfoot joint	Y		A2	20.632	$864.44
28261	Revision of foot tendon	Y		A2	20.632	$864.44
28262	Revision of foot and ankle	Y		A2	20.632	$864.44
28264	Release of midfoot joint	Y		A2	50.4554	$2,113.98
28270	Release of foot contracture	Y		A2	20.632	$864.44
28272	Release of toe joint, each	Y		P3		$166.22
28280	Fusion of toes	Y		A2	20.632	$864.44
28285	Repair of hammertoe	Y		A2	20.632	$864.44
28286	Repair of hammertoe	Y		A2	20.632	$864.44
28288	Partial removal of foot bone	Y		A2	20.632	$864.44

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
28289	Repair hallux rigidus	Y		A2	20.632	$864.44
28290	Correction of bunion	Y		A2	30.3473	$1,271.49
28292	Correction of bunion	Y		A2	30.3473	$1,271.49
28293	Correction of bunion	Y		A2	30.3473	$1,271.49
28294	Correction of bunion	Y		A2	30.3473	$1,271.49
28296	Correction of bunion	Y		A2	30.3473	$1,271.49
28297	Correction of bunion	Y		A2	30.3473	$1,271.49
28298	Correction of bunion	Y		A2	30.3473	$1,271.49
28299	Correction of bunion	Y		A2	30.3473	$1,271.49
28300	Incision of heel bone	Y		A2	50.4554	$2,113.98
28302	Incision of ankle bone	Y		A2	20.632	$864.44
28304	Incision of midfoot bones	Y		A2	50.4554	$2,113.98
28305	Incise/graft midfoot bones	Y		A2	50.4554	$2,113.98
28306	Incision of metatarsal	Y		A2	20.632	$864.44
28307	Incision of metatarsal	Y		A2	20.632	$864.44
28308	Incision of metatarsal	Y		A2	20.632	$864.44
28309	Incision of metatarsals	Y		A2	50.4554	$2,113.98
28310	Revision of big toe	Y		A2	20.632	$864.44
28312	Revision of toe	Y		A2	20.632	$864.44
28313	Repair deformity of toe	Y		A2	20.632	$864.44
28315	Removal of sesamoid bone	Y		A2	20.632	$864.44
28320	Repair of foot bones	Y		A2	50.4554	$2,113.98
28322	Repair of metatarsals	Y		A2	50.4554	$2,113.98
28340	Resect enlarged toe tissue	Y		A2	20.632	$864.44
28341	Resect enlarged toe	Y		A2	20.632	$864.44
28344	Repair extra toe(s)	Y		A2	20.632	$864.44
28345	Repair webbed toe(s)	Y		A2	20.632	$864.44
28400	Treatment of heel fracture	Y		A2	1.4841	$62.17
28405	Treatment of heel fracture	Y		A2	19.0792	$799.38
28406	Treatment of heel fracture	Y		A2	24.2634	$1,016.59
28415	Treat heel fracture	Y		A2	60.5167	$2,535.53
28420	Treat/graft heel fracture	Y		A2	43.7071	$1,831.24
28430	Treatment of ankle fracture	Y		P2	1.4839	$62.17
28435	Treatment of ankle fracture	Y		A2	1.4841	$62.17
28436	Treatment of ankle fracture	Y		A2	24.2634	$1,016.59
28445	Treat ankle fracture	Y		A2	43.7071	$1,831.24
28446	Osteochondral talus autogrft	Y		G2	50.4553	$2,113.98
28450	Treat midfoot fracture, each	Y		P2	1.4839	$62.17
28455	Treat midfoot fracture, each	Y		P2	1.4839	$62.17

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
28456	Treat midfoot fracture	Y		A2	24.2634	$1,016.59
28465	Treat midfoot fracture, each	Y		A2	43.7071	$1,831.24
28470	Treat metatarsal fracture	Y		P2	1.4839	$62.17
28475	Treat metatarsal fracture	Y		P2	1.4839	$62.17
28476	Treat metatarsal fracture	Y		A2	24.2634	$1,016.59
28485	Treat metatarsal fracture	Y		A2	43.7071	$1,831.24
28490	Treat big toe fracture	Y		P2	1.4839	$62.17
28495	Treat big toe fracture	Y		P2	1.4839	$62.17
28496	Treat big toe fracture	Y		A2	24.2634	$1,016.59
28505	Treat big toe fracture	Y		A2	24.2634	$1,016.59
28510	Treatment of toe fracture	Y		P3		$50.82
28515	Treatment of toe fracture	Y		P2	1.4839	$62.17
28525	Treat toe fracture	Y		A2	24.2634	$1,016.59
28530	Treat sesamoid bone fracture	Y		P3		$49.10
28531	Treat sesamoid bone fracture	Y		A2	24.2634	$1,016.59
28540	Treat foot dislocation	Y		P2	1.4839	$62.17
28545	Treat foot dislocation	Y		A2	24.2634	$1,016.59
28546	Treat foot dislocation	Y		A2	24.2634	$1,016.59
28555	Repair foot dislocation	Y		A2	43.7071	$1,831.24
28570	Treat foot dislocation	Y		P3		$68.75
28575	Treat foot dislocation	Y		A2	19.0792	$799.38
28576	Treat foot dislocation	Y		A2	24.2634	$1,016.59
28585	Repair foot dislocation	Y		A2	24.2634	$1,016.59
28600	Treat foot dislocation	Y		P2	1.4839	$62.17
28605	Treat foot dislocation	Y		A2	1.4841	$62.17
28606	Treat foot dislocation	Y		A2	24.2634	$1,016.59
28615	Repair foot dislocation	Y		A2	43.7071	$1,831.24
28630	Treat toe dislocation	Y	CH	P3		$56.22
28635	Treat toe dislocation	Y		A2	14.1484	$592.79
28636	Treat toe dislocation	Y		A2	24.2634	$1,016.59
28645	Repair toe dislocation	Y		A2	24.2634	$1,016.59
28660	Treat toe dislocation	Y		P3		$41.00
28665	Treat toe dislocation	Y		A2	14.1484	$592.79
28666	Treat toe dislocation	Y		A2	24.2634	$1,016.59
28675	Repair of toe dislocation	Y		A2	24.2634	$1,016.59
28705	Fusion of foot bones	Y		A2	50.4554	$2,113.98
28715	Fusion of foot bones	Y		A2	80.4692	$3,371.49
28725	Fusion of foot bones	Y		A2	50.4554	$2,113.98
28730	Fusion of foot bones	Y		A2	50.4554	$2,113.98

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
28735	Fusion of foot bones	Y		A2	50.4554	$2,113.98
28737	Revision of foot bones	Y		A2	50.4554	$2,113.98
28740	Fusion of foot bones	Y		A2	50.4554	$2,113.98
28750	Fusion of big toe joint	Y		A2	50.4554	$2,113.98
28755	Fusion of big toe joint	Y		A2	20.632	$864.44
28760	Fusion of big toe joint	Y		A2	50.4554	$2,113.98
28810	Amputation toe & metatarsal	Y		A2	20.632	$864.44
28820	Amputation of toe	Y		A2	20.632	$864.44
28825	Partial amputation of toe	Y		A2	20.632	$864.44
28890	High energy eswt, plantar f	Y		P3		$146.08
29000	Application of body cast	N		G2	1.0371	$43.45
29010	Application of body cast	N		P2	2.2646	$94.88
29015	Application of body cast	N		P2	2.2646	$94.88
29020	Application of body cast	N		G2	1.0371	$43.45
29025	Application of body cast	N		P2	1.0371	$43.45
29035	Application of body cast	N		P2	2.2646	$94.88
29040	Application of body cast	N		G2	1.0371	$43.45
29044	Application of body cast	N		P2	2.2646	$94.88
29046	Application of body cast	N		G2	2.2646	$94.88
29049	Application of figure eight	N	CH	P3		$38.06
29055	Application of shoulder cast	N		P2	2.2646	$94.88
29058	Application of shoulder cast	N	CH	P3		$33.39
29065	Application of long arm cast	N		P3		$40.02
29075	Application of forearm cast	N		P3		$38.55
29085	Apply hand/wrist cast	N	CH	P3		$39.53
29086	Apply finger cast	N		P3		$33.88
29105	Apply long arm splint	N	CH	P3		$34.37
29125	Apply forearm splint	N		P3		$30.20
29126	Apply forearm splint	N		P3		$32.16
29130	Application of finger splint	N		P3		$13.75
29131	Application of finger splint	N		P3		$20.13
29200	Strapping of chest	N		P3		$19.64
29240	Strapping of shoulder	N		P3		$20.87
29260	Strapping of elbow or wrist	N		P3		$20.62
29280	Strapping of hand or finger	N		P3		$21.11
29305	Application of hip cast	N		P2	2.2646	$94.88
29325	Application of hip casts	N		P2	2.2646	$94.88
29345	Application of long leg cast	N		P3		$52.54
29355	Application of long leg cast	N		P3		$52.54

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
29358	Apply long leg cast brace	N		P3		$65.80
29365	Application of long leg cast	N		P3		$49.60
29405	Apply short leg cast	N		P3		$36.83
29425	Apply short leg cast	N		P3		$37.32
29435	Apply short leg cast	N		P3		$47.14
29440	Addition of walker to cast	N		P3		$17.68
29445	Apply rigid leg cast	N		P3		$48.86
29450	Application of leg cast	N		P2	1.0371	$43.45
29505	Application, long leg splint	N	CH	P3		$33.39
29515	Application lower leg splint	N		P3		$29.22
29520	Strapping of hip	N		P3		$20.13
29530	Strapping of knee	N		P3		$20.62
29540	Strapping of ankle and/or ft	N		P3		$15.71
29550	Strapping of toes	N		P3		$15.96
29580	Application of paste boot	N		P3		$21.36
29581	Apply multlay comprs lwr leg	N		P2	1.0371	$43.45
29590	Application of foot splint	N		P3		$17.19
29700	Removal/revision of cast	N		P3		$28.73
29705	Removal/revision of cast	N		P3		$24.55
29710	Removal/revision of cast	N		P3		$44.68
29715	Removal/revision of cast	N	CH	P3		$33.15
29720	Repair of body cast	N	CH	P3		$36.34
29730	Windowing of cast	N		P3		$23.57
29740	Wedging of cast	N		P3		$30.94
29750	Wedging of clubfoot cast	N	CH	P3		$33.64
29800	Jaw arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29804	Jaw arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29805	Shoulder arthroscopy, dx	Y		A2	27.5586	$1,154.65
29806	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29807	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29819	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29820	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29821	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29822	Shoulder arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29823	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29824	Shoulder arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29825	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29826	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29827	Arthroscop rotator cuff repr	Y		A2	43.8195	$1,835.95

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
29828	Arthroscopy biceps tenodesis	Y		G2	43.8195	$1,835.95
29830	Elbow arthroscopy	Y		A2	27.5586	$1,154.65
29834	Elbow arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29835	Elbow arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29836	Elbow arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29837	Elbow arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29838	Elbow arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29840	Wrist arthroscopy	Y		A2	27.5586	$1,154.65
29843	Wrist arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29844	Wrist arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29845	Wrist arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29846	Wrist arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29847	Wrist arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29848	Wrist endoscopy/surgery	Y		A2	27.5586	$1,154.65
29850	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29851	Knee arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29855	Tibial arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29856	Tibial arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29860	Hip arthroscopy, dx	Y		A2	43.8195	$1,835.95
29861	Hip arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29862	Hip arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29863	Hip arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29866	Autgrft implnt, knee w/scope	Y		G2	43.8195	$1,835.95
29870	Knee arthroscopy, dx	Y		A2	27.5586	$1,154.65
29871	Knee arthroscopy/drainage	Y		A2	27.5586	$1,154.65
29873	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29874	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29875	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29876	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29877	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29879	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29880	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29881	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29882	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29883	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29884	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29885	Knee arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29886	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29887	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
29888	Knee arthroscopy/surgery	Y		A2	80.4692	$3,371.49
29889	Knee arthroscopy/surgery	Y		A2	80.4692	$3,371.49
29891	Ankle arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29892	Ankle arthroscopy/surgery	Y		A2	80.4692	$3,371.49
29893	Scope, plantar fasciotomy	Y		A2	20.632	$864.44
29894	Ankle arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29895	Ankle arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29897	Ankle arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29898	Ankle arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29899	Ankle arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29900	Mcp joint arthroscopy, dx	Y		A2	27.5586	$1,154.65
29901	Mcp joint arthroscopy, surg	Y		A2	27.5586	$1,154.65
29902	Mcp joint arthroscopy, surg	Y		A2	27.5586	$1,154.65
29904	Subtalar arthro w/fb rmvl	Y		G2	27.5586	$1,154.65
29905	Subtalar arthro w/exc	Y		G2	27.5586	$1,154.65
29906	Subtalar arthro w/deb	Y		G2	27.5586	$1,154.65
29907	Subtalar arthro w/fusion	Y		G2	43.8195	$1,835.95
30000	Drainage of nose lesion	Y	CH	P3		$121.29
30020	Drainage of nose lesion	Y	CH	P3		$120.06
30100	Intranasal biopsy	Y		P3		$73.41
30110	Removal of nose polyp(s)	Y		P3		$114.66
30115	Removal of nose polyp(s)	Y		A2	15.8303	$663.26
30117	Removal of intranasal lesion	Y		A2	15.8303	$663.26
30118	Removal of intranasal lesion	Y		A2	23.2154	$972.69
30120	Revision of nose	Y		A2	23.2154	$972.69
30124	Removal of nose lesion	Y		R2	7.1577	$299.89
30125	Removal of nose lesion	Y		A2	40.7633	$1,707.90
30130	Excise inferior turbinate	Y		A2	15.8303	$663.26
30140	Resect inferior turbinate	Y		A2	23.2154	$972.69
30150	Partial removal of nose	Y		A2	40.7633	$1,707.90
30160	Removal of nose	Y		A2	40.7633	$1,707.90
30200	Injection treatment of nose	Y		P3		$58.19
30210	Nasal sinus therapy	Y		P3		$74.15
30220	Insert nasal septal button	Y		A2	7.1579	$299.89
30300	Remove nasal foreign body	N		P2	0.6271	$26.27
30310	Remove nasal foreign body	Y		A2	15.8303	$663.26
30320	Remove nasal foreign body	Y		A2	15.8303	$663.26
30400	Reconstruction of nose	Y		A2	40.7633	$1,707.90
30410	Reconstruction of nose	Y		A2	40.7633	$1,707.90

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
30420	Reconstruction of nose	Y		A2	40.7633	$1,707.90
30430	Revision of nose	Y		A2	23.2154	$972.69
30435	Revision of nose	Y		A2	40.7633	$1,707.90
30450	Revision of nose	Y		A2	40.7633	$1,707.90
30460	Revision of nose	Y		A2	40.7633	$1,707.90
30462	Revision of nose	Y		A2	40.7633	$1,707.90
30465	Repair nasal stenosis	Y		A2	40.7633	$1,707.90
30520	Repair of nasal septum	Y		A2	23.2154	$972.69
30540	Repair nasal defect	Y		A2	40.7633	$1,707.90
30545	Repair nasal defect	Y		A2	40.7633	$1,707.90
30560	Release of nasal adhesions	Y		A2	3.1243	$130.89
30580	Repair upper jaw fistula	Y		A2	40.7633	$1,707.90
30600	Repair mouth/nose fistula	Y		A2	40.7633	$1,707.90
30620	Intranasal reconstruction	Y		A2	40.7633	$1,707.90
30630	Repair nasal septum defect	Y		A2	23.2154	$972.69
30801	Ablate inf turbinate, superf	Y		A2	7.1579	$299.89
30802	Ablate inf turbinate submuc	Y		A2	15.8303	$663.26
30901	Control of nosebleed	Y	CH	P3		$39.77
30903	Control of nosebleed	Y		A2	1.0674	$44.72
30905	Control of nosebleed	Y		A2	1.0674	$44.72
30906	Repeat control of nosebleed	Y		A2	1.0674	$44.72
30915	Ligation, nasal sinus artery	Y		A2	25.0391	$1,049.08
30920	Ligation, upper jaw artery	Y		A2	25.0391	$1,049.08
30930	Ther fx, nasal inf turbinate	Y		A2	15.8303	$663.26
31000	Irrigation, maxillary sinus	Y		P3		$94.03
31002	Irrigation, sphenoid sinus	Y		R2	7.1577	$299.89
31020	Exploration, maxillary sinus	Y		A2	23.2154	$972.69
31030	Exploration, maxillary sinus	Y		A2	40.7633	$1,707.90
31032	Explore sinus, remove polyps	Y		A2	40.7633	$1,707.90
31040	Exploration behind upper jaw	Y		R2	23.2156	$972.69
31050	Exploration, sphenoid sinus	Y		A2	40.7633	$1,707.90
31051	Sphenoid sinus surgery	Y		A2	40.7633	$1,707.90
31070	Exploration of frontal sinus	Y		A2	23.2154	$972.69
31075	Exploration of frontal sinus	Y		A2	40.7633	$1,707.90
31080	Removal of frontal sinus	Y		A2	40.7633	$1,707.90
31081	Removal of frontal sinus	Y		A2	40.7633	$1,707.90
31084	Removal of frontal sinus	Y		A2	40.7633	$1,707.90
31085	Removal of frontal sinus	Y		A2	40.7633	$1,707.90
31086	Removal of frontal sinus	Y		A2	40.7633	$1,707.90

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
31087	Removal of frontal sinus	Y		A2	40.7633	$1,707.90
31090	Exploration of sinuses	Y		A2	40.7633	$1,707.90
31200	Removal of ethmoid sinus	Y		A2	40.7633	$1,707.90
31201	Removal of ethmoid sinus	Y		A2	40.7633	$1,707.90
31205	Removal of ethmoid sinus	Y		A2	40.7633	$1,707.90
31231	Nasal endoscopy, dx	Y		P2	1.7069	$71.52
31233	Nasal/sinus endoscopy, dx	Y		A2	1.707	$71.52
31235	Nasal/sinus endoscopy, dx	Y		A2	19.9943	$837.72
31237	Nasal/sinus endoscopy, surg	Y		A2	19.9943	$837.72
31238	Nasal/sinus endoscopy, surg	Y		A2	19.9943	$837.72
31239	Nasal/sinus endoscopy, surg	Y		A2	28.5579	$1,196.52
31240	Nasal/sinus endoscopy, surg	Y		A2	19.9943	$837.72
31254	Revision of ethmoid sinus	Y		A2	28.5579	$1,196.52
31255	Removal of ethmoid sinus	Y		A2	28.5579	$1,196.52
31256	Exploration maxillary sinus	Y		A2	28.5579	$1,196.52
31267	Endoscopy, maxillary sinus	Y		A2	28.5579	$1,196.52
31276	Sinus endoscopy, surgical	Y		A2	28.5579	$1,196.52
31287	Nasal/sinus endoscopy, surg	Y		A2	28.5579	$1,196.52
31288	Nasal/sinus endoscopy, surg	Y		A2	28.5579	$1,196.52
31300	Removal of larynx lesion	Y		A2	23.2154	$972.69
31320	Diagnostic incision, larynx	Y		A2	40.7633	$1,707.90
31400	Revision of larynx	Y		A2	40.7633	$1,707.90
31420	Removal of epiglottis	Y		A2	40.7633	$1,707.90
31500	Insert emergency airway	N		G2	2.2071	$92.47
31502	Change of windpipe airway	N		G2	1.2941	$54.22
31505	Diagnostic laryngoscopy	Y		P2	0.8386	$35.14
31510	Laryngoscopy with biopsy	Y		A2	19.9943	$837.72
31511	Remove foreign body, larynx	Y		A2	1.707	$71.52
31512	Removal of larynx lesion	Y		A2	19.9943	$837.72
31513	Injection into vocal cord	Y		A2	1.707	$71.52
31515	Laryngoscopy for aspiration	Y		A2	19.9943	$837.72
31520	Dx laryngoscopy, newborn	Y		G2	1.7069	$71.52
31525	Dx laryngoscopy excl nb	Y		A2	19.9943	$837.72
31526	Dx laryngoscopy w/oper scope	Y		A2	19.9943	$837.72
31527	Laryngoscopy for treatment	Y		A2	28.5579	$1,196.52
31528	Laryngoscopy and dilation	Y		A2	19.9943	$837.72
31529	Laryngoscopy and dilation	Y		A2	19.9943	$837.72
31530	Laryngoscopy w/fb removal	Y		A2	19.9943	$837.72
31531	Laryngoscopy w/fb & op scope	Y		A2	19.9943	$837.72

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
31535	Laryngoscopy w/biopsy	Y		A2	19.9943	$837.72
31536	Laryngoscopy w/bx & op scope	Y		A2	19.9943	$837.72
31540	Laryngoscopy w/exc of tumor	Y		A2	19.9943	$837.72
31541	Larynscop w/tumr exc + scope	Y		A2	19.9943	$837.72
31545	Remove vc lesion w/scope	Y		A2	28.5579	$1,196.52
31546	Remove vc lesion scope/graft	Y		A2	28.5579	$1,196.52
31560	Laryngoscop w/arytenoidectom	Y		A2	28.5579	$1,196.52
31561	Larynscop, remve cart + scop	Y		A2	28.5579	$1,196.52
31570	Laryngoscope w/vc inj	Y		A2	19.9943	$837.72
31571	Laryngoscop w/vc inj + scope	Y		A2	28.5579	$1,196.52
31575	Diagnostic laryngoscopy	Y		P3		$52.30
31576	Laryngoscopy with biopsy	Y		A2	19.9943	$837.72
31577	Remove foreign body, larynx	Y		A2	3.6737	$153.92
31578	Removal of larynx lesion	Y		A2	28.5579	$1,196.52
31579	Diagnostic laryngoscopy	Y		P3		$91.82
31580	Revision of larynx	Y		A2	40.7633	$1,707.90
31582	Revision of larynx	Y		A2	40.7633	$1,707.90
31588	Revision of larynx	Y		A2	40.7633	$1,707.90
31590	Reinnervate larynx	Y		A2	40.7633	$1,707.90
31595	Larynx nerve surgery	Y		A2	40.7633	$1,707.90
31603	Incision of windpipe	Y		A2	7.1579	$299.89
31605	Incision of windpipe	Y		G2	7.1577	$299.89
31611	Surgery/speech prosthesis	Y		A2	23.2154	$972.69
31612	Puncture/clear windpipe	Y		A2	23.2154	$972.69
31613	Repair windpipe opening	Y		A2	23.2154	$972.69
31614	Repair windpipe opening	Y		A2	40.7633	$1,707.90
31615	Visualization of windpipe	Y		A2	7.1579	$299.89
31620	Endobronchial us add-on	N		N1		
31622	Dx bronchoscope/wash	Y		A2	9.5849	$401.59
31623	Dx bronchoscope/brush	Y		A2	9.5849	$401.59
31624	Dx bronchoscope/lavage	Y		A2	9.5849	$401.59
31625	Bronchoscopy w/biopsy(s)	Y		A2	9.5849	$401.59
31626	Bronchoscopy w/markers	Y		G2	9.585	$401.59
31627	Navigational bronchoscopy	N		N1		
31628	Bronchoscopy/lung bx, each	Y		A2	9.5849	$401.59
31629	Bronchoscopy/needle bx, each	Y		A2	9.5849	$401.59
31630	Bronchoscopy dilate/fx repr	Y		A2	25.923	$1,086.12
31631	Bronchoscopy, dilate w/stent	Y		A2	25.923	$1,086.12
31632	Bronchoscopy/lung bx, addl	Y		G2	9.585	$401.59

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
31633	Bronchoscopy/needle bx addl	Y		G2	9.585	$401.59
31635	Bronchoscopy w/fb removal	Y		A2	9.5849	$401.59
31636	Bronchoscopy, bronch stents	Y		A2	25.923	$1,086.12
31637	Bronchoscopy, stent add-on	Y		A2	9.5849	$401.59
31638	Bronchoscopy, revise stent	Y		A2	25.923	$1,086.12
31640	Bronchoscopy w/tumor excise	Y		A2	25.923	$1,086.12
31641	Bronchoscopy, treat blockage	Y		A2	25.923	$1,086.12
31643	Diag bronchoscope/catheter	Y		A2	9.5849	$401.59
31645	Bronchoscopy, clear airways	Y		A2	9.5849	$401.59
31646	Bronchoscopy, reclear airway	Y		A2	9.5849	$401.59
31656	Bronchoscopy, inj for x-ray	Y		A2	9.5849	$401.59
31715	Injection for bronchus x-ray	N		N1		
31717	Bronchial brush biopsy	Y		A2	3.6737	$153.92
31720	Clearance of airways	N		A2	0.38	$15.92
31730	Intro, windpipe wire/tube	Y		A2	3.6737	$153.92
31750	Repair of windpipe	Y		A2	40.7633	$1,707.90
31755	Repair of windpipe	Y		A2	40.7633	$1,707.90
31820	Closure of windpipe lesion	Y		A2	23.2154	$972.69
31825	Repair of windpipe defect	Y		A2	23.2154	$972.69
31830	Revise windpipe scar	Y		A2	23.2154	$972.69
32400	Needle biopsy chest lining	Y		A2	9.0033	$377.22
32405	Biopsy, lung or mediastinum	Y		A2	9.0033	$377.22
32420	Puncture/clear lung	Y		A2	5.1351	$215.15
32421	Thoracentesis for aspiration	Y		A2	5.1351	$215.15
32422	Thoracentesis w/tube insert	Y		G2	5.135	$215.15
32550	Insert pleural cath	Y		G2	28.2959	$1,185.54
32552	Remove lung catheter	N		G2	1.2941	$54.22
32553	Ins mark thor for rt perq	N		G2	12.3307	$516.63
32960	Therapeutic pneumothorax	Y		G2	5.135	$215.15
32998	Perq rf ablate tx, pul tumor	Y		G2	52.0029	$2,178.82
33010	Drainage of heart sac	Y		A2	5.1351	$215.15
33011	Repeat drainage of heart sac	Y		A2	5.1351	$215.15
33206	Insertion of heart pacemaker	Y		J8	159.0066	$6,662.06
33207	Insertion of heart pacemaker	Y		J8	159.0066	$6,662.06
33208	Insertion of heart pacemaker	Y		J8	198.3627	$8,311.00
33210	Insertion of heart electrode	Y		G2	47.8299	$2,003.98
33211	Insertion of heart electrode	Y		G2	47.8299	$2,003.98
33212	Insertion of pulse generator	Y		H8	132.1295	$5,535.96
33213	Insertion of pulse generator	Y		H8	155.3449	$6,508.64

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
33214	Upgrade of pacemaker system	Y		J8	198.3627	$8,311.00
33215	Reposition pacing-defib lead	Y		G2	21.1143	$884.65
33216	Insert 1 electrode pm-defib	Y		G2	47.8299	$2,003.98
33217	Insert 2 electrode pm-defib	Y		G2	47.8299	$2,003.98
33218	Repair lead pace-defib, one	Y		G2	21.1143	$884.65
33220	Repair lead pace-defib, dual	Y		G2	21.1143	$884.65
33222	Revise pocket, pacemaker	Y		A2	15.5759	$652.60
33223	Revise pocket for defib	Y		A2	15.5759	$652.60
33224	Insert pacing lead & connect	Y		J8	204.4024	$8,564.05
33225	L ventric pacing lead add-on	Y		J8	204.4024	$8,564.05
33226	Reposition l ventric lead	Y		G2	21.1143	$884.65
33233	Removal of pacemaker system	Y		A2	21.1144	$884.65
33234	Removal of pacemaker system	Y		G2	21.1143	$884.65
33235	Removal pacemaker electrode	Y		G2	21.1143	$884.65
33240	Insert pulse generator	Y		J8	517.5292	$21,683.44
33241	Remove pulse generator	Y		G2	21.1143	$884.65
33249	Eltrd/insert pace-defib	Y		J8	600.0685	$25,141.67
33282	Implant pat-active ht record	N		J8	111.6435	$4,677.64
33284	Remove pat-active ht record	Y		G2	7.9785	$334.28
33508	Endoscopic vein harvest	N		N1		
34490	Removal of vein clot	Y		G2	38.0067	$1,592.40
35188	Repair blood vessel lesion	Y		A2	38.0066	$1,592.40
35207	Repair blood vessel lesion	Y		A2	38.0066	$1,592.40
35460	Repair venous blockage	Y		G2	47.445	$1,987.85
35473	Repair arterial blockage	Y		G2	47.445	$1,987.85
35475	Repair arterial blockage	Y		G2	47.445	$1,987.85
35476	Repair venous blockage	Y		G2	47.445	$1,987.85
35492	Atherectomy, percutaneous	Y		G2	88.9846	$3,728.28
35572	Harvest femoropopliteal vein	N		N1		
35761	Exploration of artery/vein	Y		G2	33.2027	$1,391.13
35875	Removal of clot in graft	Y		A2	38.0066	$1,592.40
35876	Removal of clot in graft	Y		A2	38.0066	$1,592.40
36000	Place needle in vein	N		N1		
36002	Pseudoaneurysm injection trt	N		G2	2.0678	$86.64
36005	Injection ext venography	N		N1		
36010	Place catheter in vein	N		N1		
36011	Place catheter in vein	N		N1		
36012	Place catheter in vein	N		N1		
36013	Place catheter in artery	N		N1		

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
36014	Place catheter in artery	N		N1		
36015	Place catheter in artery	N		N1		
36100	Establish access to artery	N		N1		
36120	Establish access to artery	N		N1		
36140	Establish access to artery	N		N1		
36147	Access av dial grft for eval	Y		P2	2.1674	$90.81
36148	Access av dial grft for proc	N		N1		
36160	Establish access to aorta	N		N1		
36200	Place catheter in aorta	N		N1		
36215	Place catheter in artery	N		N1		
36216	Place catheter in artery	N		N1		
36217	Place catheter in artery	N		N1		
36218	Place catheter in artery	N		N1		
36245	Place catheter in artery	N		N1		
36246	Place catheter in artery	N		N1		
36247	Place catheter in artery	N		N1		
36248	Place catheter in artery	N		N1		
36260	Insertion of infusion pump	Y		A2	28.0512	$1,175.29
36261	Revision of infusion pump	Y		A2	21.1144	$884.65
36262	Removal of infusion pump	Y		A2	21.1144	$884.65
36400	Bl draw < 3 yrs fem/jugular	N		N1		
36405	Bl draw < 3 yrs scalp vein	N		N1		
36406	Bl draw < 3 yrs other vein	N		N1		
36410	Non-routine bl draw > 3 yrs	N		N1		
36416	Capillary blood draw	N		N1		
36420	Vein access cutdown < 1 yr	N		R2	0.2223	$9.31
36425	Vein access cutdown > 1 yr	N		R2	0.2223	$9.31
36430	Blood transfusion service	N		P3		$24.55
36440	Bl push transfuse, 2 yr or <	N		R2	3.1003	$129.90
36450	Bl exchange/transfuse, nb	N		R2	3.1003	$129.90
36455	Bl exchange/transfuse non-nb	N		G2	3.1003	$129.90
36468	Injection(s), spider veins	Y		R2	0.7983	$33.45
36469	Injection(s), spider veins	Y		R2	0.7983	$33.45
36470	Injection therapy of vein	Y		P2	0.7983	$33.45
36471	Injection therapy of veins	Y		P2	0.7983	$33.45
36475	Endovenous rf, 1st vein	Y		A2	40.3828	$1,691.95
36476	Endovenous rf, vein add-on	Y		A2	25.0391	$1,049.08
36478	Endovenous laser, 1st vein	Y		A2	25.0391	$1,049.08
36479	Endovenous laser vein addon	Y		A2	25.0391	$1,049.08

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
36481	Insertion of catheter, vein	N		N1		
36500	Insertion of catheter, vein	N		N1		
36510	Insertion of catheter, vein	N		N1		
36511	Apheresis wbc	N		G2	11.385	$477.01
36512	Apheresis rbc	N		G2	11.385	$477.01
36513	Apheresis platelets	N		G2	11.385	$477.01
36514	Apheresis plasma	N		G2	11.385	$477.01
36515	Apheresis, adsorp/reinfuse	N		P2	30.8064	$1,290.73
36516	Apheresis, selective	N		P2	30.8064	$1,290.73
36522	Photopheresis	N		G2	30.8064	$1,290.73
36555	Insert non-tunnel cv cath	Y		A2	10.3678	$434.39
36556	Insert non-tunnel cv cath	Y		A2	10.3678	$434.39
36557	Insert tunneled cv cath	Y		A2	23.3551	$978.52
36558	Insert tunneled cv cath	Y		A2	23.3551	$978.52
36560	Insert tunneled cv cath	Y		A2	28.0512	$1,175.29
36561	Insert tunneled cv cath	Y		A2	28.0512	$1,175.29
36563	Insert tunneled cv cath	Y		A2	28.0512	$1,175.29
36565	Insert tunneled cv cath	Y		A2	28.0512	$1,175.29
36566	Insert tunneled cv cath	Y		A2	28.0512	$1,175.29
36568	Insert picc cath	Y		A2	10.3678	$434.39
36569	Insert picc cath	Y		A2	10.3678	$434.39
36570	Insert picvad cath	Y		A2	23.3551	$978.52
36571	Insert picvad cath	Y		A2	23.3551	$978.52
36575	Repair tunneled cv cath	Y		A2	5.7506	$240.94
36576	Repair tunneled cv cath	Y		A2	10.3678	$434.39
36578	Replace tunneled cv cath	Y		A2	23.3551	$978.52
36580	Replace cvad cath	Y		A2	10.3678	$434.39
36581	Replace tunneled cv cath	Y		A2	23.3551	$978.52
36582	Replace tunneled cv cath	Y		A2	28.0512	$1,175.29
36583	Replace tunneled cv cath	Y		A2	28.0512	$1,175.29
36584	Replace picc cath	Y		A2	10.3678	$434.39
36585	Replace picvad cath	Y		A2	23.3551	$978.52
36589	Removal tunneled cv cath	Y		A2	5.7506	$240.94
36590	Removal tunneled cv cath	Y		A2	10.3678	$434.39
36591	Draw blood off venous device	N		N1		
36592	Collect blood from picc	N		N1		
36593	Declot vascular device	Y		P3		$20.13
36595	Mech remov tunneled cv cath	Y		G2	23.3549	$978.52
36596	Mech remov tunneled cv cath	Y		G2	10.3679	$434.39

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
36597	Reposition venous catheter	Y		G2	10.3679	$434.39
36598	Inj w/fluor, eval cv device	Y		P3		$60.89
36600	Withdrawal of arterial blood	N		N1		
36620	Insertion catheter, artery	N		N1		
36625	Insertion catheter, artery	N		N1		
36640	Insertion catheter, artery	Y		A2	28.0512	$1,175.29
36680	Insert needle, bone cavity	Y		G2	1.6137	$67.61
36800	Insertion of cannula	Y		A2	30.2764	$1,268.52
36810	Insertion of cannula	Y		A2	30.2764	$1,268.52
36815	Insertion of cannula	Y		A2	30.2764	$1,268.52
36818	Av fuse, uppr arm, cephalic	Y		A2	38.0066	$1,592.40
36819	Av fuse, uppr arm, basilic	Y		A2	38.0066	$1,592.40
36820	Av fusion/forearm vein	Y		A2	38.0066	$1,592.40
36821	Av fusion direct any site	Y		A2	38.0066	$1,592.40
36825	Artery-vein autograft	Y		A2	38.0066	$1,592.40
36830	Artery-vein nonautograft	Y		A2	38.0066	$1,592.40
36831	Open thrombect av fistula	Y		A2	38.0066	$1,592.40
36832	Av fistula revision, open	Y		A2	38.0066	$1,592.40
36833	Av fistula revision	Y		A2	38.0066	$1,592.40
36835	Artery to vein shunt	Y		A2	30.2764	$1,268.52
36860	External cannula declotting	Y		A2	2.1674	$90.81
36861	Cannula declotting	Y		A2	30.2764	$1,268.52
36870	Percut thrombect av fistula	Y		A2	40.6721	$1,704.08
37184	Prim art mech thrombectomy	Y		G2	38.0067	$1,592.40
37185	Prim art m-thrombect add-on	Y		G2	38.0067	$1,592.40
37186	Sec art m-thrombect add-on	Y		G2	38.0067	$1,592.40
37187	Venous mech thrombectomy	Y		G2	38.0067	$1,592.40
37188	Venous m-thrombectomy add-on	Y		G2	38.0067	$1,592.40
37200	Transcatheter biopsy	Y		G2	28.0512	$1,175.29
37203	Transcatheter retrieval	Y		G2	28.0512	$1,175.29
37204	Transcatheter occlusion	Y	CH	G2	88.9846	$3,728.28
37205	Transcath iv stent, percut	Y	CH	P3		$2,856.13
37206	Transcath iv stent/perc addl	Y	CH	P3		$1,743.93
37210	Embolization uterine fibroid	Y	CH	P3		$2,266.64
37250	Iv us first vessel add-on	N		N1		
37251	Iv us each add vessel add-on	N		N1		
37500	Endoscopy ligate perf veins	Y		A2	40.3828	$1,691.95
37607	Ligation of a-v fistula	Y		A2	25.0391	$1,049.08
37609	Temporal artery procedure	Y		A2	16.564	$694.00

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
37650	Revision of major vein	Y		A2	25.0391	$1,049.08
37700	Revise leg vein	Y		A2	25.0391	$1,049.08
37718	Ligate/strip short leg vein	Y		A2	25.0391	$1,049.08
37722	Ligate/strip long leg vein	Y		A2	40.3828	$1,691.95
37735	Removal of leg veins/lesion	Y		A2	40.3828	$1,691.95
37760	Ligate leg veins radical	Y		A2	25.0391	$1,049.08
37761*	Ligate leg veins open	Y		R2	25.039	$1,049.08
37765	Phleb veins - extrem - to 20	Y	CH	P3		$186.84
37766	Phleb veins - extrem 20+	Y	CH	P3		$212.62
37780	Revision of leg vein	Y		A2	25.0391	$1,049.08
37785	Ligate/divide/excise vein	Y		A2	25.0391	$1,049.08
37790	Penile venous occlusion	Y		A2	33.1047	$1,387.01
38200	Injection for spleen x-ray	N		N1		
38204	BI donor search management	N		N1		
38206	Harvest auto stem cells	N		G2	11.385	$477.01
38220	Bone marrow aspiration	Y		P3		$78.57
38221	Bone marrow biopsy	Y		P3		$80.78
38230	Bone marrow collection	N		G2	30.8064	$1,290.73
38241	Bone marrow/stem transplant	N		G2	30.8064	$1,290.73
38242	Lymphocyte infuse transplant	N		R2	11.385	$477.01
38300	Drainage, lymph node lesion	Y		A2	12.1142	$507.56
38305	Drainage, lymph node lesion	Y		A2	18.4054	$771.15
38308	Incision of lymph channels	Y		A2	22.992	$963.33
38500	Biopsy/removal, lymph nodes	Y		A2	22.992	$963.33
38505	Needle biopsy, lymph nodes	Y		A2	7.4175	$310.77
38510	Biopsy/removal, lymph nodes	Y		A2	22.992	$963.33
38520	Biopsy/removal, lymph nodes	Y		A2	22.992	$963.33
38525	Biopsy/removal, lymph nodes	Y		A2	22.992	$963.33
38530	Biopsy/removal, lymph nodes	Y		A2	22.992	$963.33
38542	Explore deep node(s), neck	Y		A2	46.3447	$1,941.75
38550	Removal, neck/armpit lesion	Y		A2	22.992	$963.33
38555	Removal, neck/armpit lesion	Y		A2	22.992	$963.33
38570	Laparoscopy, lymph node biop	Y		A2	43.6665	$1,829.55
38571	Laparoscopy, lymphadenectomy	Y		A2	64.6377	$2,708.19
38572	Laparoscopy, lymphadenectomy	Y		A2	43.6665	$1,829.55
38700	Removal of lymph nodes, neck	Y		G2	22.9922	$963.33
38740	Remove armpit lymph nodes	Y		A2	46.3447	$1,941.75
38745	Remove armpit lymph nodes	Y		A2	46.3447	$1,941.75
38760	Remove groin lymph nodes	Y		A2	22.992	$963.33

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
38790	Inject for lymphatic x-ray	N		N1		
38792	Identify sentinel node	N		N1		
38794	Access thoracic lymph duct	N		N1		
40490	Biopsy of lip	Y		P3		$57.70
40500	Partial excision of lip	Y		A2	15.8303	$663.26
40510	Partial excision of lip	Y		A2	23.2154	$972.69
40520	Partial excision of lip	Y		A2	15.8303	$663.26
40525	Reconstruct lip with flap	Y		A2	23.2154	$972.69
40527	Reconstruct lip with flap	Y		A2	23.2154	$972.69
40530	Partial removal of lip	Y		A2	23.2154	$972.69
40650	Repair lip	Y		A2	7.1579	$299.89
40652	Repair lip	Y		A2	7.1579	$299.89
40654	Repair lip	Y		A2	7.1579	$299.89
40700	Repair cleft lip/nasal	Y		A2	40.7633	$1,707.90
40701	Repair cleft lip/nasal	Y		A2	40.7633	$1,707.90
40702	Repair cleft lip/nasal	Y		R2	40.7633	$1,707.90
40720	Repair cleft lip/nasal	Y		A2	40.7633	$1,707.90
40761	Repair cleft lip/nasal	Y		A2	40.7633	$1,707.90
40800	Drainage of mouth lesion	Y		P2	1.358	$56.90
40801	Drainage of mouth lesion	Y		A2	7.1579	$299.89
40804	Removal, foreign body, mouth	N		P2	0.6271	$26.27
40805	Removal, foreign body, mouth	Y		P3		$150.75
40806	Incision of lip fold	Y		P3		$65.80
40808	Biopsy of mouth lesion	Y		P3		$102.14
40810	Excision of mouth lesion	Y		P3		$106.56
40812	Excise/repair mouth lesion	Y		P3		$135.28
40814	Excise/repair mouth lesion	Y		A2	15.8303	$663.26
40816	Excision of mouth lesion	Y		A2	23.2154	$972.69
40818	Excise oral mucosa for graft	Y		A2	3.1243	$130.89
40819	Excise lip or cheek fold	Y		A2	7.1579	$299.89
40820	Treatment of mouth lesion	Y		P3		$149.52
40830	Repair mouth laceration	Y		G2	3.1241	$130.89
40831	Repair mouth laceration	Y		A2	7.1579	$299.89
40840	Reconstruction of mouth	Y		A2	23.2154	$972.69
40842	Reconstruction of mouth	Y		A2	23.2154	$972.69
40843	Reconstruction of mouth	Y		A2	23.2154	$972.69
40844	Reconstruction of mouth	Y		A2	40.7633	$1,707.90
40845	Reconstruction of mouth	Y		A2	40.7633	$1,707.90
41000	Drainage of mouth lesion	Y		P3		$76.36

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
41005	Drainage of mouth lesion	Y		A2	3.1243	$130.89
41006	Drainage of mouth lesion	Y		A2	23.2154	$972.69
41007	Drainage of mouth lesion	Y		A2	15.8303	$663.26
41008	Drainage of mouth lesion	Y		A2	15.8303	$663.26
41009	Drainage of mouth lesion	Y		A2	3.1243	$130.89
41010	Incision of tongue fold	Y		A2	7.1579	$299.89
41015	Drainage of mouth lesion	Y		A2	3.1243	$130.89
41016	Drainage of mouth lesion	Y		A2	7.1579	$299.89
41017	Drainage of mouth lesion	Y		A2	7.1579	$299.89
41018	Drainage of mouth lesion	Y		A2	7.1579	$299.89
41019	Place needles h&n for rt	Y		G2	23.2156	$972.69
41100	Biopsy of tongue	Y		P3		$80.04
41105	Biopsy of tongue	Y		P3		$79.79
41108	Biopsy of floor of mouth	Y		P3		$73.90
41110	Excision of tongue lesion	Y		P3		$106.80
41112	Excision of tongue lesion	Y		A2	15.8303	$663.26
41113	Excision of tongue lesion	Y		A2	15.8303	$663.26
41114	Excision of tongue lesion	Y		A2	23.2154	$972.69
41115	Excision of tongue fold	Y		P3		$123.01
41116	Excision of mouth lesion	Y		A2	15.8303	$663.26
41120	Partial removal of tongue	Y		A2	23.2154	$972.69
41250	Repair tongue laceration	Y		A2	1.0674	$44.72
41251	Repair tongue laceration	Y		A2	3.1243	$130.89
41252	Repair tongue laceration	Y		A2	7.1579	$299.89
41500	Fixation of tongue	Y		A2	23.2154	$972.69
41510	Tongue to lip surgery	Y		A2	15.8303	$663.26
41512	Tongue suspension	Y		G2	7.1577	$299.89
41520	Reconstruction, tongue fold	Y		A2	7.1579	$299.89
41530	Tongue base vol reduction	Y		G2	23.2156	$972.69
41800	Drainage of gum lesion	Y		A2	1.3578	$56.90
41805	Removal foreign body, gum	Y		P3		$132.34
41806	Removal foreign body,jawbone	Y		P3		$171.13
41820	Excision, gum, each quadrant	Y		R2	7.1577	$299.89
41821	Excision of gum flap	Y		G2	7.1577	$299.89
41822	Excision of gum lesion	Y		P3		$136.26
41823	Excision of gum lesion	Y		P3		$196.91
41825	Excision of gum lesion	Y		P3		$107.78
41826	Excision of gum lesion	Y		P3		$144.86
41827	Excision of gum lesion	Y		A2	23.2154	$972.69

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
41828	Excision of gum lesion	Y		P3		$127.18
41830	Removal of gum tissue	Y		P3		$178.00
41850	Treatment of gum lesion	Y		R2	15.8303	$663.26
41870	Gum graft	Y		G2	23.2156	$972.69
41872	Repair gum	Y		P3		$172.85
41874	Repair tooth socket	Y		P3		$171.37
42000	Drainage mouth roof lesion	Y		A2	3.1243	$130.89
42100	Biopsy roof of mouth	Y		P3		$68.75
42104	Excision lesion, mouth roof	Y		P3		$103.85
42106	Excision lesion, mouth roof	Y		P3		$130.13
42107	Excision lesion, mouth roof	Y		A2	23.2154	$972.69
42120	Remove palate/lesion	Y		A2	40.7633	$1,707.90
42140	Excision of uvula	Y		A2	7.1579	$299.89
42145	Repair palate, pharynx/uvula	Y		A2	23.2154	$972.69
42160	Treatment mouth roof lesion	Y		P3		$117.11
42180	Repair palate	Y		A2	3.1243	$130.89
42182	Repair palate	Y		A2	40.7633	$1,707.90
42200	Reconstruct cleft palate	Y		A2	40.7633	$1,707.90
42205	Reconstruct cleft palate	Y		A2	40.7633	$1,707.90
42210	Reconstruct cleft palate	Y		A2	40.7633	$1,707.90
42215	Reconstruct cleft palate	Y		A2	40.7633	$1,707.90
42220	Reconstruct cleft palate	Y		A2	40.7633	$1,707.90
42225	Reconstruct cleft palate	Y		G2	40.7633	$1,707.90
42226	Lengthening of palate	Y		A2	40.7633	$1,707.90
42227	Lengthening of palate	Y		G2	40.7633	$1,707.90
42235	Repair palate	Y		A2	15.8303	$663.26
42260	Repair nose to lip fistula	Y		A2	23.2154	$972.69
42280	Preparation, palate mold	Y		P3		$68.99
42281	Insertion, palate prosthesis	Y		G2	15.8303	$663.26
42300	Drainage of salivary gland	Y		A2	15.8303	$663.26
42305	Drainage of salivary gland	Y		A2	15.8303	$663.26
42310	Drainage of salivary gland	Y		A2	3.1243	$130.89
42320	Drainage of salivary gland	Y		A2	3.1243	$130.89
42330	Removal of salivary stone	Y		P3		$103.36
42335	Removal of salivary stone	Y		P3		$172.36
42340	Removal of salivary stone	Y		A2	15.8303	$663.26
42400	Biopsy of salivary gland	Y		P3		$55.49
42405	Biopsy of salivary gland	Y		A2	23.2154	$972.69
42408	Excision of salivary cyst	Y		A2	15.8303	$663.26

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
42409	Drainage of salivary cyst	Y		A2	15.8303	$663.26
42410	Excise parotid gland/lesion	Y		A2	40.7633	$1,707.90
42415	Excise parotid gland/lesion	Y		A2	40.7633	$1,707.90
42420	Excise parotid gland/lesion	Y		A2	40.7633	$1,707.90
42425	Excise parotid gland/lesion	Y		A2	40.7633	$1,707.90
42440	Excise submaxillary gland	Y		A2	40.7633	$1,707.90
42450	Excise sublingual gland	Y		A2	23.2154	$972.69
42500	Repair salivary duct	Y		A2	23.2154	$972.69
42505	Repair salivary duct	Y		A2	40.7633	$1,707.90
42507	Parotid duct diversion	Y		A2	40.7633	$1,707.90
42508	Parotid duct diversion	Y		A2	40.7633	$1,707.90
42509	Parotid duct diversion	Y		A2	40.7633	$1,707.90
42510	Parotid duct diversion	Y		A2	40.7633	$1,707.90
42550	Injection for salivary x-ray	N		N1		
42600	Closure of salivary fistula	Y		A2	15.8303	$663.26
42650	Dilation of salivary duct	Y		P3		$38.30
42660	Dilation of salivary duct	Y		P3		$44.93
42665	Ligation of salivary duct	Y		A2	23.2154	$972.69
42700	Drainage of tonsil abscess	Y		A2	3.1243	$130.89
42720	Drainage of throat abscess	Y		A2	15.8303	$663.26
42725	Drainage of throat abscess	Y		A2	40.7633	$1,707.90
42800	Biopsy of throat	Y		P3		$73.66
42802	Biopsy of throat	Y		A2	15.8303	$663.26
42804	Biopsy of upper nose/throat	Y		A2	15.8303	$663.26
42806	Biopsy of upper nose/throat	Y		A2	23.2154	$972.69
42808	Excise pharynx lesion	Y		A2	23.2154	$972.69
42809	Remove pharynx foreign body	N		G2	0.6271	$26.27
42810	Excision of neck cyst	Y		A2	23.2154	$972.69
42815	Excision of neck cyst	Y		A2	40.7633	$1,707.90
42820	Remove tonsils and adenoids	Y		A2	23.2154	$972.69
42821	Remove tonsils and adenoids	Y		A2	23.2154	$972.69
42825	Removal of tonsils	Y		A2	23.2154	$972.69
42826	Removal of tonsils	Y		A2	23.2154	$972.69
42830	Removal of adenoids	Y		A2	23.2154	$972.69
42831	Removal of adenoids	Y		A2	23.2154	$972.69
42835	Removal of adenoids	Y		A2	23.2154	$972.69
42836	Removal of adenoids	Y		A2	23.2154	$972.69
42860	Excision of tonsil tags	Y		A2	23.2154	$972.69
42870	Excision of lingual tonsil	Y		A2	23.2154	$972.69

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
42890	Partial removal of pharynx	Y		A2	40.7633	$1,707.90
42892	Revision of pharyngeal walls	Y		A2	40.7633	$1,707.90
42900	Repair throat wound	Y		A2	7.1579	$299.89
42950	Reconstruction of throat	Y		A2	23.2154	$972.69
42955	Surgical opening of throat	Y		A2	23.2154	$972.69
42960	Control throat bleeding	Y		A2	1.0674	$44.72
42962	Control throat bleeding	Y		A2	40.7633	$1,707.90
42970	Control nose/throat bleeding	Y		R2	1.0674	$44.72
42972	Control nose/throat bleeding	Y		A2	15.8303	$663.26
43030	Throat muscle surgery	Y		G2	15.8303	$663.26
43130	Removal of esophagus pouch	Y		G2	40.7633	$1,707.90
43200	Esophagus endoscopy	Y		A2	8.0729	$338.24
43201	Esoph scope w/submucous inj	Y		A2	8.0729	$338.24
43202	Esophagus endoscopy, biopsy	Y		A2	8.0729	$338.24
43204	Esoph scope w/sclerosis inj	Y		A2	8.0729	$338.24
43205	Esophagus endoscopy/ligation	Y		A2	8.0729	$338.24
43215	Esophagus endoscopy	Y		A2	8.0729	$338.24
43216	Esophagus endoscopy/lesion	Y		A2	14.8265	$621.20
43217	Esophagus endoscopy	Y		A2	8.0729	$338.24
43219	Esophagus endoscopy	Y		A2	24.9797	$1,046.59
43220	Esoph endoscopy, dilation	Y		A2	8.0729	$338.24
43226	Esoph endoscopy, dilation	Y		A2	8.0729	$338.24
43227	Esoph endoscopy, repair	Y		A2	8.0729	$338.24
43228	Esoph endoscopy, ablation	Y		A2	14.8265	$621.20
43231	Esoph endoscopy w/us exam	Y		A2	8.0729	$338.24
43232	Esoph endoscopy w/us fn bx	Y		A2	8.0729	$338.24
43234	Upper GI endoscopy, exam	Y		A2	8.0729	$338.24
43235	Uppr gi endoscopy, diagnosis	Y		A2	8.0729	$338.24
43236	Uppr gi scope w/submuc inj	Y		A2	8.0729	$338.24
43237	Endoscopic us exam, esoph	Y		A2	8.0729	$338.24
43238	Uppr gi endoscopy w/us fn bx	Y		A2	8.0729	$338.24
43239	Upper GI endoscopy, biopsy	Y		A2	8.0729	$338.24
43240	Esoph endoscope w/drain cyst	Y		A2	8.0729	$338.24
43241	Upper GI endoscopy with tube	Y		A2	8.0729	$338.24
43242	Uppr gi endoscopy w/us fn bx	Y		A2	14.8265	$621.20
43243	Upper gi endoscopy & inject	Y		A2	8.0729	$338.24
43244	Upper GI endoscopy/ligation	Y		A2	8.0729	$338.24
43245	Uppr gi scope dilate strictr	Y		A2	8.0729	$338.24
43246	Place gastrostomy tube	Y		A2	8.0729	$338.24

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
43247	Operative upper GI endoscopy	Y		A2	8.0729	$338.24
43248	Uppr gi endoscopy/guide wire	Y		A2	8.0729	$338.24
43249	Esoph endoscopy, dilation	Y		A2	8.0729	$338.24
43250	Upper GI endoscopy/tumor	Y		A2	8.0729	$338.24
43251	Operative upper GI endoscopy	Y		A2	8.0729	$338.24
43255	Operative upper GI endoscopy	Y		A2	8.0729	$338.24
43256	Uppr gi endoscopy w/stent	Y		A2	24.9797	$1,046.59
43257	Uppr gi scope w/thrml txmnt	Y		A2	14.8265	$621.20
43258	Operative upper GI endoscopy	Y		A2	8.0729	$338.24
43259	Endoscopic ultrasound exam	Y		A2	8.0729	$338.24
43260	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43261	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43262	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43263	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43264	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43265	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43267	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43268	Endo cholangiopancreatograph	Y		A2	24.9797	$1,046.59
43269	Endo cholangiopancreatograph	Y		A2	24.9797	$1,046.59
43271	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43272	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43273	Endoscopic pancreatoscopy	Y		G2	20.9644	$878.37
43450	Dilate esophagus	Y		A2	5.843	$244.81
43453	Dilate esophagus	Y		A2	5.843	$244.81
43456	Dilate esophagus	Y		A2	5.843	$244.81
43458	Dilate esophagus	Y		A2	8.0729	$338.24
43600	Biopsy of stomach	Y		A2	8.0729	$338.24
43653	Laparoscopy, gastrostomy	Y		A2	43.6665	$1,829.55
43752	Nasal/orogastric w/stent	N		G2	1.1337	$47.50
43760	Change gastrostomy tube	Y		A2	2.1674	$90.81
43761	Reposition gastrostomy tube	Y		A2	8.0729	$338.24
43870	Repair stomach opening	Y		A2	14.8265	$621.20
43886	Revise gastric port, open	Y		G2	20.1058	$842.39
43887	Remove gastric port, open	Y		G2	4.2374	$177.54
43888	Change gastric port, open	Y		G2	20.1058	$842.39
44100	Biopsy of bowel	Y		A2	8.0729	$338.24
44312	Revision of ileostomy	Y		A2	20.106	$842.39
44340	Revision of colostomy	Y		A2	20.106	$842.39
44360	Small bowel endoscopy	Y		A2	9.2212	$386.35

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
44361	Small bowel endoscopy/biopsy	Y		A2	9.2212	$386.35
44363	Small bowel endoscopy	Y		A2	9.2212	$386.35
44364	Small bowel endoscopy	Y		A2	9.2212	$386.35
44365	Small bowel endoscopy	Y		A2	9.2212	$386.35
44366	Small bowel endoscopy	Y		A2	9.2212	$386.35
44369	Small bowel endoscopy	Y		A2	9.2212	$386.35
44370	Small bowel endoscopy/stent	Y		A2	24.9797	$1,046.59
44372	Small bowel endoscopy	Y		A2	9.2212	$386.35
44373	Small bowel endoscopy	Y		A2	9.2212	$386.35
44376	Small bowel endoscopy	Y		A2	9.2212	$386.35
44377	Small bowel endoscopy/biopsy	Y		A2	9.2212	$386.35
44378	Small bowel endoscopy	Y		A2	9.2212	$386.35
44379	S bowel endoscope w/stent	Y		A2	24.9797	$1,046.59
44380	Small bowel endoscopy	Y		A2	9.2212	$386.35
44382	Small bowel endoscopy	Y		A2	9.2212	$386.35
44383	Ileoscopy w/stent	Y		A2	24.9797	$1,046.59
44385	Endoscopy of bowel pouch	Y		A2	8.4722	$354.98
44386	Endoscopy, bowel pouch/biop	Y		A2	8.4722	$354.98
44388	Colonoscopy	Y		A2	8.4722	$354.98
44389	Colonoscopy with biopsy	Y		A2	8.4722	$354.98
44390	Colonoscopy for foreign body	Y		A2	8.4722	$354.98
44391	Colonoscopy for bleeding	Y		A2	8.4722	$354.98
44392	Colonoscopy & polypectomy	Y		A2	8.4722	$354.98
44393	Colonoscopy, lesion removal	Y		A2	8.4722	$354.98
44394	Colonoscopy w/snare	Y		A2	8.4722	$354.98
44397	Colonoscopy w/stent	Y		A2	24.9797	$1,046.59
44500	Intro, gastrointestinal tube	Y		G2	5.7507	$240.94
44701	Intraop colon lavage add-on	N		N1		
45000	Drainage of pelvic abscess	Y		A2	14.6363	$613.23
45005	Drainage of rectal abscess	Y		A2	14.6363	$613.23
45020	Drainage of rectal abscess	Y		A2	14.6363	$613.23
45100	Biopsy of rectum	Y		A2	22.3595	$936.81
45108	Removal of anorectal lesion	Y		A2	22.3595	$936.81
45150	Excision of rectal stricture	Y		A2	22.3595	$936.81
45160	Excision of rectal lesion	Y		A2	22.3595	$936.81
45171	Exc rect tum transanal part	Y		G2	14.6362	$613.23
45172	Exc rect tum transanal full	Y		G2	22.3594	$936.81
45190	Destruction, rectal tumor	Y		A2	22.3595	$936.81
45300	Proctosigmoidoscopy dx	Y		P3		$58.43

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
45303	Proctosigmoidoscopy dilate	Y		P2	8.6377	$361.90
45305	Proctosigmoidoscopy w/bx	Y		A2	8.6376	$361.90
45307	Proctosigmoidoscopy fb	Y		A2	22.3495	$936.40
45308	Proctosigmoidoscopy removal	Y		A2	8.6376	$361.90
45309	Proctosigmoidoscopy removal	Y		A2	8.6376	$361.90
45315	Proctosigmoidoscopy removal	Y		A2	8.6376	$361.90
45317	Proctosigmoidoscopy bleed	Y		A2	8.6376	$361.90
45320	Proctosigmoidoscopy ablate	Y		A2	22.3495	$936.40
45321	Proctosigmoidoscopy volvul	Y		A2	22.3495	$936.40
45327	Proctosigmoidoscopy w/stent	Y		A2	24.9797	$1,046.59
45330	Diagnostic sigmoidoscopy	Y		P3		$70.96
45331	Sigmoidoscopy and biopsy	Y		A2	5.2575	$220.28
45332	Sigmoidoscopy w/fb removal	Y		A2	5.2575	$220.28
45333	Sigmoidoscopy & polypectomy	Y		A2	8.6376	$361.90
45334	Sigmoidoscopy for bleeding	Y		A2	8.6376	$361.90
45335	Sigmoidoscopy w/submuc inj	Y		A2	5.2575	$220.28
45337	Sigmoidoscopy & decompress	Y		A2	5.2575	$220.28
45338	Sigmoidoscopy w/tumr remove	Y		A2	8.6376	$361.90
45339	Sigmoidoscopy w/ablate tumr	Y		A2	8.6376	$361.90
45340	Sig w/balloon dilation	Y		A2	8.6376	$361.90
45341	Sigmoidoscopy w/ultrasound	Y		A2	8.6376	$361.90
45342	Sigmoidoscopy w/us guide bx	Y		A2	8.6376	$361.90
45345	Sigmoidoscopy w/stent	Y		A2	24.9797	$1,046.59
45355	Surgical colonoscopy	Y		A2	8.4722	$354.98
45378	Diagnostic colonoscopy	Y		A2	8.4722	$354.98
45379	Colonoscopy w/fb removal	Y		A2	8.4722	$354.98
45380	Colonoscopy and biopsy	Y		A2	8.4722	$354.98
45381	Colonoscopy, submucous inj	Y		A2	8.4722	$354.98
45382	Colonoscopy/control bleeding	Y		A2	8.4722	$354.98
45383	Lesion removal colonoscopy	Y		A2	8.4722	$354.98
45384	Lesion remove colonoscopy	Y		A2	8.4722	$354.98
45385	Lesion removal colonoscopy	Y		A2	8.4722	$354.98
45386	Colonoscopy dilate stricture	Y		A2	8.4722	$354.98
45387	Colonoscopy w/stent	Y		A2	24.9797	$1,046.59
45391	Colonoscopy w/endoscope us	Y		A2	8.4722	$354.98
45392	Colonoscopy w/endoscopic fnb	Y		A2	8.4722	$354.98
45500	Repair of rectum	Y		A2	22.3595	$936.81
45505	Repair of rectum	Y		A2	29.6501	$1,242.28
45520	Treatment of rectal prolapse	Y		P2	0.7983	$33.45

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
45541	Correct rectal prolapse	Y		G2	29.6501	$1,242.28
45560	Repair of rectocele	Y		A2	29.6501	$1,242.28
45900	Reduction of rectal prolapse	Y		A2	5.6974	$238.71
45905	Dilation of anal sphincter	Y		A2	22.3595	$936.81
45910	Dilation of rectal narrowing	Y		A2	22.3595	$936.81
45915	Remove rectal obstruction	Y		A2	14.6363	$613.23
45990	Surg dx exam, anorectal	Y		A2	22.3595	$936.81
46020	Placement of seton	Y		A2	22.3595	$936.81
46030	Removal of rectal marker	Y		A2	5.6974	$238.71
46040	Incision of rectal abscess	Y		A2	22.3595	$936.81
46045	Incision of rectal abscess	Y		A2	22.3595	$936.81
46050	Incision of anal abscess	Y		A2	14.6363	$613.23
46060	Incision of rectal abscess	Y		A2	22.3595	$936.81
46070	Incision of anal septum	Y		G2	14.6362	$613.23
46080	Incision of anal sphincter	Y		A2	22.3595	$936.81
46083	Incise external hemorrhoid	Y		P2	1.8791	$78.73
46200	Removal of anal fissure	Y		A2	22.3595	$936.81
46220	Excise anal ext tag/papilla	Y		A2	14.6363	$613.23
46221	Ligation of hemorrhoid(s)	Y		P3		$110.98
46230	Removal of anal tags	Y		A2	22.3595	$936.81
46250	Remove ext hem groups = 2	Y		A2	22.3595	$936.81
46255	Remove int/ext hem 1 group	Y		A2	22.3595	$936.81
46257	Remove in/ex hem grp & fiss	Y		A2	22.3595	$936.81
46258	Remove in/ex hem grp w/fistu	Y		A2	22.3595	$936.81
46260	Remove in/ex hem groups = 2	Y		A2	22.3595	$936.81
46261	Remove in/ex hem grps & fiss	Y		A2	22.3595	$936.81
46262	Remove in/ex hem grps w/fist	Y		A2	22.3595	$936.81
46270	Remove anal fist subq	Y		A2	22.3595	$936.81
46275	Remove anal fist inter	Y		A2	22.3595	$936.81
46280	Remove anal fist complex	Y		A2	22.3595	$936.81
46285	Remove anal fist 2 stage	Y		A2	22.3595	$936.81
46288	Repair anal fistula	Y		A2	22.3595	$936.81
46320	Removal of hemorrhoid clot	Y		P3		$74.64
46500	Injection into hemorrhoid(s)	Y		P3		$105.33
46505	Chemodenervation anal musc	Y		G2	22.3594	$936.81
46600	Diagnostic anoscopy	N		P2	0.6271	$26.27
46604	Anoscopy and dilation	Y	CH	P3		$358.95
46606	Anoscopy and biopsy	Y		P3		$116.13
46608	Anoscopy, remove for body	Y		A2	8.6376	$361.90

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
46610	Anoscopy, remove lesion	Y		A2	22.3495	$936.40
46611	Anoscopy	Y		A2	8.6376	$361.90
46612	Anoscopy, remove lesions	Y		A2	22.3495	$936.40
46614	Anoscopy, control bleeding	Y		P3		$59.91
46615	Anoscopy	Y		A2	22.3495	$936.40
46700	Repair of anal stricture	Y		A2	22.3595	$936.81
46706	Repr of anal fistula w/glue	Y		A2	29.6501	$1,242.28
46707	Repair anorectal fist w/plug	Y		G2	29.6501	$1,242.28
46750	Repair of anal sphincter	Y		A2	29.6501	$1,242.28
46753	Reconstruction of anus	Y		A2	22.3595	$936.81
46754	Removal of suture from anus	Y		A2	22.3595	$936.81
46760	Repair of anal sphincter	Y		A2	29.6501	$1,242.28
46761	Repair of anal sphincter	Y		A2	29.6501	$1,242.28
46762	Implant artificial sphincter	Y		A2	29.6501	$1,242.28
46900	Destruction, anal lesion(s)	Y	CH	P3		$107.29
46910	Destruction, anal lesion(s)	Y		P3		$112.94
46916	Cryosurgery, anal lesion(s)	Y		P2	1.391	$58.28
46917	Laser surgery, anal lesions	Y		A2	19.836	$831.08
46922	Excision of anal lesion(s)	Y		A2	19.836	$831.08
46924	Destruction, anal lesion(s)	Y		A2	19.836	$831.08
46930	Destroy internal hemorrhoids	Y		P3		$99.44
46940	Treatment of anal fissure	Y		P3		$86.18
46942	Treatment of anal fissure	Y		P3		$83.97
46945	Remove by ligat int hem grp	Y		P3		$138.23
46946	Remove by ligat int hem grps	Y		A2	14.6363	$613.23
46947	Hemorrhoidopexy by stapling	Y		A2	29.6501	$1,242.28
47000	Needle biopsy of liver	Y		A2	9.0033	$377.22
47001	Needle biopsy, liver add-on	N		N1		
47382	Percut ablate liver rf	Y		G2	52.0029	$2,178.82
47500	Injection for liver x-rays	N		N1		
47505	Injection for liver x-rays	N		N1		
47510	Insert catheter, bile duct	Y		A2	29.4324	$1,233.16
47511	Insert bile duct drain	Y		A2	29.4324	$1,233.16
47525	Change bile duct catheter	Y		A2	14.8714	$623.08
47530	Revise/reinsert bile tube	Y		A2	14.8714	$623.08
47552	Biliary endoscopy thru skin	Y		A2	29.4324	$1,233.16
47553	Biliary endoscopy thru skin	Y		A2	29.4324	$1,233.16
47554	Biliary endoscopy thru skin	Y		A2	29.4324	$1,233.16
47555	Biliary endoscopy thru skin	Y		A2	29.4324	$1,233.16

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
47556	Biliary endoscopy thru skin	Y		A2	29.4324	$1,233.16
47560	Laparoscopy w/cholangio	Y		A2	35.196	$1,474.64
47561	Laparo w/cholangio/biopsy	Y		A2	35.196	$1,474.64
47562	Laparoscopic cholecystectomy	Y		G2	43.6667	$1,829.55
47563	Laparo cholecystectomy/graph	Y		G2	43.6667	$1,829.55
47564	Laparo cholecystectomy/explr	Y		G2	43.6667	$1,829.55
47630	Remove bile duct stone	Y		A2	29.4324	$1,233.16
48102	Needle biopsy, pancreas	Y		A2	9.0033	$377.22
49080	Puncture, peritoneal cavity	Y		A2	5.1351	$215.15
49081	Removal of abdominal fluid	Y		A2	5.1351	$215.15
49180	Biopsy, abdominal mass	Y		A2	9.0033	$377.22
49250	Excision of umbilicus	Y		A2	23.8219	$998.09
49320	Diag laparo separate proc	Y		A2	35.196	$1,474.64
49321	Laparoscopy, biopsy	Y		A2	35.196	$1,474.64
49322	Laparoscopy, aspiration	Y		A2	35.196	$1,474.64
49324	Lap insertion perm ip cath	Y		G2	35.196	$1,474.64
49325	Lap revision perm ip cath	Y		G2	35.196	$1,474.64
49326	Lap w/omentopexy add-on	Y		G2	35.196	$1,474.64
49400	Air injection into abdomen	N		N1		
49402	Remove foreign body, adbomen	Y		A2	23.8219	$998.09
49411	Ins mark abd/pel for rt perq	N		P3		$267.37
49419	Insrt abdom cath for chemotx	Y		A2	30.2764	$1,268.52
49420	Insert abdom drain, temp	Y		A2	28.2961	$1,185.54
49421	Insert abdom drain, perm	Y		A2	28.2961	$1,185.54
49422	Remove perm cannula/catheter	Y		A2	21.1144	$884.65
49423	Exchange drainage catheter	Y		G2	14.8713	$623.08
49424	Assess cyst, contrast inject	N		N1		
49426	Revise abdomen-venous shunt	Y		A2	23.8219	$998.09
49427	Injection, abdominal shunt	N		N1		
49429	Removal of shunt	Y		G2	21.1143	$884.65
49435	Insert subq exten to ip cath	Y		G2	14.8713	$623.08
49436	Embedded ip cath exit-site	Y		G2	14.8713	$623.08
49440	Place gastrostomy tube perc	Y		G2	8.0729	$338.24
49441	Place duod/jej tube perc	Y		G2	8.0729	$338.24
49442	Place cecostomy tube perc	Y		G2	14.6362	$613.23
49446	Change g-tube to g-j perc	Y		G2	8.0729	$338.24
49450	Replace g/c tube perc	Y		G2	5.7507	$240.94
49451	Replace duod/jej tube perc	Y		G2	5.7507	$240.94
49452	Replace g-j tube perc	Y		G2	5.7507	$240.94

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
49460	Fix g/colon tube w/device	Y		G2	5.7507	$240.94
49465	Fluoro exam of g/colon tube	N		N1		
49495	Rpr ing hernia baby, reduc	Y		A2	30.3315	$1,270.83
49496	Rpr ing hernia baby, blocked	Y		A2	30.3315	$1,270.83
49500	Rpr ing hernia, init, reduce	Y		A2	30.3315	$1,270.83
49501	Rpr ing hernia, init blocked	Y		A2	30.3315	$1,270.83
49505	Prp i/hern init reduc >5 yr	Y		A2	30.3315	$1,270.83
49507	Prp i/hern init block >5 yr	Y		A2	30.3315	$1,270.83
49520	Rerepair ing hernia, reduce	Y		A2	30.3315	$1,270.83
49521	Rerepair ing hernia, blocked	Y		A2	30.3315	$1,270.83
49525	Repair ing hernia, sliding	Y		A2	30.3315	$1,270.83
49540	Repair lumbar hernia	Y		A2	30.3315	$1,270.83
49550	Rpr rem hernia, init, reduce	Y		A2	30.3315	$1,270.83
49553	Rpr fem hernia, init blocked	Y		A2	30.3315	$1,270.83
49555	Rerepair fem hernia, reduce	Y		A2	30.3315	$1,270.83
49557	Rerepair fem hernia, blocked	Y		A2	30.3315	$1,270.83
49560	Rpr ventral hern init, reduc	Y		A2	30.3315	$1,270.83
49561	Rpr ventral hern init, block	Y		A2	30.3315	$1,270.83
49565	Rerepair ventrl hern, reduce	Y		A2	30.3315	$1,270.83
49566	Rerepair ventrl hern, block	Y		A2	30.3315	$1,270.83
49568	Hernia repair w/mesh	Y		A2	30.3315	$1,270.83
49570	Rpr epigastric hern, reduce	Y		A2	30.3315	$1,270.83
49572	Rpr epigastric hern, blocked	Y		A2	30.3315	$1,270.83
49580	Rpr umbil hern, reduc < 5 yr	Y		A2	30.3315	$1,270.83
49582	Rpr umbil hern, block < 5 yr	Y		A2	30.3315	$1,270.83
49585	Rpr umbil hern, reduc > 5 yr	Y		A2	30.3315	$1,270.83
49587	Rpr umbil hern, block > 5 yr	Y		A2	30.3315	$1,270.83
49590	Repair spigelian hernia	Y		A2	30.3315	$1,270.83
49600	Repair umbilical lesion	Y		A2	30.3315	$1,270.83
49650	Lap ing hernia repair init	Y		A2	43.6665	$1,829.55
49651	Lap ing hernia repair recur	Y		A2	43.6665	$1,829.55
49652	Lap vent/abd hernia repair	Y		G2	64.6377	$2,708.19
49653	Lap vent/abd hern proc comp	Y		G2	64.6377	$2,708.19
49654	Lap inc hernia repair	Y		G2	64.6377	$2,708.19
49655	Lap inc hern repair comp	Y		G2	64.6377	$2,708.19
49656	Lap inc hernia repair recur	Y		G2	64.6377	$2,708.19
49657	Lap inc hern recur comp	Y		G2	64.6377	$2,708.19
50080	Removal of kidney stone	Y		G2	42.3333	$1,773.68
50081	Removal of kidney stone	Y		G2	42.3333	$1,773.68

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
50200	Renal biopsy perq	Y		A2	9.0033	$377.22
50382	Change ureter stent, percut	Y		G2	24.0156	$1,006.21
50384	Remove ureter stent, percut	Y		G2	16.1088	$674.93
50385	Change stent via transureth	Y		G2	24.0156	$1,006.21
50386	Remove stent via transureth	Y		P2	6.5459	$274.26
50387	Change ext/int ureter stent	Y		G2	14.8713	$623.08
50389	Remove renal tube w/fluoro	Y		G2	6.5459	$274.26
50390	Drainage of kidney lesion	Y		A2	9.0033	$377.22
50391	Instll rx agnt into rnal tub	Y	CH	P3		$40.02
50392	Insert kidney drain	Y		A2	16.1089	$674.93
50393	Insert ureteral tube	Y		A2	24.0157	$1,006.21
50394	Injection for kidney x-ray	N		N1		
50395	Create passage to kidney	Y		A2	24.0157	$1,006.21
50396	Measure kidney pressure	Y		A2	1.8791	$78.73
50398	Change kidney tube	Y		A2	14.8714	$623.08
50551	Kidney endoscopy	Y		A2	6.5459	$274.26
50553	Kidney endoscopy	Y		A2	24.0157	$1,006.21
50555	Kidney endoscopy & biopsy	Y		A2	6.5459	$274.26
50557	Kidney endoscopy & treatment	Y		A2	24.0157	$1,006.21
50561	Kidney endoscopy & treatment	Y		A2	24.0157	$1,006.21
50562	Renal scope w/tumor resect	Y		G2	6.5459	$274.26
50570	Kidney endoscopy	Y		G2	6.5459	$274.26
50572	Kidney endoscopy	Y		G2	6.5459	$274.26
50574	Kidney endoscopy & biopsy	Y		G2	6.5459	$274.26
50575	Kidney endoscopy	Y		G2	34.0301	$1,425.79
50576	Kidney endoscopy & treatment	Y		G2	16.1088	$674.93
50580	Kidney endoscopy & treatment	Y		G2	16.1088	$674.93
50590	Fragmenting of kidney stone	Y		G2	37.9296	$1,589.17
50592	Perc rf ablate renal tumor	Y		G2	52.0029	$2,178.82
50593	Perc cryo ablate renal tum	Y	CH	P2	52.0029	$2,178.82
50684	Injection for ureter x-ray	N		N1		
50686	Measure ureter pressure	Y		P2	0.9984	$41.83
50688	Change of ureter tube/stent	Y		A2	14.8714	$623.08
50690	Injection for ureter x-ray	N		N1		
50727	Revise ureter	Y		G2	18.6773	$782.54
50947	Laparo new ureter/bladder	Y		A2	43.6665	$1,829.55
50948	Laparo new ureter/bladder	Y		A2	43.6665	$1,829.55
50951	Endoscopy of ureter	Y		A2	6.5459	$274.26
50953	Endoscopy of ureter	Y		A2	6.5459	$274.26

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
50955	Ureter endoscopy & biopsy	Y		A2	24.0157	$1,006.21
50957	Ureter endoscopy & treatment	Y		A2	24.0157	$1,006.21
50961	Ureter endoscopy & treatment	Y		A2	24.0157	$1,006.21
50970	Ureter endoscopy	Y		A2	6.5459	$274.26
50972	Ureter endoscopy & catheter	Y		A2	6.5459	$274.26
50974	Ureter endoscopy & biopsy	Y		A2	16.1089	$674.93
50976	Ureter endoscopy & treatment	Y		A2	16.1089	$674.93
50980	Ureter endoscopy & treatment	Y		A2	24.0157	$1,006.21
51020	Incise & treat bladder	Y		A2	24.0157	$1,006.21
51030	Incise & treat bladder	Y		A2	24.0157	$1,006.21
51040	Incise & drain bladder	Y		A2	24.0157	$1,006.21
51045	Incise bladder/drain ureter	Y		A2	6.5459	$274.26
51050	Removal of bladder stone	Y		A2	24.0157	$1,006.21
51065	Remove ureter calculus	Y		A2	24.0157	$1,006.21
51080	Drainage of bladder abscess	Y		A2	18.4054	$771.15
51100	Drain bladder by needle	Y		P3		$24.55
51101	Drain bladder by trocar/cath	Y		P2	0.9984	$41.83
51102	Drain bl w/cath insertion	Y		A2	18.6773	$782.54
51500	Removal of bladder cyst	Y		A2	30.3315	$1,270.83
51520	Removal of bladder lesion	Y		A2	24.0157	$1,006.21
51535	Repair of ureter lesion	Y		G2	24.0156	$1,006.21
51600	Injection for bladder x-ray	N		N1		
51605	Preparation for bladder xray	N		N1		
51610	Injection for bladder x-ray	N		N1		
51700	Irrigation of bladder	Y		P3		$39.28
51701	Insert bladder catheter	N		P2	0.6271	$26.27
51702	Insert temp bladder cath	N		P2	0.6271	$26.27
51703	Insert bladder cath, complex	Y		P2	0.9984	$41.83
51705	Change of bladder tube	Y		P3		$53.28
51710	Change of bladder tube	Y		A2	5.7506	$240.94
51715	Endoscopic injection/implant	Y		A2	29.4341	$1,233.23
51720	Treatment of bladder lesion	Y		P3		$42.97
51725	Simple cystometrogram	Y	CH	P3		$94.53
51726	Complex cystometrogram	Y		A2	2.8049	$117.53
51727	Cystometrogram w/up	Y		P2	2.8051	$117.53
51728	Cystometrogram w/vp	Y		P2	2.8051	$117.53
51729	Cystometrogram w/vp&up	Y		P2	2.8051	$117.53
51736	Urine flow measurement	N		P3		$16.45
51741	Electro-uroflowmetry, first	Y		P3		$19.15

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
51784	Anal/urinary muscle study	Y		P2	0.9984	$41.83
51785	Anal/urinary muscle study	Y		A2	1.8791	$78.73
51792	Urinary reflex study	Y		P2	0.9984	$41.83
51797	Intraabdominal pressure test	Y	CH	P3		$66.04
51798	Us urine capacity measure	N		P3		$13.75
51880	Repair of bladder opening	Y		A2	24.0157	$1,006.21
51992	Laparo sling operation	Y		A2	43.6665	$1,829.55
52000	Cystoscopy	Y		A2	6.5459	$274.26
52001	Cystoscopy, removal of clots	Y		A2	16.1089	$674.93
52005	Cystoscopy & ureter catheter	Y		A2	24.0157	$1,006.21
52007	Cystoscopy and biopsy	Y		A2	24.0157	$1,006.21
52010	Cystoscopy & duct catheter	Y		A2	6.5459	$274.26
52204	Cystoscopy w/biopsy(s)	Y		A2	24.0157	$1,006.21
52214	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52224	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52234	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52235	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52240	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52250	Cystoscopy and radiotracer	Y		A2	24.0157	$1,006.21
52260	Cystoscopy and treatment	Y		A2	16.1089	$674.93
52265	Cystoscopy and treatment	Y	CH	P3		$215.57
52270	Cystoscopy & revise urethra	Y		A2	16.1089	$674.93
52275	Cystoscopy & revise urethra	Y		A2	24.0157	$1,006.21
52276	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52277	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52281	Cystoscopy and treatment	Y		A2	16.1089	$674.93
52282	Cystoscopy, implant stent	Y		A2	34.03	$1,425.79
52283	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52285	Cystoscopy and treatment	Y		A2	16.1089	$674.93
52290	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52300	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52301	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52305	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52310	Cystoscopy and treatment	Y		A2	16.1089	$674.93
52315	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52317	Remove bladder stone	Y		A2	24.0157	$1,006.21
52318	Remove bladder stone	Y		A2	24.0157	$1,006.21
52320	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52325	Cystoscopy, stone removal	Y		A2	24.0157	$1,006.21

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
52327	Cystoscopy, inject material	Y		A2	34.03	$1,425.79
52330	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52332	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52334	Create passage to kidney	Y		A2	24.0157	$1,006.21
52341	Cysto w/ureter stricture tx	Y		A2	24.0157	$1,006.21
52342	Cysto w/up stricture tx	Y		A2	24.0157	$1,006.21
52343	Cysto w/renal stricture tx	Y		A2	24.0157	$1,006.21
52344	Cysto/uretero, stricture tx	Y		A2	24.0157	$1,006.21
52345	Cysto/uretero w/up stricture	Y		A2	24.0157	$1,006.21
52346	Cystouretero w/renal strict	Y		A2	24.0157	$1,006.21
52351	Cystouretero & or pyeloscope	Y		A2	24.0157	$1,006.21
52352	Cystouretero w/stone remove	Y		A2	24.0157	$1,006.21
52353	Cystouretero w/lithotripsy	Y		A2	34.03	$1,425.79
52354	Cystouretero w/biopsy	Y		A2	24.0157	$1,006.21
52355	Cystouretero w/excise tumor	Y		A2	24.0157	$1,006.21
52400	Cystouretero w/congen repr	Y		A2	24.0157	$1,006.21
52402	Cystourethro cut ejacul duct	Y		A2	24.0157	$1,006.21
52450	Incision of prostate	Y		A2	24.0157	$1,006.21
52500	Revision of bladder neck	Y		A2	24.0157	$1,006.21
52601	Prostatectomy (TURP)	Y		A2	34.03	$1,425.79
52630	Remove prostate regrowth	Y		A2	34.03	$1,425.79
52640	Relieve bladder contracture	Y		A2	24.0157	$1,006.21
52647	Laser surgery of prostate	Y		A2	42.3333	$1,773.68
52648	Laser surgery of prostate	Y		A2	42.3333	$1,773.68
52700	Drainage of prostate abscess	Y		A2	24.0157	$1,006.21
53000	Incision of urethra	Y		A2	19.4327	$814.19
53010	Incision of urethra	Y		A2	19.4327	$814.19
53020	Incision of urethra	Y		A2	19.4327	$814.19
53025	Incision of urethra	Y		R2	19.4327	$814.19
53040	Drainage of urethra abscess	Y		A2	19.4327	$814.19
53060	Drainage of urethra abscess	Y		P3		$58.43
53080	Drainage of urinary leakage	Y		A2	19.4327	$814.19
53085	Drainage of urinary leakage	Y		G2	19.4327	$814.19
53200	Biopsy of urethra	Y		A2	19.4327	$814.19
53210	Removal of urethra	Y		A2	29.4341	$1,233.23
53215	Removal of urethra	Y		A2	19.4327	$814.19
53220	Treatment of urethra lesion	Y		A2	29.4341	$1,233.23
53230	Removal of urethra lesion	Y		A2	29.4341	$1,233.23
53235	Removal of urethra lesion	Y		A2	19.4327	$814.19

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
53240	Surgery for urethra pouch	Y		A2	29.4341	$1,233.23
53250	Removal of urethra gland	Y		A2	19.4327	$814.19
53260	Treatment of urethra lesion	Y		A2	19.4327	$814.19
53265	Treatment of urethra lesion	Y		A2	19.4327	$814.19
53270	Removal of urethra gland	Y		A2	19.4327	$814.19
53275	Repair of urethra defect	Y		A2	19.4327	$814.19
53400	Revise urethra, stage 1	Y		A2	29.4341	$1,233.23
53405	Revise urethra, stage 2	Y		A2	29.4341	$1,233.23
53410	Reconstruction of urethra	Y		A2	29.4341	$1,233.23
53420	Reconstruct urethra, stage 1	Y		A2	29.4341	$1,233.23
53425	Reconstruct urethra, stage 2	Y		A2	29.4341	$1,233.23
53430	Reconstruction of urethra	Y		A2	29.4341	$1,233.23
53431	Reconstruct urethra/bladder	Y		A2	29.4341	$1,233.23
53440	Male sling procedure	N		H8	137.6421	$5,766.93
53442	Remove/revise male sling	Y		A2	29.4341	$1,233.23
53444	Insert tandem cuff	N		H8	137.6421	$5,766.93
53445	Insert uro/ves nck sphincter	N		H8	239.1324	$10,019.17
53446	Remove uro sphincter	Y		A2	29.4341	$1,233.23
53447	Remove/replace ur sphincter	N		H8	239.1324	$10,019.17
53449	Repair uro sphincter	Y		A2	29.4341	$1,233.23
53450	Revision of urethra	Y		A2	29.4341	$1,233.23
53460	Revision of urethra	Y		A2	19.4327	$814.19
53502	Repair of urethra injury	Y		A2	19.4327	$814.19
53505	Repair of urethra injury	Y		A2	29.4341	$1,233.23
53510	Repair of urethra injury	Y		A2	19.4327	$814.19
53515	Repair of urethra injury	Y		A2	29.4341	$1,233.23
53520	Repair of urethra defect	Y		A2	29.4341	$1,233.23
53600	Dilate urethra stricture	Y		P3		$30.20
53601	Dilate urethra stricture	Y	CH	P3		$34.86
53605	Dilate urethra stricture	Y		A2	16.1089	$674.93
53620	Dilate urethra stricture	Y		P3		$45.42
53621	Dilate urethra stricture	Y		P3		$47.88
53660	Dilation of urethra	Y	CH	P3		$34.13
53661	Dilation of urethra	Y	CH	P3		$33.39
53665	Dilation of urethra	Y		A2	19.4327	$814.19
53850	Prostatic microwave thermotx	Y	CH	P3		$1,411.00
53852	Prostatic rf thermotx	Y	CH	P3		$1,330.96
53855	Insert prost urethral stent	Y		P2	1.8791	$78.73
54000	Slitting of prepuce	Y		A2	19.4327	$814.19

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
54001	Slitting of prepuce	Y		A2	19.4327	$814.19
54015	Drain penis lesion	Y		A2	18.4054	$771.15
54050	Destruction, penis lesion(s)	Y		P2	0.7983	$33.45
54055	Destruction, penis lesion(s)	Y		P3		$52.30
54056	Cryosurgery, penis lesion(s)	Y		P2	0.7983	$33.45
54057	Laser surg, penis lesion(s)	Y		A2	19.836	$831.08
54060	Excision of penis lesion(s)	Y		A2	19.836	$831.08
54065	Destruction, penis lesion(s)	Y		A2	19.836	$831.08
54100	Biopsy of penis	Y		A2	16.564	$694.00
54105	Biopsy of penis	Y		A2	21.9314	$918.88
54110	Treatment of penis lesion	Y		A2	33.1047	$1,387.01
54111	Treat penis lesion, graft	Y		A2	33.1047	$1,387.01
54112	Treat penis lesion, graft	Y		A2	33.1047	$1,387.01
54115	Treatment of penis lesion	Y		A2	18.4054	$771.15
54120	Partial removal of penis	Y		A2	33.1047	$1,387.01
54150	Circumcision w/regionl block	Y		A2	21.6247	$906.03
54160	Circumcision, neonate	Y		A2	21.6247	$906.03
54161	Circum 28 days or older	Y		A2	21.6247	$906.03
54162	Lysis penil circumic lesion	Y		A2	21.6247	$906.03
54163	Repair of circumcision	Y		A2	21.6247	$906.03
54164	Frenulotomy of penis	Y		A2	21.6247	$906.03
54200	Treatment of penis lesion	Y		P3		$51.31
54205	Treatment of penis lesion	Y		A2	33.1047	$1,387.01
54220	Treatment of penis lesion	Y		A2	1.8791	$78.73
54230	Prepare penis study	N		N1		
54231	Dynamic cavernosometry	Y		P3		$49.35
54235	Penile injection	Y		P3		$35.11
54240	Penis study	Y		P3		$24.80
54250	Penis study	Y		P3		$8.84
54300	Revision of penis	Y		A2	33.1047	$1,387.01
54304	Revision of penis	Y		A2	33.1047	$1,387.01
54308	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54312	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54316	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54318	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54322	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54324	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54326	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54328	Revise penis/urethra	Y		A2	33.1047	$1,387.01

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
54340	Secondary urethral surgery	Y		A2	33.1047	$1,387.01
54344	Secondary urethral surgery	Y		A2	33.1047	$1,387.01
54348	Secondary urethral surgery	Y		A2	33.1047	$1,387.01
54352	Reconstruct urethra/penis	Y		A2	33.1047	$1,387.01
54360	Penis plastic surgery	Y		A2	33.1047	$1,387.01
54380	Repair penis	Y		A2	33.1047	$1,387.01
54385	Repair penis	Y		A2	33.1047	$1,387.01
54400	Insert semi-rigid prosthesis	N		H8	137.6421	$5,766.93
54401	Insert self-contd prosthesis	N		H8	239.1324	$10,019.17
54405	Insert multi-comp penis pros	N		H8	239.1324	$10,019.17
54406	Remove muti-comp penis pros	Y		A2	33.1047	$1,387.01
54408	Repair multi-comp penis pros	Y		A2	33.1047	$1,387.01
54410	Remove/replace penis prosth	N		H8	239.1324	$10,019.17
54415	Remove self-contd penis pros	Y		A2	33.1047	$1,387.01
54416	Remv/repl penis contain pros	N		H8	239.1324	$10,019.17
54420	Revision of penis	Y		A2	33.1047	$1,387.01
54435	Revision of penis	Y		A2	33.1047	$1,387.01
54440	Repair of penis	Y		A2	33.1047	$1,387.01
54450	Preputial stretching	Y		A2	2.8049	$117.53
54500	Biopsy of testis	Y		A2	14.3296	$600.38
54505	Biopsy of testis	Y		A2	21.6247	$906.03
54512	Excise lesion testis	Y		A2	21.6247	$906.03
54520	Removal of testis	Y		A2	21.6247	$906.03
54522	Orchiectomy, partial	Y		A2	21.6247	$906.03
54530	Removal of testis	Y		A2	30.3315	$1,270.83
54550	Exploration for testis	Y		A2	30.3315	$1,270.83
54560	Exploration for testis	Y		G2	21.6247	$906.03
54600	Reduce testis torsion	Y		A2	21.6247	$906.03
54620	Suspension of testis	Y		A2	21.6247	$906.03
54640	Suspension of testis	Y		A2	30.3315	$1,270.83
54660	Revision of testis	Y		A2	21.6247	$906.03
54670	Repair testis injury	Y		A2	21.6247	$906.03
54680	Relocation of testis(es)	Y		A2	21.6247	$906.03
54690	Laparoscopy, orchiectomy	Y		A2	43.6665	$1,829.55
54692	Laparoscopy, orchiopexy	Y		G2	64.6377	$2,708.19
54700	Drainage of scrotum	Y		A2	21.6247	$906.03
54800	Biopsy of epididymis	Y		A2	4.2381	$177.57
54830	Remove epididymis lesion	Y		A2	21.6247	$906.03
54840	Remove epididymis lesion	Y		A2	21.6247	$906.03

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
54860	Removal of epididymis	Y		A2	21.6247	$906.03
54861	Removal of epididymis	Y		A2	21.6247	$906.03
54865	Explore epididymis	Y		A2	21.6247	$906.03
54900	Fusion of spermatic ducts	Y		A2	21.6247	$906.03
54901	Fusion of spermatic ducts	Y		A2	21.6247	$906.03
55000	Drainage of hydrocele	Y		P3		$50.09
55040	Removal of hydrocele	Y		A2	30.3315	$1,270.83
55041	Removal of hydroceles	Y		A2	30.3315	$1,270.83
55060	Repair of hydrocele	Y		A2	21.6247	$906.03
55100	Drainage of scrotum abscess	Y		A2	12.1142	$507.56
55110	Explore scrotum	Y		A2	21.6247	$906.03
55120	Removal of scrotum lesion	Y		A2	21.6247	$906.03
55150	Removal of scrotum	Y		A2	21.6247	$906.03
55175	Revision of scrotum	Y		A2	21.6247	$906.03
55180	Revision of scrotum	Y		A2	21.6247	$906.03
55200	Incision of sperm duct	Y		A2	21.6247	$906.03
55250	Removal of sperm duct(s)	Y		A2	21.6247	$906.03
55300	Prepare, sperm duct x-ray	N		N1		
55400	Repair of sperm duct	Y		A2	21.6247	$906.03
55450	Ligation of sperm duct	Y		P3		$156.64
55500	Removal of hydrocele	Y		A2	21.6247	$906.03
55520	Removal of sperm cord lesion	Y		A2	21.6247	$906.03
55530	Revise spermatic cord veins	Y		A2	21.6247	$906.03
55535	Revise spermatic cord veins	Y		A2	30.3315	$1,270.83
55540	Revise hernia & sperm veins	Y		A2	30.3315	$1,270.83
55550	Laparo ligate spermatic vein	Y		A2	43.6665	$1,829.55
55600	Incise sperm duct pouch	Y		R2	21.6247	$906.03
55680	Remove sperm pouch lesion	Y		A2	21.6247	$906.03
55700	Biopsy of prostate	Y		A2	12.1244	$507.98
55705	Biopsy of prostate	Y		A2	12.1244	$507.98
55706	Prostate saturation sampling	Y		G2	12.1242	$507.98
55720	Drainage of prostate abscess	Y		A2	24.0157	$1,006.21
55725	Drainage of prostate abscess	Y		A2	24.0157	$1,006.21
55860	Surgical exposure, prostate	Y		G2	18.6773	$782.54
55870	Electroejaculation	Y		P3		$60.89
55873	Cryoablate prostate	Y		H8	154.894	$6,489.75
55875	Transperi needle place, pros	N		A2	34.03	$1,425.79
55876	Place rt device/marker, pros	N		P3		$55.24
55920	Place needles pelvic for rt	Y		G2	23.822	$998.09

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
56405	I & D of vulva/perineum	Y		P3		$35.85
56420	Drainage of gland abscess	Y	CH	P3		$47.63
56440	Surgery for vulva lesion	Y		A2	18.8307	$788.97
56441	Lysis of labial lesion(s)	Y		A2	18.8307	$788.97
56442	Hymenotomy	Y		A2	18.8307	$788.97
56501	Destroy, vulva lesions, sim	Y		P3		$48.61
56515	Destroy vulva lesion/s compl	Y		A2	19.836	$831.08
56605	Biopsy of vulva/perineum	Y		P3		$27.99
56606	Biopsy of vulva/perineum	Y		P3		$11.54
56620	Partial removal of vulva	Y		A2	18.8307	$788.97
56625	Complete removal of vulva	Y		A2	18.8307	$788.97
56700	Partial removal of hymen	Y		A2	18.8307	$788.97
56740	Remove vagina gland lesion	Y		A2	18.8307	$788.97
56800	Repair of vagina	Y		A2	18.8307	$788.97
56805	Repair clitoris	Y		G2	18.8307	$788.97
56810	Repair of perineum	Y		A2	18.8307	$788.97
56820	Exam of vulva w/scope	Y		P3		$36.34
56821	Exam/biopsy of vulva w/scope	Y		P3		$46.89
57000	Exploration of vagina	Y		A2	18.8307	$788.97
57010	Drainage of pelvic abscess	Y		A2	18.8307	$788.97
57020	Drainage of pelvic fluid	Y		A2	6.1397	$257.24
57022	I & d vaginal hematoma, pp	Y		R2	12.1141	$507.56
57023	I & d vag hematoma, non-ob	Y		A2	18.4054	$771.15
57061	Destroy vag lesions, simple	Y		P3		$44.44
57065	Destroy vag lesions, complex	Y		A2	18.8307	$788.97
57100	Biopsy of vagina	Y		P3		$28.97
57105	Biopsy of vagina	Y		A2	18.8307	$788.97
57130	Remove vagina lesion	Y		A2	18.8307	$788.97
57135	Remove vagina lesion	Y		A2	18.8307	$788.97
57150	Treat vagina infection	Y		P3		$18.91
57155	Insert uteri tandems/ovoids	Y		A2	6.1397	$257.24
57160	Insert pessary/other device	Y		P3		$29.71
57170	Fitting of diaphragm/cap	Y		P2	0.1376	$5.77
57180	Treat vaginal bleeding	Y		A2	1.4521	$60.84
57200	Repair of vagina	Y		A2	18.8307	$788.97
57210	Repair vagina/perineum	Y		A2	18.8307	$788.97
57220	Revision of urethra	Y		A2	41.0953	$1,721.81
57230	Repair of urethral lesion	Y		A2	32.4832	$1,360.98
57240	Repair bladder & vagina	Y		A2	32.4832	$1,360.98

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
57250	Repair rectum & vagina	Y		A2	32.4832	$1,360.98
57260	Repair of vagina	Y		A2	32.4832	$1,360.98
57265	Extensive repair of vagina	Y		A2	41.0953	$1,721.81
57267	Insert mesh/pelvic flr addon	Y		A2	32.4832	$1,360.98
57268	Repair of bowel bulge	Y		A2	32.4832	$1,360.98
57287	Revise/remove sling repair	Y		G2	32.4831	$1,360.98
57288	Repair bladder defect	Y		A2	41.0953	$1,721.81
57289	Repair bladder & vagina	Y		A2	32.4832	$1,360.98
57291	Construction of vagina	Y		A2	32.4832	$1,360.98
57295	Revise vag graft via vagina	Y		G2	18.8307	$788.97
57300	Repair rectum-vagina fistula	Y		A2	32.4832	$1,360.98
57320	Repair bladder-vagina lesion	Y		G2	32.4831	$1,360.98
57400	Dilation of vagina	Y		A2	18.8307	$788.97
57410	Pelvic examination	Y		A2	18.8307	$788.97
57415	Remove vaginal foreign body	Y		A2	18.8307	$788.97
57420	Exam of vagina w/scope	Y		P3		$37.56
57421	Exam/biopsy of vag w/scope	Y		P3		$49.10
57426	Revise prosth vag graft lap	Y		G2	18.8307	$788.97
57452	Exam of cervix w/scope	Y		P3		$35.35
57454	Bx/curett of cervix w/scope	Y		P3		$43.95
57455	Biopsy of cervix w/scope	Y		P3		$45.91
57456	Endocerv curettage w/scope	Y		P3		$44.19
57460	Bx of cervix w/scope, leep	Y		P3		$127.18
57461	Conz of cervix w/scope, leep	Y		P3		$136.26
57500	Biopsy of cervix	Y		P3		$58.92
57505	Endocervical curettage	Y		P3		$39.04
57510	Cauterization of cervix	Y		P3		$40.51
57511	Cryocautery of cervix	Y	CH	P3		$48.86
57513	Laser surgery of cervix	Y		A2	18.8307	$788.97
57520	Conization of cervix	Y		A2	18.8307	$788.97
57522	Conization of cervix	Y		A2	18.8307	$788.97
57530	Removal of cervix	Y		A2	32.4832	$1,360.98
57550	Removal of residual cervix	Y		A2	32.4832	$1,360.98
57556	Remove cervix, repair bowel	Y		A2	41.0953	$1,721.81
57558	D&c of cervical stump	Y		A2	18.8307	$788.97
57700	Revision of cervix	Y		A2	18.8307	$788.97
57720	Revision of cervix	Y		A2	18.8307	$788.97
57800	Dilation of cervical canal	Y		P3		$21.36
58100	Biopsy of uterus lining	Y		P3		$35.11

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
58110	Bx done w/colposcopy add-on	N		N1		
58120	Dilation and curettage	Y		A2	18.8307	$788.97
58145	Myomectomy vag method	Y		A2	32.4832	$1,360.98
58301	Remove intrauterine device	Y		P3		$32.41
58321	Artificial insemination	Y		P3		$29.71
58322	Artificial insemination	Y		P3		$30.69
58323	Sperm washing	Y		P3		$5.89
58340	Catheter for hysterography	N		N1		
58345	Reopen fallopian tube	Y		R2	18.8307	$788.97
58346	Insert heyman uteri capsule	Y		A2	18.8307	$788.97
58350	Reopen fallopian tube	Y		A2	32.4832	$1,360.98
58353	Endometr ablate, thermal	Y		A2	32.4832	$1,360.98
58356	Endometrial cryoablation	Y		P3		$1,237.42
58545	Laparoscopic myomectomy	Y		A2	35.196	$1,474.64
58546	Laparo-myomectomy, complex	Y		A2	43.6665	$1,829.55
58550	Laparo-asst vag hysterectomy	Y		A2	64.6377	$2,708.19
58552	Laparo-vag hyst incl t/o	Y		G2	43.6667	$1,829.55
58555	Hysteroscopy, dx, sep proc	Y		A2	21.0879	$883.54
58558	Hysteroscopy, biopsy	Y		A2	21.0879	$883.54
58559	Hysteroscopy, lysis	Y		A2	21.0879	$883.54
58560	Hysteroscopy, resect septum	Y		A2	34.7943	$1,457.81
58561	Hysteroscopy, remove myoma	Y		A2	34.7943	$1,457.81
58562	Hysteroscopy, remove fb	Y		A2	21.0879	$883.54
58563	Hysteroscopy, ablation	Y		A2	34.7943	$1,457.81
58565	Hysteroscopy, sterilization	Y		A2	41.0953	$1,721.81
58600	Division of fallopian tube	Y		G2	32.4831	$1,360.98
58615	Occlude fallopian tube(s)	Y		G2	18.8307	$788.97
58660	Laparoscopy, lysis	Y		A2	43.6665	$1,829.55
58661	Laparoscopy, remove adnexa	Y		A2	43.6665	$1,829.55
58662	Laparoscopy, excise lesions	Y		A2	43.6665	$1,829.55
58670	Laparoscopy, tubal cautery	Y		A2	43.6665	$1,829.55
58671	Laparoscopy, tubal block	Y		A2	43.6665	$1,829.55
58672	Laparoscopy, fimbrioplasty	Y		A2	43.6665	$1,829.55
58673	Laparoscopy, salpingostomy	Y		A2	43.6665	$1,829.55
58800	Drainage of ovarian cyst(s)	Y		A2	18.8307	$788.97
58805	Drainage of ovarian cyst(s)	Y		G2	32.4831	$1,360.98
58820	Drain ovary abscess, open	Y		A2	32.4832	$1,360.98
58900	Biopsy of ovary(s)	Y		A2	18.8307	$788.97
58970	Retrieval of oocyte	Y		A2	3.2336	$135.48

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
58974	Transfer of embryo	Y		A2	3.2336	$135.48
58976	Transfer of embryo	Y		A2	3.2336	$135.48
59000	Amniocentesis, diagnostic	Y		P3		$51.07
59001	Amniocentesis, therapeutic	Y		R2	6.1396	$257.24
59012	Fetal cord puncture,prenatal	Y		G2	3.2335	$135.48
59015	Chorion biopsy	Y		P3		$43.95
59020	Fetal contract stress test	Y		P3		$22.34
59025	Fetal non-stress test	Y		P3		$12.03
59070	Transabdom amnioinfus w/us	Y		G2	1.4521	$60.84
59072	Umbilical cord occlud w/us	Y		G2	3.2335	$135.48
59076	Fetal shunt placement, w/us	Y		G2	3.2335	$135.48
59100	Remove uterus lesion	Y		R2	32.4831	$1,360.98
59150	Treat ectopic pregnancy	Y		G2	43.6667	$1,829.55
59151	Treat ectopic pregnancy	Y		G2	43.6667	$1,829.55
59160	D & c after delivery	Y		A2	18.8307	$788.97
59200	Insert cervical dilator	Y		P3		$27.99
59300	Episiotomy or vaginal repair	Y		P3		$63.34
59320	Revision of cervix	Y		A2	18.8307	$788.97
59412	Antepartum manipulation	Y		G2	18.8307	$788.97
59414	Deliver placenta	Y		G2	18.8307	$788.97
59812	Treatment of miscarriage	Y		A2	18.8307	$788.97
59820	Care of miscarriage	Y		A2	18.8307	$788.97
59821	Treatment of miscarriage	Y		A2	18.8307	$788.97
59840	Abortion	Y		A2	18.8307	$788.97
59841	Abortion	Y		A2	18.8307	$788.97
59866	Abortion (mpr)	Y		G2	3.2335	$135.48
59870	Evacuate mole of uterus	Y		A2	18.8307	$788.97
59871	Remove cerclage suture	Y		A2	18.8307	$788.97
60000	Drain thyroid/tongue cyst	Y		A2	7.1579	$299.89
60100	Biopsy of thyroid	Y		P3		$37.56
60200	Remove thyroid lesion	Y		A2	46.3447	$1,941.75
60210	Partial thyroid excision	Y		G2	46.3448	$1,941.75
60212	Partial thyroid excision	Y		G2	46.3448	$1,941.75
60220	Partial removal of thyroid	Y		G2	46.3448	$1,941.75
60225	Partial removal of thyroid	Y		G2	46.3448	$1,941.75
60280	Remove thyroid duct lesion	Y		A2	46.3447	$1,941.75
60281	Remove thyroid duct lesion	Y		A2	46.3447	$1,941.75
60300	Aspir/inj thyroid cyst	Y		P3		$52.30
61000	Remove cranial cavity fluid	Y		R2	7.0178	$294.03

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
61001	Remove cranial cavity fluid	Y		R2	7.0178	$294.03
61020	Remove brain cavity fluid	Y		A2	7.0178	$294.03
61026	Injection into brain canal	Y		A2	7.0178	$294.03
61050	Remove brain canal fluid	Y		A2	7.0178	$294.03
61055	Injection into brain canal	Y		A2	7.0178	$294.03
61070	Brain canal shunt procedure	Y		A2	5.7506	$240.94
61215	Insert brain-fluid device	Y		A2	38.1505	$1,598.43
61330	Decompress eye socket	Y		G2	40.7633	$1,707.90
61334	Explore orbit/remove object	Y		G2	40.7633	$1,707.90
61770	Incise skull for treatment	Y		G2	34.1189	$1,429.51
61790	Treat trigeminal nerve	Y		A2	17.5922	$737.08
61791	Treat trigeminal tract	Y		A2	12.0953	$506.77
61795	Brain surgery using computer	N		N1		
61880	Revise/remove neuroelectrode	Y		G2	19.9365	$835.30
61885	Insrt/redo neurostim 1 array	N		H8	320.6516	$13,434.66
61886	Implant neurostim arrays	N		H8	416.5122	$17,451.03
61888	Revise/remove neuroreceiver	Y		A2	26.8896	$1,126.62
62160	Neuroendoscopy add-on	N		N1		
62194	Replace/irrigate catheter	Y		A2	7.0178	$294.03
62225	Replace/irrigate catheter	Y		A2	14.8714	$623.08
62230	Replace/revise brain shunt	Y		A2	38.1505	$1,598.43
62252	Csf shunt reprogram	N		P3		$39.77
62263	Epidural lysis mult sessions	Y		A2	7.0178	$294.03
62264	Epidural lysis on single day	Y		A2	12.0953	$506.77
62267	Interdiscal perq aspir, dx	Y		G2	4.2381	$177.57
62268	Drain spinal cord cyst	Y		A2	7.0178	$294.03
62269	Needle biopsy, spinal cord	Y		A2	9.0033	$377.22
62270	Spinal fluid tap, diagnostic	Y		A2	3.5267	$147.76
62272	Drain cerebro spinal fluid	Y		A2	3.5267	$147.76
62273	Inject epidural patch	Y		A2	7.0178	$294.03
62280	Treat spinal cord lesion	Y		A2	7.0178	$294.03
62281	Treat spinal cord lesion	Y		A2	7.0178	$294.03
62282	Treat spinal canal lesion	Y		A2	7.0178	$294.03
62284	Injection for myelogram	N		N1		
62287	Percutaneous diskectomy	Y		A2	34.1188	$1,429.51
62290	Inject for spine disk x-ray	N		N1		
62291	Inject for spine disk x-ray	N		N1		
62292	Injection into disk lesion	Y		R2	7.0178	$294.03
62294	Injection into spinal artery	Y		A2	7.0178	$294.03

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
62310	Inject spine c/t	Y		A2	7.0178	$294.03
62311	Inject spine l/s (cd)	Y		A2	7.0178	$294.03
62318	Inject spine w/cath, c/t	Y		A2	7.0178	$294.03
62319	Inject spine w/cath l/s (cd)	Y		A2	12.0953	$506.77
62350	Implant spinal canal cath	Y		A2	38.1505	$1,598.43
62355	Remove spinal canal catheter	Y		A2	12.0953	$506.77
62360	Insert spine infusion device	Y		A2	38.1505	$1,598.43
62361	Implant spine infusion pump	Y		H8	291.0141	$12,192.91
62362	Implant spine infusion pump	Y		H8	291.0141	$12,192.91
62365	Remove spine infusion device	Y		A2	34.1188	$1,429.51
62367	Analyze spine infusion pump	N		P3		$15.96
62368	Analyze spine infusion pump	N		P3		$21.36
63600	Remove spinal cord lesion	Y		A2	17.5922	$737.08
63610	Stimulation of spinal cord	Y		A2	17.5922	$737.08
63615	Remove lesion of spinal cord	Y		R2	17.5923	$737.08
63650	Implant neuroelectrodes	N		H8	86.0561	$3,605.58
63655	Implant neuroelectrodes	N		J8	120.9392	$5,067.11
63661	Remove spine eltrd perq aray	Y		G2	19.9365	$835.30
63662	Remove spine eltrd plate	Y		G2	19.9365	$835.30
63663	Revise spine eltrd perq aray	Y		G2	19.9365	$835.30
63664	Revise spine eltrd plate	Y		G2	19.9365	$835.30
63685	Insrt/redo spine n generator	N		H8	320.6516	$13,434.66
63688	Revise/remove neuroreceiver	Y		A2	26.8896	$1,126.62
63744	Revision of spinal shunt	Y		A2	38.1505	$1,598.43
63746	Removal of spinal shunt	Y		A2	12.0953	$506.77
64400	N block inj, trigeminal	Y		P3		$49.10
64402	N block inj, facial	Y		P3		$45.42
64405	N block inj, occipital	Y		P3		$41.74
64408	N block inj, vagus	Y		P3		$49.10
64410	N block inj, phrenic	Y		A2	7.0178	$294.03
64412	N block inj, spinal accessor	Y		P3		$72.67
64413	N block inj, cervical plexus	Y		P3		$45.42
64415	N block inj, brachial plexus	Y		A2	3.5267	$147.76
64416	N block cont infuse, b plex	Y		G2	7.0178	$294.03
64417	N block inj, axillary	Y		A2	3.5267	$147.76
64418	N block inj, suprascapular	Y		P3		$62.36
64420	N block inj, intercost, sng	Y		A2	3.5267	$147.76
64421	N block inj, intercost, mlt	Y		A2	7.0178	$294.03
64425	N block inj, ilio-ing/hypogi	Y		P3		$45.91

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
64430	N block inj, pudendal	Y		A2	7.0178	$294.03
64435	N block inj, paracervical	Y		P3		$59.17
64445	N block inj, sciatic, sng	Y		P3		$55.00
64446	N blk inj, sciatic, cont inf	Y		G2	12.0953	$506.77
64447	N block inj fem, single	Y		R2	7.0178	$294.03
64448	N block inj fem, cont inf	Y		G2	7.0178	$294.03
64449	N block inj, lumbar plexus	Y		G2	7.0178	$294.03
64450	N block, other peripheral	Y		P3		$39.28
64455	N block inj, plantar digit	Y		P3		$14.73
64479	Inj foramen epidural c/t	Y		A2	7.0178	$294.03
64480	Inj foramen epidural add-on	Y		A2	3.5267	$147.76
64483	Inj foramen epidural l/s	Y		A2	7.0178	$294.03
64484	Inj foramen epidural add-on	Y		A2	3.5267	$147.76
64490	Inj paravert f jnt c/t 1 lev	Y		G2	7.0178	$294.03
64491	Inj paravert f jnt c/t 2 lev	Y		G2	2.4234	$101.54
64492	Inj paravert f jnt c/t 3 lev	Y		G2	2.4234	$101.54
64493	Inj paravert f jnt l/s 1 lev	Y		G2	7.0178	$294.03
64494	Inj paravert f jnt l/s 2 lev	Y		G2	2.4234	$101.54
64495	Inj paravert f jnt l/s 3 lev	Y		G2	2.4234	$101.54
64505	N block, spenopalatine gangl	Y		P3		$34.37
64508	N block, carotid sinus s/p	Y		P3		$79.30
64510	N block, stellate ganglion	Y		A2	7.0178	$294.03
64517	N block inj, hypogas plxs	Y		A2	7.0178	$294.03
64520	N block, lumbar/thoracic	Y		A2	7.0178	$294.03
64530	N block inj, celiac pelus	Y		A2	7.0178	$294.03
64553	Implant neuroelectrodes	N		H8	86.0561	$3,605.58
64555	Implant neuroelectrodes	N		J8	86.0561	$3,605.58
64560	Implant neuroelectrodes	N		J8	86.0561	$3,605.58
64561	Implant neuroelectrodes	N		H8	86.0561	$3,605.58
64565	Implant neuroelectrodes	N		J8	86.0561	$3,605.58
64573	Implant neuroelectrodes	N		H8	313.8252	$13,148.65
64575	Implant neuroelectrodes	N		H8	120.9392	$5,067.11
64577	Implant neuroelectrodes	N		H8	120.9392	$5,067.11
64580	Implant neuroelectrodes	N		H8	120.9392	$5,067.11
64581	Implant neuroelectrodes	N		H8	120.9392	$5,067.11
64585	Revise/remove neuroelectrode	Y		A2	19.9365	$835.30
64590	Insrt/redo pn/gastr stimul	N		H8	320.6516	$13,434.66
64595	Revise/rmv pn/gastr stimul	Y		A2	26.8896	$1,126.62
64600	Injection treatment of nerve	Y		A2	12.0953	$506.77

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
64605	Injection treatment of nerve	Y		A2	17.5922	$737.08
64610	Injection treatment of nerve	Y		A2	17.5922	$737.08
64612	Destroy nerve, face muscle	Y		P3		$57.70
64613	Destroy nerve, neck muscle	Y		P3		$53.52
64614	Destroy nerve, extrem musc	Y		P3		$60.89
64620	Injection treatment of nerve	Y		A2	7.0178	$294.03
64622	Destr paravertebrl nerve l/s	Y		A2	12.0953	$506.77
64623	Destr paravertebral n add-on	Y		A2	7.0178	$294.03
64626	Destr paravertebrl nerve c/t	Y		A2	7.0178	$294.03
64627	Destr paravertebral n add-on	Y		A2	2.4235	$101.54
64630	Injection treatment of nerve	Y		A2	7.0178	$294.03
64632	N block inj, common digit	Y		P3		$28.23
64640	Injection treatment of nerve	Y		P3		$81.51
64650	Chemodenerv eccrine glands	Y		P3		$30.20
64653	Chemodenerv eccrine glands	Y		P3		$33.64
64680	Injection treatment of nerve	Y		A2	7.0178	$294.03
64681	Injection treatment of nerve	Y		A2	12.0953	$506.77
64702	Revise finger/toe nerve	Y		A2	17.5922	$737.08
64704	Revise hand/foot nerve	Y		A2	17.5922	$737.08
64708	Revise arm/leg nerve	Y		A2	17.5922	$737.08
64712	Revision of sciatic nerve	Y		A2	17.5922	$737.08
64713	Revision of arm nerve(s)	Y		A2	17.5922	$737.08
64714	Revise low back nerve(s)	Y		A2	17.5922	$737.08
64716	Revision of cranial nerve	Y		A2	17.5922	$737.08
64718	Revise ulnar nerve at elbow	Y		A2	17.5922	$737.08
64719	Revise ulnar nerve at wrist	Y		A2	17.5922	$737.08
64721	Carpal tunnel surgery	Y		A2	17.5922	$737.08
64722	Relieve pressure on nerve(s)	Y		A2	17.5922	$737.08
64726	Release foot/toe nerve	Y		A2	17.5922	$737.08
64727	Internal nerve revision	Y		A2	17.5922	$737.08
64732	Incision of brow nerve	Y		A2	17.5922	$737.08
64734	Incision of cheek nerve	Y		A2	17.5922	$737.08
64736	Incision of chin nerve	Y		A2	17.5922	$737.08
64738	Incision of jaw nerve	Y		A2	17.5922	$737.08
64740	Incision of tongue nerve	Y		A2	17.5922	$737.08
64742	Incision of facial nerve	Y		A2	17.5922	$737.08
64744	Incise nerve, back of head	Y		A2	17.5922	$737.08
64746	Incise diaphragm nerve	Y		A2	17.5922	$737.08
64761	Incision of pelvis nerve	Y		G2	17.5923	$737.08

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
64763	Incise hip/thigh nerve	Y		G2	17.5923	$737.08
64766	Incise hip/thigh nerve	Y		G2	34.1189	$1,429.51
64771	Sever cranial nerve	Y		A2	17.5922	$737.08
64772	Incision of spinal nerve	Y		A2	17.5922	$737.08
64774	Remove skin nerve lesion	Y		A2	17.5922	$737.08
64776	Remove digit nerve lesion	Y		A2	17.5922	$737.08
64778	Digit nerve surgery add-on	Y		A2	17.5922	$737.08
64782	Remove limb nerve lesion	Y		A2	17.5922	$737.08
64783	Limb nerve surgery add-on	Y		A2	17.5922	$737.08
64784	Remove nerve lesion	Y		A2	17.5922	$737.08
64786	Remove sciatic nerve lesion	Y		A2	34.1188	$1,429.51
64787	Implant nerve end	Y		A2	17.5922	$737.08
64788	Remove skin nerve lesion	Y		A2	17.5922	$737.08
64790	Removal of nerve lesion	Y		A2	17.5922	$737.08
64792	Removal of nerve lesion	Y		A2	34.1188	$1,429.51
64795	Biopsy of nerve	Y		A2	17.5922	$737.08
64802	Remove sympathetic nerves	Y		A2	17.5922	$737.08
64820	Remove sympathetic nerves	Y		G2	17.5923	$737.08
64821	Remove sympathetic nerves	Y		A2	27.1049	$1,135.64
64822	Remove sympathetic nerves	Y		G2	27.1049	$1,135.64
64823	Remove sympathetic nerves	Y		G2	27.1049	$1,135.64
64831	Repair of digit nerve	Y		A2	34.1188	$1,429.51
64832	Repair nerve add-on	Y		A2	34.1188	$1,429.51
64834	Repair of hand or foot nerve	Y		A2	34.1188	$1,429.51
64835	Repair of hand or foot nerve	Y		A2	34.1188	$1,429.51
64836	Repair of hand or foot nerve	Y		A2	34.1188	$1,429.51
64837	Repair nerve add-on	Y		A2	34.1188	$1,429.51
64840	Repair of leg nerve	Y		A2	34.1188	$1,429.51
64856	Repair/transpose nerve	Y		A2	34.1188	$1,429.51
64857	Repair arm/leg nerve	Y		A2	34.1188	$1,429.51
64858	Repair sciatic nerve	Y		A2	34.1188	$1,429.51
64859	Nerve surgery	Y		A2	34.1188	$1,429.51
64861	Repair of arm nerves	Y		A2	34.1188	$1,429.51
64862	Repair of low back nerves	Y		A2	34.1188	$1,429.51
64864	Repair of facial nerve	Y		A2	34.1188	$1,429.51
64865	Repair of facial nerve	Y		A2	34.1188	$1,429.51
64870	Fusion of facial/other nerve	Y		A2	34.1188	$1,429.51
64872	Subsequent repair of nerve	Y		A2	34.1188	$1,429.51
64874	Repair & revise nerve add-on	Y		A2	34.1188	$1,429.51

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
64876	Repair nerve/shorten bone	Y		A2	34.1188	$1,429.51
64885	Nerve graft, head or neck	Y		A2	34.1188	$1,429.51
64886	Nerve graft, head or neck	Y		A2	34.1188	$1,429.51
64890	Nerve graft, hand or foot	Y		A2	34.1188	$1,429.51
64891	Nerve graft, hand or foot	Y		A2	34.1188	$1,429.51
64892	Nerve graft, arm or leg	Y		A2	34.1188	$1,429.51
64893	Nerve graft, arm or leg	Y		A2	34.1188	$1,429.51
64895	Nerve graft, hand or foot	Y		A2	34.1188	$1,429.51
64896	Nerve graft, hand or foot	Y		A2	34.1188	$1,429.51
64897	Nerve graft, arm or leg	Y		A2	34.1188	$1,429.51
64898	Nerve graft, arm or leg	Y		A2	34.1188	$1,429.51
64901	Nerve graft add-on	Y		A2	34.1188	$1,429.51
64902	Nerve graft add-on	Y		A2	34.1188	$1,429.51
64905	Nerve pedicle transfer	Y		A2	34.1188	$1,429.51
64907	Nerve pedicle transfer	Y		A2	34.1188	$1,429.51
64910	Nerve repair w/allograft	Y		G2	34.1189	$1,429.51
65091	Revise eye	Y		A2	35.7611	$1,498.32
65093	Revise eye with implant	Y		A2	35.7611	$1,498.32
65101	Removal of eye	Y		A2	35.7611	$1,498.32
65103	Remove eye/insert implant	Y		A2	35.7611	$1,498.32
65105	Remove eye/attach implant	Y		A2	35.7611	$1,498.32
65110	Removal of eye	Y		A2	35.7611	$1,498.32
65112	Remove eye/revise socket	Y		A2	35.7611	$1,498.32
65114	Remove eye/revise socket	Y		A2	35.7611	$1,498.32
65125	Revise ocular implant	Y		G2	24.4266	$1,023.43
65130	Insert ocular implant	Y		A2	24.4265	$1,023.43
65135	Insert ocular implant	Y		A2	24.4265	$1,023.43
65140	Attach ocular implant	Y		A2	35.7611	$1,498.32
65150	Revise ocular implant	Y		A2	24.4265	$1,023.43
65155	Reinsert ocular implant	Y		A2	35.7611	$1,498.32
65175	Removal of ocular implant	Y		A2	18.1698	$761.28
65205	Remove foreign body from eye	N		P3		$18.66
65210	Remove foreign body from eye	N		P3		$24.31
65220	Remove foreign body from eye	N		G2	0.8468	$35.48
65222	Remove foreign body from eye	N		P3		$26.52
65235	Remove foreign body from eye	Y		A2	15.5346	$650.87
65260	Remove foreign body from eye	Y		A2	4.8105	$201.55
65265	Remove foreign body from eye	Y		A2	21.159	$886.52
65270	Repair of eye wound	Y		A2	18.1698	$761.28

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
65272	Repair of eye wound	Y		A2	22.292	$933.99
65275	Repair of eye wound	Y		A2	22.292	$933.99
65280	Repair of eye wound	Y		A2	21.159	$886.52
65285	Repair of eye wound	Y		A2	36.9483	$1,548.07
65286	Repair of eye wound	Y	CH	P3		$296.83
65290	Repair of eye socket wound	Y		A2	23.0114	$964.13
65400	Removal of eye lesion	Y		A2	15.5346	$650.87
65410	Biopsy of cornea	Y		A2	15.5346	$650.87
65420	Removal of eye lesion	Y		A2	15.5346	$650.87
65426	Removal of eye lesion	Y		A2	22.292	$933.99
65430	Corneal smear	N		P2	0.8468	$35.48
65435	Curette/treat cornea	Y		P3		$29.46
65436	Curette/treat cornea	Y		P3		$132.58
65450	Treatment of corneal lesion	N		G2	2.0838	$87.31
65600	Revision of cornea	Y		P3		$152.22
65710	Corneal transplant	Y		A2	35.4855	$1,486.77
65730	Corneal transplant	Y		A2	35.4855	$1,486.77
65750	Corneal transplant	Y		A2	35.4855	$1,486.77
65755	Corneal transplant	Y		A2	35.4855	$1,486.77
65756	Corneal trnspl, endothelial	Y		G2	35.4855	$1,486.77
65757	Prep corneal endo allograft	N		N1		
65770	Revise cornea with implant	Y		H8	151.1101	$6,331.21
65772	Correction of astigmatism	Y		A2	15.5346	$650.87
65775	Correction of astigmatism	Y		A2	15.5346	$650.87
65780	Ocular reconst, transplant	Y		A2	35.4855	$1,486.77
65781	Ocular reconst, transplant	Y		A2	35.4855	$1,486.77
65782	Ocular reconst, transplant	Y		A2	35.4855	$1,486.77
65800	Drainage of eye	Y		A2	7.1602	$299.99
65805	Drainage of eye	Y		A2	15.5346	$650.87
65810	Drainage of eye	Y		A2	22.292	$933.99
65815	Drainage of eye	Y		A2	22.292	$933.99
65820	Relieve inner eye pressure	Y		A2	22.292	$933.99
65850	Incision of eye	Y		A2	22.292	$933.99
65855	Laser surgery of eye	Y		P3		$123.25
65860	Incise inner eye adhesions	Y		P3		$114.17
65865	Incise inner eye adhesions	Y		A2	15.5346	$650.87
65870	Incise inner eye adhesions	Y		A2	22.292	$933.99
65875	Incise inner eye adhesions	Y		A2	22.292	$933.99
65880	Incise inner eye adhesions	Y		A2	15.5346	$650.87

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
65900	Remove eye lesion	Y		A2	2.2567	$94.56
65920	Remove implant of eye	Y		A2	22.292	$933.99
65930	Remove blood clot from eye	Y		A2	22.292	$933.99
66020	Injection treatment of eye	Y		A2	15.5346	$650.87
66030	Injection treatment of eye	Y		A2	15.5346	$650.87
66130	Remove eye lesion	Y		A2	22.292	$933.99
66150	Glaucoma surgery	Y		A2	22.292	$933.99
66155	Glaucoma surgery	Y		A2	22.292	$933.99
66160	Glaucoma surgery	Y		A2	22.292	$933.99
66165	Glaucoma surgery	Y		A2	22.292	$933.99
66170	Glaucoma surgery	Y		A2	22.292	$933.99
66172	Incision of eye	Y		A2	22.292	$933.99
66180	Implant eye shunt	Y		A2	40.4623	$1,695.29
66185	Revise eye shunt	Y		A2	22.292	$933.99
66220	Repair eye lesion	Y		A2	36.9483	$1,548.07
66225	Repair/graft eye lesion	Y		A2	40.4623	$1,695.29
66250	Follow-up surgery of eye	Y		A2	15.5346	$650.87
66500	Incision of iris	Y		A2	2.2567	$94.56
66505	Incision of iris	Y		A2	7.1602	$299.99
66600	Remove iris and lesion	Y		A2	22.292	$933.99
66605	Removal of iris	Y		A2	22.292	$933.99
66625	Removal of iris	Y		A2	7.1602	$299.99
66630	Removal of iris	Y		A2	22.292	$933.99
66635	Removal of iris	Y		A2	22.292	$933.99
66680	Repair iris & ciliary body	Y		A2	22.292	$933.99
66682	Repair iris & ciliary body	Y		A2	22.292	$933.99
66700	Destruction, ciliary body	Y		A2	15.5346	$650.87
66710	Ciliary transsleral therapy	Y		A2	15.5346	$650.87
66711	Ciliary endoscopic ablation	Y		A2	15.5346	$650.87
66720	Destruction, ciliary body	Y		A2	15.5346	$650.87
66740	Destruction, ciliary body	Y		A2	22.292	$933.99
66761	Revision of iris	Y		P3		$172.36
66762	Revision of iris	Y	CH	P3		$176.04
66770	Removal of inner eye lesion	Y	CH	P3		$191.51
66820	Incision, secondary cataract	Y		G2	7.1601	$299.99
66821	After cataract laser surgery	Y		A2	5.0594	$211.98
66825	Reposition intraocular lens	Y		A2	22.292	$933.99
66830	Removal of lens lesion	Y		A2	7.1602	$299.99
66840	Removal of lens material	Y		A2	13.0166	$545.37

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
66850	Removal of lens material	Y		A2	28.1963	$1,181.37
66852	Removal of lens material	Y		A2	28.1963	$1,181.37
66920	Extraction of lens	Y		A2	28.1963	$1,181.37
66930	Extraction of lens	Y		A2	28.1963	$1,181.37
66940	Extraction of lens	Y		A2	13.0166	$545.37
66982	Cataract surgery, complex	Y		A2	22.524	$943.71
66983	Cataract surg w/iol, 1 stage	Y		A2	22.524	$943.71
66984	Cataract surg w/iol, 1 stage	Y		A2	22.524	$943.71
66985	Insert lens prosthesis	Y		A2	22.524	$943.71
66986	Exchange lens prosthesis	Y		A2	22.524	$943.71
66990	Ophthalmic endoscope add-on	N		N1		
67005	Partial removal of eye fluid	Y		A2	21.159	$886.52
67010	Partial removal of eye fluid	Y		A2	36.9483	$1,548.07
67015	Release of eye fluid	Y		A2	36.9483	$1,548.07
67025	Replace eye fluid	Y		A2	36.9483	$1,548.07
67027	Implant eye drug system	Y		A2	36.9483	$1,548.07
67028	Injection eye drug	Y		P3		$76.11
67030	Incise inner eye strands	Y		A2	21.159	$886.52
67031	Laser surgery, eye strands	Y		A2	5.0594	$211.98
67036	Removal of inner eye fluid	Y		A2	36.9483	$1,548.07
67039	Laser treatment of retina	Y		A2	36.9483	$1,548.07
67040	Laser treatment of retina	Y		A2	36.9483	$1,548.07
67041	Vit for macular pucker	Y		G2	36.9485	$1,548.07
67042	Vit for macular hole	Y		G2	36.9485	$1,548.07
67043	Vit for membrane dissect	Y		G2	36.9485	$1,548.07
67101	Repair detached retina	Y		P3		$291.19
67105	Repair detached retina	Y		P2	5.0594	$211.98
67107	Repair detached retina	Y		A2	36.9483	$1,548.07
67108	Repair detached retina	Y		A2	36.9483	$1,548.07
67110	Repair detached retina	Y		P3		$312.55
67112	Rerepair detached retina	Y		A2	36.9483	$1,548.07
67113	Repair retinal detach, cplx	Y		G2	36.9485	$1,548.07
67115	Release encircling material	Y		A2	21.159	$886.52
67120	Remove eye implant material	Y		A2	21.159	$886.52
67121	Remove eye implant material	Y		A2	36.9483	$1,548.07
67141	Treatment of retina	Y		A2	4.8105	$201.55
67145	Treatment of retina	Y	CH	P3		$186.10
67208	Treatment of retinal lesion	Y	CH	P3		$200.59
67210	Treatment of retinal lesion	Y		P2	5.0594	$211.98

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
67218	Treatment of retinal lesion	Y		A2	21.159	$886.52
67220	Treatment of choroid lesion	Y		P2	4.8105	$201.55
67221	Ocular photodynamic ther	Y		P3		$105.82
67225	Eye photodynamic ther add-on	Y		P3		$8.10
67227	Treatment of retinal lesion	Y		A2	21.159	$886.52
67228	Treatment of retinal lesion	Y		P2	5.0594	$211.98
67229*	Tr retinal les preterm inf	Y		R2	5.0594	$211.98
67250	Reinforce eye wall	Y		A2	18.1698	$761.28
67255	Reinforce/graft eye wall	Y		A2	21.159	$886.52
67311	Revise eye muscle	Y		A2	23.0114	$964.13
67312	Revise two eye muscles	Y		A2	23.0114	$964.13
67314	Revise eye muscle	Y		A2	23.0114	$964.13
67316	Revise two eye muscles	Y		A2	23.0114	$964.13
67318	Revise eye muscle(s)	Y		A2	23.0114	$964.13
67320	Revise eye muscle(s) add-on	Y		A2	23.0114	$964.13
67331	Eye surgery follow-up add-on	Y		A2	23.0114	$964.13
67332	Rerevise eye muscles add-on	Y		A2	23.0114	$964.13
67334	Revise eye muscle w/suture	Y		A2	23.0114	$964.13
67335	Eye suture during surgery	Y		A2	23.0114	$964.13
67340	Revise eye muscle add-on	Y		A2	23.0114	$964.13
67343	Release eye tissue	Y		A2	23.0114	$964.13
67345	Destroy nerve of eye muscle	Y		P3		$78.08
67346	Biopsy, eye muscle	Y		A2	15.1275	$633.81
67400	Explore/biopsy eye socket	Y		A2	18.1698	$761.28
67405	Explore/drain eye socket	Y		A2	24.4265	$1,023.43
67412	Explore/treat eye socket	Y		A2	18.1698	$761.28
67413	Explore/treat eye socket	Y		A2	24.4265	$1,023.43
67414	Explr/decompress eye socket	Y		G2	35.7612	$1,498.32
67415	Aspiration, orbital contents	Y		A2	18.1698	$761.28
67420	Explore/treat eye socket	Y		A2	35.7611	$1,498.32
67430	Explore/treat eye socket	Y		A2	35.7611	$1,498.32
67440	Explore/drain eye socket	Y		A2	35.7611	$1,498.32
67445	Explr/decompress eye socket	Y		A2	35.7611	$1,498.32
67450	Explore/biopsy eye socket	Y		A2	35.7611	$1,498.32
67500	Inject/treat eye socket	N		G2	2.0838	$87.31
67505	Inject/treat eye socket	Y		P3		$26.52
67515	Inject/treat eye socket	Y		P3		$27.74
67550	Insert eye socket implant	Y		A2	35.7611	$1,498.32
67560	Revise eye socket implant	Y		A2	24.4265	$1,023.43

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
67570	Decompress optic nerve	Y		A2	35.7611	$1,498.32
67700	Drainage of eyelid abscess	Y		P2	2.8731	$120.38
67710	Incision of eyelid	Y		P3		$121.78
67715	Incision of eyelid fold	Y		A2	18.1698	$761.28
67800	Remove eyelid lesion	Y		P3		$48.12
67801	Remove eyelid lesions	Y		P3		$58.68
67805	Remove eyelid lesions	Y		P3		$75.62
67808	Remove eyelid lesion(s)	Y		A2	18.1698	$761.28
67810	Biopsy of eyelid	Y	CH	P3		$109.99
67820	Revise eyelashes	N		P3		$15.96
67825	Revise eyelashes	Y		P3		$48.61
67830	Revise eyelashes	Y		A2	7.0748	$296.42
67835	Revise eyelashes	Y		A2	18.1698	$761.28
67840	Remove eyelid lesion	Y		P3		$130.62
67850	Treat eyelid lesion	Y		P3		$102.14
67875	Closure of eyelid by suture	Y		G2	7.0747	$296.42
67880	Revision of eyelid	Y		A2	15.5346	$650.87
67882	Revision of eyelid	Y		A2	18.1698	$761.28
67900	Repair brow defect	Y		A2	24.4265	$1,023.43
67901	Repair eyelid defect	Y		A2	18.1698	$761.28
67902	Repair eyelid defect	Y		A2	24.4265	$1,023.43
67903	Repair eyelid defect	Y		A2	18.1698	$761.28
67904	Repair eyelid defect	Y		A2	18.1698	$761.28
67906	Repair eyelid defect	Y		A2	18.1698	$761.28
67908	Repair eyelid defect	Y		A2	18.1698	$761.28
67909	Revise eyelid defect	Y		A2	18.1698	$761.28
67911	Revise eyelid defect	Y		A2	18.1698	$761.28
67912	Correction eyelid w/implant	Y		A2	18.1698	$761.28
67914	Repair eyelid defect	Y		A2	18.1698	$761.28
67915	Repair eyelid defect	Y		P3		$147.31
67916	Repair eyelid defect	Y		A2	18.1698	$761.28
67917	Repair eyelid defect	Y		A2	18.1698	$761.28
67921	Repair eyelid defect	Y		A2	18.1698	$761.28
67922	Repair eyelid defect	Y		P3		$142.89
67923	Repair eyelid defect	Y		A2	18.1698	$761.28
67924	Repair eyelid defect	Y		A2	18.1698	$761.28
67930	Repair eyelid wound	Y		P3		$149.77
67935	Repair eyelid wound	Y		A2	18.1698	$761.28
67938	Remove eyelid foreign body	N		P2	2.0838	$87.31

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
67950	Revision of eyelid	Y		A2	18.1698	$761.28
67961	Revision of eyelid	Y		A2	18.1698	$761.28
67966	Revision of eyelid	Y		A2	18.1698	$761.28
67971	Reconstruction of eyelid	Y		A2	18.1698	$761.28
67973	Reconstruction of eyelid	Y		A2	24.4265	$1,023.43
67974	Reconstruction of eyelid	Y		A2	18.1698	$761.28
67975	Reconstruction of eyelid	Y		A2	18.1698	$761.28
68020	Incise/drain eyelid lining	Y		P3		$42.97
68040	Treatment of eyelid lesions	N		P3		$21.61
68100	Biopsy of eyelid lining	Y		P3		$78.57
68110	Remove eyelid lining lesion	Y		P3		$103.12
68115	Remove eyelid lining lesion	Y		A2	18.1698	$761.28
68130	Remove eyelid lining lesion	Y		A2	15.5346	$650.87
68135	Remove eyelid lining lesion	Y		P3		$55.24
68200	Treat eyelid by injection	N		P3		$15.71
68320	Revise/graft eyelid lining	Y		A2	24.4265	$1,023.43
68325	Revise/graft eyelid lining	Y		A2	24.4265	$1,023.43
68326	Revise/graft eyelid lining	Y		A2	18.1698	$761.28
68328	Revise/graft eyelid lining	Y		A2	24.4265	$1,023.43
68330	Revise eyelid lining	Y		A2	22.292	$933.99
68335	Revise/graft eyelid lining	Y		A2	24.4265	$1,023.43
68340	Separate eyelid adhesions	Y		A2	18.1698	$761.28
68360	Revise eyelid lining	Y		A2	22.292	$933.99
68362	Revise eyelid lining	Y		A2	22.292	$933.99
68371	Harvest eye tissue, alograft	Y		A2	15.5346	$650.87
68400	Incise/drain tear gland	Y		P2	2.8731	$120.38
68420	Incise/drain tear sac	Y		P3		$152.47
68440	Incise tear duct opening	Y		P3		$44.44
68500	Removal of tear gland	Y		A2	24.4265	$1,023.43
68505	Partial removal, tear gland	Y		A2	24.4265	$1,023.43
68510	Biopsy of tear gland	Y		A2	18.1698	$761.28
68520	Removal of tear sac	Y		A2	24.4265	$1,023.43
68525	Biopsy of tear sac	Y		A2	18.1698	$761.28
68530	Clearance of tear duct	Y		P2	2.8731	$120.38
68540	Remove tear gland lesion	Y		A2	18.1698	$761.28
68550	Remove tear gland lesion	Y		A2	24.4265	$1,023.43
68700	Repair tear ducts	Y		A2	18.1698	$761.28
68705	Revise tear duct opening	Y	CH	P3		$103.36
68720	Create tear sac drain	Y		A2	24.4265	$1,023.43

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
68745	Create tear duct drain	Y		A2	24.4265	$1,023.43
68750	Create tear duct drain	Y		A2	24.4265	$1,023.43
68760	Close tear duct opening	Y		P3		$87.90
68761	Close tear duct opening	Y		P3		$61.87
68770	Close tear system fistula	Y		A2	24.4265	$1,023.43
68801	Dilate tear duct opening	N		P2	0.8468	$35.48
68810	Probe nasolacrimal duct	Y		A2	2.8732	$120.38
68811	Probe nasolacrimal duct	Y		A2	18.1698	$761.28
68815	Probe nasolacrimal duct	Y		A2	18.1698	$761.28
68816	Probe nl duct w/balloon	Y		G2	18.1699	$761.28
68840	Explore/irrigate tear ducts	N		P3		$50.58
68850	Injection for tear sac x-ray	N		N1		
69000	Drain external ear lesion	Y		P2	1.358	$56.90
69005	Drain external ear lesion	Y		P3		$92.07
69020	Drain outer ear canal lesion	Y		P2	1.358	$56.90
69100	Biopsy of external ear	Y		P3		$50.82
69105	Biopsy of external ear canal	Y		P3		$76.60
69110	Remove external ear, partial	Y		A2	16.564	$694.00
69120	Removal of external ear	Y		A2	23.2154	$972.69
69140	Remove ear canal lesion(s)	Y		A2	23.2154	$972.69
69145	Remove ear canal lesion(s)	Y		A2	16.564	$694.00
69150	Extensive ear canal surgery	Y		A2	7.1579	$299.89
69200	Clear outer ear canal	N		P2	0.6271	$26.27
69205	Clear outer ear canal	Y		A2	21.9314	$918.88
69210	Remove impacted ear wax	N		P3		$18.91
69220	Clean out mastoid cavity	Y		P2	0.7983	$33.45
69222	Clean out mastoid cavity	Y		P3		$117.36
69300	Revise external ear	Y		A2	23.2154	$972.69
69310	Rebuild outer ear canal	Y		A2	40.7633	$1,707.90
69320	Rebuild outer ear canal	Y		A2	40.7633	$1,707.90
69400	Inflate middle ear canal	Y		P3		$80.53
69401	Inflate middle ear canal	Y		P3		$43.21
69405	Catheterize middle ear canal	Y		P3		$112.45
69420	Incision of eardrum	Y		P3		$98.45
69421	Incision of eardrum	Y		A2	15.8303	$663.26
69424	Remove ventilating tube	Y		P3		$68.25
69433	Create eardrum opening	Y		P3		$98.70
69436	Create eardrum opening	Y		A2	15.8303	$663.26
69440	Exploration of middle ear	Y		A2	23.2154	$972.69

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
69450	Eardrum revision	Y		A2	40.7633	$1,707.90
69501	Mastoidectomy	Y		A2	40.7633	$1,707.90
69502	Mastoidectomy	Y		A2	23.2154	$972.69
69505	Remove mastoid structures	Y		A2	40.7633	$1,707.90
69511	Extensive mastoid surgery	Y		A2	40.7633	$1,707.90
69530	Extensive mastoid surgery	Y		A2	40.7633	$1,707.90
69540	Remove ear lesion	Y		P3		$114.66
69550	Remove ear lesion	Y		A2	40.7633	$1,707.90
69552	Remove ear lesion	Y		A2	40.7633	$1,707.90
69601	Mastoid surgery revision	Y		A2	40.7633	$1,707.90
69602	Mastoid surgery revision	Y		A2	40.7633	$1,707.90
69603	Mastoid surgery revision	Y		A2	40.7633	$1,707.90
69604	Mastoid surgery revision	Y		A2	40.7633	$1,707.90
69605	Mastoid surgery revision	Y		A2	40.7633	$1,707.90
69610	Repair of eardrum	Y		P3		$155.66
69620	Repair of eardrum	Y		A2	23.2154	$972.69
69631	Repair eardrum structures	Y		A2	40.7633	$1,707.90
69632	Rebuild eardrum structures	Y		A2	40.7633	$1,707.90
69633	Rebuild eardrum structures	Y		A2	40.7633	$1,707.90
69635	Repair eardrum structures	Y		A2	40.7633	$1,707.90
69636	Rebuild eardrum structures	Y		A2	40.7633	$1,707.90
69637	Rebuild eardrum structures	Y		A2	40.7633	$1,707.90
69641	Revise middle ear & mastoid	Y		A2	40.7633	$1,707.90
69642	Revise middle ear & mastoid	Y		A2	40.7633	$1,707.90
69643	Revise middle ear & mastoid	Y		A2	40.7633	$1,707.90
69644	Revise middle ear & mastoid	Y		A2	40.7633	$1,707.90
69645	Revise middle ear & mastoid	Y		A2	40.7633	$1,707.90
69646	Revise middle ear & mastoid	Y		A2	40.7633	$1,707.90
69650	Release middle ear bone	Y		A2	23.2154	$972.69
69660	Revise middle ear bone	Y		A2	40.7633	$1,707.90
69661	Revise middle ear bone	Y		A2	40.7633	$1,707.90
69662	Revise middle ear bone	Y		A2	40.7633	$1,707.90
69666	Repair middle ear structures	Y		A2	40.7633	$1,707.90
69667	Repair middle ear structures	Y		A2	40.7633	$1,707.90
69670	Remove mastoid air cells	Y		A2	40.7633	$1,707.90
69676	Remove middle ear nerve	Y		A2	40.7633	$1,707.90
69700	Close mastoid fistula	Y		A2	40.7633	$1,707.90
69711	Remove/repair hearing aid	Y		A2	40.7633	$1,707.90
69714	Implant temple bone w/stimul	Y		H8	162.8173	$6,821.72

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
69715	Temple bne implnt w/stimulat	Y		H8	162.8173	$6,821.72
69717	Temple bone implant revision	Y		H8	162.8173	$6,821.72
69718	Revise temple bone implant	Y		H8	162.8173	$6,821.72
69720	Release facial nerve	Y		A2	40.7633	$1,707.90
69740	Repair facial nerve	Y		A2	40.7633	$1,707.90
69745	Repair facial nerve	Y		A2	40.7633	$1,707.90
69801	Incise inner ear	Y		A2	23.2154	$972.69
69802	Incise inner ear	Y		A2	23.2154	$972.69
69805	Explore inner ear	Y		A2	40.7633	$1,707.90
69806	Explore inner ear	Y		A2	40.7633	$1,707.90
69820	Establish inner ear window	Y		A2	40.7633	$1,707.90
69840	Revise inner ear window	Y		A2	40.7633	$1,707.90
69905	Remove inner ear	Y		A2	40.7633	$1,707.90
69910	Remove inner ear & mastoid	Y		A2	40.7633	$1,707.90
69915	Incise inner ear nerve	Y		A2	40.7633	$1,707.90
69930	Implant cochlear device	Y		H8	694.0902	$29,080.99
69990	Microsurgery add-on	N		N1		
C9716	Radiofrequency energy to anu	Y		G2	29.6501	$1,242.28
C9724	EPS gast cardia plic	Y		G2	14.8264	$621.20
C9725	Place endorectal app	Y		G2	5.6974	$238.71
C9726	Rxt breast appl place/remov	Y		G2	23.4205	$981.27
C9727	Insert palate implants	Y		G2	7.1577	$299.89
C9728	Place device/marker, non pro	N		R2	12.3307	$516.63
G0104**	CA screen;flexi sigmoidscope	N		P3		$70.96
G0105**	Colorectal scrn; hi risk ind	Y		A2	7.4996	$314.22
G0121**	Colon ca scrn not hi rsk ind	Y		A2	7.4996	$314.22
G0127	Trim nail(s)	Y		P3		$10.80
G0186	Dstry eye lesn,fdr vssl tech	Y		R2	4.8105	$201.55
G0247	Routine footcare pt w lops	Y		P3		$19.40
G0259	Inject for sacroiliac joint	N		N1		
G0260	Inj for sacroiliac jt anesth	Y		A2	7.0178	$294.03
G0268	Removal of impacted wax md	N		N1		
G0269	Occlusive device in vein art	N		N1		
G0289	Arthro, loose body + chondro	N		N1		
G0364	Bone marrow aspirate &biopsy	N		P3		$4.66

NOTE 1: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount. Section 4104 of the Affordable Care Act (ACA) waives coinsurance for most preventive services, identified with a double asterisk (**).

ADDENDUM B.—PROPOSED OPPS PAYMENT BY HCPCS CODE FOR CY 2011

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00100	Anesth, salivary gland		N					
00102	Anesth, repair of cleft lip		N					
00103	Anesth, blepharoplasty		N					
00104	Anesth, electroshock		N					
00120	Anesth, ear surgery		N					
00124	Anesth, ear exam		N					
00126	Anesth, tympanotomy		N					
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					
00176	Anesth, pharyngeal surgery		C					
00190	Anesth, face/skull bone surg		N					
00192	Anesth, facial bone surgery		C					
00210	Anesth, cranial surg nos		N					
00211	Anesth, cran surg, hemotoma		C					
00212	Anesth, skull drainage		N					
00214	Anesth, skull drainage		C					
00215	Anesth, skull repair/fract		C					

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment

NOTE 2: Payment indicators for "office-based" procedures (P2, P3) are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the MPFS. At the time we compiled this addenda, current law requires a negative update to the MPFS payment rates for CY 2011. For a discussion of those rates, we refer readers to the CY 2011 MPFS proposed rule.

*: Asterisked codes(*) indicate that the procedure's "office-based," designation is temporary because we have insufficient claims data. We will reconsider this designation when new claims data become available.

**: Double asterisked codes (**) indicate that coinsurance is waived under section 4103 of the Affordable Care Act, which waives coinsurance for most preventive services.

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		N					
00406	Anesth, surgery of breast		N					
00410	Anesth, correct heart rhythm		N					
00450	Anesth, surgery of shoulder		N					
00452	Anesth, surgery of shoulder		C					
00454	Anesth, collar bone biopsy		N					
00470	Anesth, removal of rib		N					
00472	Anesth, chest wall repair		N					
00474	Anesth, surgery of rib(s)		C					
00500	Anesth, esophageal surgery		N					
00520	Anesth, chest procedure		N					
00522	Anesth, chest lining biopsy		N					
00524	Anesth, chest drainage		C					
00528	Anesth, chest partition view		N					
00529	Anesth, chest partition view		N					
00530	Anesth, pacemaker insertion		N					
00532	Anesth, vascular access		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00534	Anesth, cardioverter/defib		N					
00537	Anesth, cardiac electrophys		N					
00539	Anesth, trach-bronch reconst		N					
00540	Anesth, chest surgery		C					
00541	Anesth, one lung ventilation		N					
00542	Anesth, release of lung		C					
00546	Anesth, lung,chest wall surg		C					
00548	Anesth, trachea,bronchi surg		N					
00550	Anesth, sternal debridement		N					
00560	Anesth, heart surg w/o pump		C					
00561	Anesth, heart surg < age 1		C					
00562	Anesth hrt surg w/pmp age 1+		C					
00563	Anesth, heart surg w/arrest		N					
00566	Anesth, cabg w/o pump		N					
00567	Anesth, cabg w/pump		C					
00580	Anesth, heart/lung transplnt		C					
00600	Anesth, spine, cord surgery		N					
00604	Anesth, sitting procedure		C					
00620	Anesth, spine, cord surgery		N					
00622	Anesth, removal of nerves		C					
00625	Anes spine tranthor w/o vent		N					
00626	Anes, spine transthor w/vent		N					
00630	Anesth, spine, cord surgery		N					
00632	Anesth, removal of nerves		C					
00634	Anesth for chemonucleolysis		N					
00635	Anesth, lumbar puncture		N					
00640	Anesth, spine manipulation		N					
00670	Anesth, spine, cord surgery		C					
00700	Anesth, abdominal wall surg		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
00792	Anesth, hemorr/excise liver		C					
00794	Anesth, pancreas removal		C					
00796	Anesth, for liver transplant		C					
00797	Anesth, surgery for obesity		N					
00800	Anesth, abdominal wall surg		N					
00802	Anesth, fat layer removal		C					
00810	Anesth, low intestine scope		N					
00820	Anesth, abdominal wall surg		N					
00830	Anesth, repair of hernia		N					
00832	Anesth, repair of hernia		N					
00834	Anesth, hernia repair< 1 yr		N					
00836	Anesth hernia repair preemie		N					
00840	Anesth, surg lower abdomen		N					
00842	Anesth, amniocentesis		N					
00844	Anesth, pelvis surgery		C					
00846	Anesth, hysterectomy		C					
00848	Anesth, pelvic organ surg		C					
00851	Anesth, tubal ligation		N					
00860	Anesth, surgery of abdomen		N					
00862	Anesth, kidney/ureter surg		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00864	Anesth, removal of bladder		C					
00865	Anesth, removal of prostate		C					
00866	Anesth, removal of adrenal		C					
00868	Anesth, kidney transplant		C					
00870	Anesth, bladder stone surg		N					
00872	Anesth kidney stone destruct		N					
00873	Anesth kidney stone destruct		N					
00880	Anesth, abdomen vessel surg		N					
00882	Anesth, major vein ligation		C					
00902	Anesth, anorectal surgery		N					
00904	Anesth, perineal surgery		C					
00906	Anesth, removal of vulva		N					
00908	Anesth, removal of prostate		C					
00910	Anesth, bladder surgery		N					
00912	Anesth, bladder tumor surg		N					
00914	Anesth, removal of prostate		N					
00916	Anesth, bleeding control		N					
00918	Anesth, stone removal		N					
00920	Anesth, genitalia surgery		N					
00921	Anesth, vasectomy		N					
00922	Anesth, sperm duct surgery		N					
00924	Anesth, testis exploration		N					
00926	Anesth, removal of testis		N					
00928	Anesth, removal of testis		N					
00930	Anesth, testis suspension		N					
00932	Anesth, amputation of penis		C					
00934	Anesth, penis, nodes removal		C					
00936	Anesth, penis, nodes removal		C					
00938	Anesth, insert penis device		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00940	Anesth, vaginal procedures		N					
00942	Anesth, surg on vag/urethral		N					
00944	Anesth, vaginal hysterectomy		C					
00948	Anesth, repair of cervix		N					
00950	Anesth, vaginal endoscopy		N					
00952	Anesth, hysteroscope/graph		N					
01112	Anesth, bone aspirate/bx		N					
01120	Anesth, pelvis surgery		N					
01130	Anesth, body cast procedure		N					
01140	Anesth, amputation at pelvis		C					
01150	Anesth, pelvic tumor surgery		C					
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					
01212	Anesth, hip disarticulation		C					
01214	Anesth, hip arthroplasty		C					
01215	Anesth, revise hip repair		N					
01220	Anesth, procedure on femur		N					
01230	Anesth, surgery of femur		N					
01232	Anesth, amputation of femur		C					
01234	Anesth, radical femur surg		C					
01250	Anesth, upper leg surgery		N					
01260	Anesth, upper leg veins surg		N					
01270	Anesth, thigh arteries surg		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01272	Anesth, femoral artery surg		C					
01274	Anesth, femoral embolectomy		C					
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					
01402	Anesth, knee arthroplasty		C					
01404	Anesth, amputation at knee		C					
01420	Anesth, knee joint casting		N					
01430	Anesth, knee veins surgery		N					
01432	Anesth, knee vessel surg		N					
01440	Anesth, knee arteries surg		N					
01442	Anesth, knee artery surg		C					
01444	Anesth, knee artery repair		C					
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					
01484	Anesth, lower leg revision		N					
01486	Anesth, ankle replacement		C					
01490	Anesth, lower leg casting		N					
01500	Anesth, leg arteries surg		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01502	Anesth, lwr leg embolectomy		C					
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					
01634	Anesth, shoulder joint amput		C					
01636	Anesth, forequarter amput		C					
01638	Anesth, shoulder replacement		C					
01650	Anesth, shoulder artery surg		N					
01652	Anesth, shoulder vessel surg		C					
01654	Anesth, shoulder vessel surg		C					
01656	Anesth, arm-leg vessel surg		C					
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					
01756	Anesth, radical humerus surg		C					
01758	Anesth, humeral lesion surg		N					
01760	Anesth, elbow replacement		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
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					
01935	Anesth, perc img dx sp proc		N					
01936	Anesth, perc img tx sp proc		N					
01951	Anesth, burn, less 4 percent		N					
01952	Anesth, burn, 4-9 percent		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01953	Anesth, burn, each 9 percent		N					
01958	Anesth, antepartum manipul		N					
01960	Anesth, vaginal delivery		N					
01961	Anesth, cs delivery		N					
01962	Anesth, emer hysterectomy		N					
01963	Anesth, cs hysterectomy		N					
01965	Anesth, inc/missed ab proc		N					
01966	Anesth, induced ab procedure		N					
01967	Anesth/analg, vag delivery		N					
01968	Anes/analg cs deliver add-on		N					
01969	Anesth/analg cs hyst add-on		N					
01990	Support for organ donor		C					
01991	Anesth, nerve block/inj		N					
01992	Anesth, n block/inj, prone		N					
01996	Hosp manage cont drug admin		N					
01999	Unlisted anesth procedure		N					
10021	Fna w/o image		T	0002	1.7752	$121.19	.	$24.24
10022	Fna w/image		T	0004	4.6624	$318.29	.	$63.66
10040	Acne surgery		T	0013	0.8782	$59.95	.	$11.99
10060	Drainage of skin abscess		T	0006	1.4939	$101.98	.	$20.40
10061	Drainage of skin abscess		T	0006	1.4939	$101.98	.	$20.40
10080	Drainage of pilonidal cyst		T	0006	1.4939	$101.98	.	$20.40
10081	Drainage of pilonidal cyst		T	0007	13.3268	$909.78	.	$181.96
10120	Remove foreign body		T	0016	2.8176	$192.35	.	$38.47
10121	Remove foreign body		T	0021	18.2223	$1,243.98	.	$248.80
10140	Drainage of hematoma/fluid		T	0007	13.3268	$909.78	.	$181.96
10160	Puncture drainage of lesion		T	0006	1.4939	$101.98	.	$20.40
10180	Complex drainage, wound		T	0008	20.2481	$1,382.28	.	$276.46
11000	Debride infected skin	CH	T	0016	2.8176	$192.35	.	$38.47

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11001	Debride infected skin add-on		T	0013	0.8782	$59.95	.	$11.99
11004	Debride genitalia & perineum		C					
11005	Debride abdom wall		C					
11006	Debride genit/per/abdom wall		C					
11008	Remove mesh from abd wall		C					
11010	Debride skin, fx		T	0019	4.9184	$335.76	.	$67.16
11011	Debride skin/muscle, fx		T	0019	4.9184	$335.76	.	$67.16
11012	Debride skin/muscle/bone, fx		T	0019	4.9184	$335.76	.	$67.16
11040	Debride skin, partial		T	0015	1.5303	$104.47	.	$20.90
11041	Debride skin, full		T	0015	1.5303	$104.47	.	$20.90
11042	Debride skin/tissue		T	0016	2.8176	$192.35	.	$38.47
11043	Debride tissue/muscle		T	0016	2.8176	$192.35	.	$38.47
11044	Debride tissue/muscle/bone		T	0020	8.7772	$599.19	.	$119.84
11055	Trim skin lesion		T	0013	0.8782	$59.95	.	$11.99
11056	Trim skin lesions, 2 to 4		T	0013	0.8782	$59.95	.	$11.99
11057	Trim skin lesions, over 4		T	0013	0.8782	$59.95	.	$11.99
11100	Biopsy, skin lesion		T	0015	1.5303	$104.47	.	$20.90
11101	Biopsy, skin add-on		T	0013	0.8782	$59.95	.	$11.99
11200	Removal of skin tags		T	0013	0.8782	$59.95	.	$11.99
11201	Remove skin tags add-on		T	0013	0.8782	$59.95	.	$11.99
11300	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11301	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11302	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11303	Shave skin lesion		T	0015	1.5303	$104.47	.	$20.90
11305	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11306	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11307	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11308	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11310	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11311	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11312	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11313	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11400	Exc tr-ext b9+marg 0.5 < cm		T	0019	4.9184	$335.76	.	$67.16
11401	Exc tr-ext b9+marg 0.6-1 cm		T	0019	4.9184	$335.76	.	$67.16
11402	Exc tr-ext b9+marg 1.1-2 cm		T	0019	4.9184	$335.76	.	$67.16
11403	Exc tr-ext b9+marg 2.1-3 cm		T	0020	8.7772	$599.19	.	$119.84
11404	Exc tr-ext b9+marg 3.1-4 cm		T	0021	18.2223	$1,243.98	.	$248.80
11406	Exc tr-ext b9+marg > 4.0 cm		T	0021	18.2223	$1,243.98	.	$248.80
11420	Exc h-f-nk-sp b9+marg 0.5 <		T	0020	8.7772	$599.19	.	$119.84
11421	Exc h-f-nk-sp b9+marg 0.6-1		T	0020	8.7772	$599.19	.	$119.84
11422	Exc h-f-nk-sp b9+marg 1.1-2		T	0020	8.7772	$599.19	.	$119.84
11423	Exc h-f-nk-sp b9+marg 2.1-3		T	0021	18.2223	$1,243.98	.	$248.80
11424	Exc h-f-nk-sp b9+marg 3.1-4		T	0021	18.2223	$1,243.98	.	$248.80
11426	Exc h-f-nk-sp b9+marg > 4 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
11440	Exc face-mm b9+marg 0.5 < cm		T	0019	4.9184	$335.76	.	$67.16
11441	Exc face-mm b9+marg 0.6-1 cm		T	0019	4.9184	$335.76	.	$67.16
11442	Exc face-mm b9+marg 1.1-2 cm		T	0020	8.7772	$599.19	.	$119.84
11443	Exc face-mm b9+marg 2.1-3 cm		T	0020	8.7772	$599.19	.	$119.84
11444	Exc face-mm b9+marg 3.1-4 cm		T	0020	8.7772	$599.19	.	$119.84
11446	Exc face-mm b9+marg > 4 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
11450	Removal, sweat gland lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11451	Removal, sweat gland lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11462	Removal, sweat gland lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11463	Removal, sweat gland lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11470	Removal, sweat gland lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11471	Removal, sweat gland lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11600	Exc tr-ext mlg+marg 0.5 < cm		T	0020	8.7772	$599.19	.	$119.84
11601	Exc tr-ext mlg+marg 0.6-1 cm		T	0019	4.9184	$335.76	.	$67.16

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11602	Exc tr-ext mlg+marg 1.1-2 cm		T	0019	4.9184	$335.76	.	$67.16
11603	Exc tr-ext mlg+marg 2.1-3 cm		T	0020	8.7772	$599.19	.	$119.84
11604	Exc tr-ext mlg+marg 3.1-4 cm		T	0020	8.7772	$599.19	.	$119.84
11606	Exc tr-ext mlg+marg > 4 cm		T	0021	18.2223	$1,243.98	.	$248.80
11620	Exc h-f-nk-sp mlg+marg 0.5 <		T	0020	8.7772	$599.19	.	$119.84
11621	Exc h-f-nk-sp mlg+marg 0.6-1		T	0019	4.9184	$335.76	.	$67.16
11622	Exc h-f-nk-sp mlg+marg 1.1-2		T	0020	8.7772	$599.19	.	$119.84
11623	Exc h-f-nk-sp mlg+marg 2.1-3		T	0021	18.2223	$1,243.98	.	$248.80
11624	Exc h-f-nk-sp mlg+marg 3.1-4		T	0021	18.2223	$1,243.98	.	$248.80
11626	Exc h-f-nk-sp mlg+mar > 4 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
11640	Exc face-mm malig+marg 0.5 <	CH	T	0019	4.9184	$335.76	.	$67.16
11641	Exc face-mm malig+marg 0.6-1	CH	T	0019	4.9184	$335.76	.	$67.16
11642	Exc face-mm malig+marg 1.1-2	CH	T	0019	4.9184	$335.76	.	$67.16
11643	Exc face-mm malig+marg 2.1-3		T	0020	8.7772	$599.19	.	$119.84
11644	Exc face-mm malig+marg 3.1-4		T	0021	18.2223	$1,243.98	.	$248.80
11646	Exc face-mm mlg+marg > 4 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
11719	Trim nail(s)		T	0012	0.4253	$29.03	.	$5.81
11720	Debride nail, 1-5		T	0013	0.8782	$59.95	.	$11.99
11721	Debride nail, 6 or more		T	0013	0.8782	$59.95	.	$11.99
11730	Removal of nail plate		T	0013	0.8782	$59.95	.	$11.99
11732	Remove nail plate, add-on		T	0013	0.8782	$59.95	.	$11.99
11740	Drain blood from under nail		T	0012	0.4253	$29.03	.	$5.81
11750	Removal of nail bed		T	0019	4.9184	$335.76	.	$67.16
11752	Remove nail bed/finger tip		T	0022	24.1269	$1,647.07	$354.45	$329.42
11755	Biopsy, nail unit		T	0019	4.9184	$335.76	.	$67.16
11760	Repair of nail bed		T	0133	1.3598	$92.83	$25.67	$18.57
11762	Reconstruction of nail bed		T	0136	17.1353	$1,169.78	.	$233.96
11765	Excision of nail fold, toe		T	0013	0.8782	$59.95	.	$11.99
11770	Removal of pilonidal lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11771	Removal of pilonidal lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11772	Removal of pilonidal lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11900	Injection into skin lesions		T	0013	0.8782	$59.95	.	$11.99
11901	Added skin lesions injection		T	0013	0.8782	$59.95	.	$11.99
11920	Correct skin color defects		T	0134	3.189	$217.70	.	$43.54
11921	Correct skin color defects		T	0134	3.189	$217.70	.	$43.54
11922	Correct skin color defects		T	0134	3.189	$217.70	.	$43.54
11950	Therapy for contour defects		T	0133	1.3598	$92.83	$25.67	$18.57
11951	Therapy for contour defects		T	0133	1.3598	$92.83	$25.67	$18.57
11952	Therapy for contour defects		T	0133	1.3598	$92.83	$25.67	$18.57
11954	Therapy for contour defects		T	0133	1.3598	$92.83	$25.67	$18.57
11960	Insert tissue expander(s)		T	0137	22.1186	$1,509.97	.	$302.00
11970	Replace tissue expander		T	0051	47.3761	$3,234.22	.	$646.85
11971	Remove tissue expander(s)		T	0022	24.1269	$1,647.07	$354.45	$329.42
11975	Insert contraceptive cap		E					
11976	Removal of contraceptive cap		T	0019	4.9184	$335.76	.	$67.16
11977	Removal/reinsert contra cap		E					
11980	Implant hormone pellet(s)		X	0340	0.6899	$47.10	.	$9.42
11981	Insert drug implant device		X	0340	0.6899	$47.10	.	$9.42
11982	Remove drug implant device		X	0340	0.6899	$47.10	.	$9.42
11983	Remove/insert drug implant		X	0340	0.6899	$47.10	.	$9.42
12001	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12002	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12004	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12005	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12006	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12007	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12011	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12013	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
12014	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12015	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12016	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12017	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12018	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12020	Closure of split wound		T	0135	4.6616	$318.23	.	$63.65
12021	Closure of split wound		T	0134	3.189	$217.70	.	$43.54
12031	Intmd wnd repair s/tr/ext		T	0133	1.3598	$92.83	$25.67	$18.57
12032	Intmd wnd repair s/tr/ext		T	0134	3.189	$217.70	.	$43.54
12034	Intmd wnd repair s/tr/ext		T	0133	1.3598	$92.83	$25.67	$18.57
12035	Intmd wnd repair s/tr/ext		T	0133	1.3598	$92.83	$25.67	$18.57
12036	Intmd wnd repair s/tr/ext		T	0134	3.189	$217.70	.	$43.54
12037	Intmd wnd repair s/tr/ext		T	0134	3.189	$217.70	.	$43.54
12041	Intmd wnd repair n-hf/genit		T	0133	1.3598	$92.83	$25.67	$18.57
12042	Intmd wnd repair n-hg/genit		T	0133	1.3598	$92.83	$25.67	$18.57
12044	Intmd wnd repair n-hg/genit		T	0133	1.3598	$92.83	$25.67	$18.57
12045	Intmd wnd repair n-hg/genit		T	0134	3.189	$217.70	.	$43.54
12046	Intmd wnd repair n-hg/genit		T	0134	3.189	$217.70	.	$43.54
12047	Intmd wnd repair n-hg/genit		T	0134	3.189	$217.70	.	$43.54
12051	Intmd wnd repair face/mm	CH	T	0134	3.189	$217.70	.	$43.54
12052	Intmd wnd repair face/mm		T	0133	1.3598	$92.83	$25.67	$18.57
12053	Intmd wnd repair face/mm		T	0133	1.3598	$92.83	$25.67	$18.57
12054	Intmd wnd repair, face/mm		T	0133	1.3598	$92.83	$25.67	$18.57
12055	Intmd wnd repair face/mm		T	0134	3.189	$217.70	.	$43.54
12056	Intmd wnd repair face/mm		T	0134	3.189	$217.70	.	$43.54
12057	Intmd wnd repair face/mm		T	0134	3.189	$217.70	.	$43.54
13100	Repair of wound or lesion		T	0135	4.6616	$318.23	.	$63.65
13101	Repair of wound or lesion		T	0135	4.6616	$318.23	.	$63.65
13102	Repair wound/lesion add-on		T	0135	4.6616	$318.23	.	$63.65

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
13120	Repair of wound or lesion		T	0134	3.189	$217.70	.	$43.54
13121	Repair of wound or lesion		T	0134	3.189	$217.70	.	$43.54
13122	Repair wound/lesion add-on		T	0133	1.3598	$92.83	$25.67	$18.57
13131	Repair of wound or lesion		T	0134	3.189	$217.70	.	$43.54
13132	Repair of wound or lesion		T	0135	4.6616	$318.23	.	$63.65
13133	Repair wound/lesion add-on		T	0134	3.189	$217.70	.	$43.54
13150	Repair of wound or lesion		T	0135	4.6616	$318.23	.	$63.65
13151	Repair of wound or lesion		T	0135	4.6616	$318.23	.	$63.65
13152	Repair of wound or lesion		T	0135	4.6616	$318.23	.	$63.65
13153	Repair wound/lesion add-on		T	0134	3.189	$217.70	.	$43.54
13160	Late closure of wound		T	0137	22.1186	$1,509.97	.	$302.00
14000	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14001	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14020	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14021	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14040	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14041	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14060	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14061	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14301	Skin tissue rearrangement		T	0137	22.1186	$1,509.97	.	$302.00
14302	Skin tissue rearrange add-on		T	0137	22.1186	$1,509.97	.	$302.00
14350	Skin tissue rearrangement		T	0137	22.1186	$1,509.97	.	$302.00
15002	Wound prep, trk/arm/leg		T	0135	4.6616	$318.23	.	$63.65
15003	Wound prep, addl 100 cm		T	0135	4.6616	$318.23	.	$63.65
15004	Wound prep, f/n/hf/g		T	0135	4.6616	$318.23	.	$63.65
15005	Wnd prep, f/n/hf/g, addl cm		T	0135	4.6616	$318.23	.	$63.65
15040	Harvest cultured skin graft		T	0134	3.189	$217.70	.	$43.54
15050	Skin pinch graft		T	0135	4.6616	$318.23	.	$63.65
15100	Skin splt grft, trnk/arm/leg		T	0137	22.1186	$1,509.97	.	$302.00

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15101	Skin splt grft t/a/l, add-on		T	0137	22.1186	$1,509.97	.	$302.00
15110	Epidrm autogrft trnk/arm/leg		T	0135	4.6616	$318.23	.	$63.65
15111	Epidrm autogrft t/a/l add-on		T	0135	4.6616	$318.23	.	$63.65
15115	Epidrm a-grft face/nck/hf/g		T	0135	4.6616	$318.23	.	$63.65
15116	Epidrm a-grft f/n/hf/g addl		T	0135	4.6616	$318.23	.	$63.65
15120	Skn splt a-grft fac/nck/hf/g		T	0137	22.1186	$1,509.97	.	$302.00
15121	Skn splt a-grft f/n/hf/g add		T	0137	22.1186	$1,509.97	.	$302.00
15130	Derm autograft, trnk/arm/leg		T	0136	17.1353	$1,169.78	.	$233.96
15131	Derm autograft t/a/l add-on		T	0136	17.1353	$1,169.78	.	$233.96
15135	Derm autograft face/nck/hf/g		T	0136	17.1353	$1,169.78	.	$233.96
15136	Derm autograft, f/n/hf/g add		T	0136	17.1353	$1,169.78	.	$233.96
15150	Cult epiderm grft t/arm/leg		T	0135	4.6616	$318.23	.	$63.65
15151	Cult epiderm grft t/a/l addl		T	0135	4.6616	$318.23	.	$63.65
15152	Cult epiderm graft t/a/l +%		T	0135	4.6616	$318.23	.	$63.65
15155	Cult epiderm graft, f/n/hf/g		T	0135	4.6616	$318.23	.	$63.65
15156	Cult epidrm grft f/n/hfg add		T	0135	4.6616	$318.23	.	$63.65
15157	Cult epiderm grft f/n/hfg +%		T	0135	4.6616	$318.23	.	$63.65
15170	Acell graft trunk/arms/legs		T	0135	4.6616	$318.23	.	$63.65
15171	Acell graft t/arm/leg add-on		T	0134	3.189	$217.70	.	$43.54
15175	Acellular graft, f/n/hf/g		T	0135	4.6616	$318.23	.	$63.65
15176	Acell graft, f/n/hf/g add-on		T	0135	4.6616	$318.23	.	$63.65
15200	Skin full graft, trunk		T	0136	17.1353	$1,169.78	.	$233.96
15201	Skin full graft trunk add-on		T	0136	17.1353	$1,169.78	.	$233.96
15220	Skin full graft sclp/arm/leg		T	0136	17.1353	$1,169.78	.	$233.96
15221	Skin full graft add-on		T	0135	4.6616	$318.23	.	$63.65
15240	Skin full grft face/genit/hf		T	0136	17.1353	$1,169.78	.	$233.96
15241	Skin full graft add-on		T	0135	4.6616	$318.23	.	$63.65
15260	Skin full graft een & lips		T	0136	17.1353	$1,169.78	.	$233.96
15261	Skin full graft add-on		T	0136	17.1353	$1,169.78	.	$233.96

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15300	Apply skinallogrft, t/arm/lg		T	0135	4.6616	$318.23	.	$63.65
15301	Apply sknallogrft t/a/l addl		T	0135	4.6616	$318.23	.	$63.65
15320	Apply skin allogrft f/n/hf/g		T	0135	4.6616	$318.23	.	$63.65
15321	Aply sknallogrft f/n/hfg add		T	0135	4.6616	$318.23	.	$63.65
15330	Aply acell alogrft t/arm/leg		T	0135	4.6616	$318.23	.	$63.65
15331	Aply acell grft t/a/l add-on		T	0135	4.6616	$318.23	.	$63.65
15335	Apply acell graft, f/n/hf/g		T	0135	4.6616	$318.23	.	$63.65
15336	Aply acell grft f/n/hf/g add		T	0135	4.6616	$318.23	.	$63.65
15340	Apply cult skin substitute		T	0134	3.189	$217.70	.	$43.54
15341	Apply cult skin sub add-on		T	0134	3.189	$217.70	.	$43.54
15360	Apply cult derm sub, t/a/l		T	0134	3.189	$217.70	.	$43.54
15361	Aply cult derm sub t/a/l add		T	0134	3.189	$217.70	.	$43.54
15365	Apply cult derm sub f/n/hf/g		T	0134	3.189	$217.70	.	$43.54
15366	Apply cult derm f/hf/g add		T	0134	3.189	$217.70	.	$43.54
15400	Apply skin xenograft, t/a/l		T	0135	4.6616	$318.23	.	$63.65
15401	Apply skn xenogrft t/a/l add		T	0135	4.6616	$318.23	.	$63.65
15420	Apply skin xgraft, f/n/hf/g		T	0135	4.6616	$318.23	.	$63.65
15421	Apply skn xgrft f/n/hf/g add		T	0135	4.6616	$318.23	.	$63.65
15430	Apply acellular xenograft		T	0135	4.6616	$318.23	.	$63.65
15431	Apply acellular xgraft add		T	0135	4.6616	$318.23	.	$63.65
15570	Form skin pedicle flap		T	0137	22.1186	$1,509.97	.	$302.00
15572	Form skin pedicle flap		T	0137	22.1186	$1,509.97	.	$302.00
15574	Form skin pedicle flap		T	0137	22.1186	$1,509.97	.	$302.00
15576	Form skin pedicle flap		T	0137	22.1186	$1,509.97	.	$302.00
15600	Skin graft		T	0137	22.1186	$1,509.97	.	$302.00
15610	Skin graft		T	0137	22.1186	$1,509.97	.	$302.00
15620	Skin graft		T	0137	22.1186	$1,509.97	.	$302.00
15630	Skin graft		T	0137	22.1186	$1,509.97	.	$302.00
15650	Transfer skin pedicle flap		T	0137	22.1186	$1,509.97	.	$302.00

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15731	Forehead flap w/vasc pedicle		T	0137	22.1186	$1,509.97	.	$302.00
15732	Muscle-skin graft, head/neck		T	0137	22.1186	$1,509.97	.	$302.00
15734	Muscle-skin graft, trunk		T	0137	22.1186	$1,509.97	.	$302.00
15736	Muscle-skin graft, arm		T	0137	22.1186	$1,509.97	.	$302.00
15738	Muscle-skin graft, leg		T	0137	22.1186	$1,509.97	.	$302.00
15740	Island pedicle flap graft		T	0136	17.1353	$1,169.78	.	$233.96
15750	Neurovascular pedicle graft		T	0137	22.1186	$1,509.97	.	$302.00
15756	Free myo/skin flap microvasc		C					
15757	Free skin flap, microvasc		C					
15758	Free fascial flap, microvasc		C					
15760	Composite skin graft		T	0137	22.1186	$1,509.97	.	$302.00
15770	Derma-fat-fascia graft		T	0137	22.1186	$1,509.97	.	$302.00
15775	Hair transplant punch grafts		T	0133	1.3598	$92.83	$25.67	$18.57
15776	Hair transplant punch grafts		T	0133	1.3598	$92.83	$25.67	$18.57
15780	Abrasion treatment of skin		T	0022	24.1269	$1,647.07	$354.45	$329.42
15781	Abrasion treatment of skin		T	0019	4.9184	$335.76	.	$67.16
15782	Abrasion treatment of skin		T	0019	4.9184	$335.76	.	$67.16
15783	Abrasion treatment of skin		T	0016	2.8176	$192.35	.	$38.47
15786	Abrasion, lesion, single		T	0013	0.8782	$59.95	.	$11.99
15787	Abrasion, lesions, add-on		T	0013	0.8782	$59.95	.	$11.99
15788	Chemical peel, face, epiderm		T	0013	0.8782	$59.95	.	$11.99
15789	Chemical peel, face, dermal		T	0015	1.5303	$104.47	.	$20.90
15792	Chemical peel, nonfacial		T	0015	1.5303	$104.47	.	$20.90
15793	Chemical peel, nonfacial		T	0013	0.8782	$59.95	.	$11.99
15819	Plastic surgery, neck		T	0134	3.189	$217.70	.	$43.54
15820	Revision of lower eyelid		T	0137	22.1186	$1,509.97	.	$302.00
15821	Revision of lower eyelid		T	0137	22.1186	$1,509.97	.	$302.00
15822	Revision of upper eyelid		T	0137	22.1186	$1,509.97	.	$302.00
15823	Revision of upper eyelid		T	0137	22.1186	$1,509.97	.	$302.00

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15824	Removal of forehead wrinkles		T	0137	22.1186	$1,509.97	.	$302.00
15825	Removal of neck wrinkles		T	0137	22.1186	$1,509.97	.	$302.00
15826	Removal of brow wrinkles		T	0137	22.1186	$1,509.97	.	$302.00
15828	Removal of face wrinkles		T	0137	22.1186	$1,509.97	.	$302.00
15829	Removal of skin wrinkles		T	0137	22.1186	$1,509.97	.	$302.00
15830	Exc skin abd		T	0022	24.1269	$1,647.07	$354.45	$329.42
15832	Excise excessive skin tissue		T	0022	24.1269	$1,647.07	$354.45	$329.42
15833	Excise excessive skin tissue		T	0022	24.1269	$1,647.07	$354.45	$329.42
15834	Excise excessive skin tissue		T	0022	24.1269	$1,647.07	$354.45	$329.42
15835	Excise excessive skin tissue		T	0022	24.1269	$1,647.07	$354.45	$329.42
15836	Excise excessive skin tissue		T	0021	18.2223	$1,243.98	.	$248.80
15837	Excise excessive skin tissue		T	0021	18.2223	$1,243.98	.	$248.80
15838	Excise excessive skin tissue		T	0021	18.2223	$1,243.98	.	$248.80
15839	Excise excessive skin tissue		T	0021	18.2223	$1,243.98	.	$248.80
15840	Graft for face nerve palsy		T	0137	22.1186	$1,509.97	.	$302.00
15841	Graft for face nerve palsy		T	0137	22.1186	$1,509.97	.	$302.00
15842	Flap for face nerve palsy		T	0137	22.1186	$1,509.97	.	$302.00
15845	Skin and muscle repair, face		T	0137	22.1186	$1,509.97	.	$302.00
15847	Exc skin abd add-on		T	0022	24.1269	$1,647.07	$354.45	$329.42
15850	Removal of sutures		T	0016	2.8176	$192.35	.	$38.47
15851	Removal of sutures		T	0016	2.8176	$192.35	.	$38.47
15852	Dressing change not for burn		X	0340	0.6899	$47.10	.	$9.42
15860	Test for blood flow in graft		X	0340	0.6899	$47.10	.	$9.42
15876	Suction assisted lipectomy		T	0137	22.1186	$1,509.97	.	$302.00
15877	Suction assisted lipectomy		T	0137	22.1186	$1,509.97	.	$302.00
15878	Suction assisted lipectomy		T	0137	22.1186	$1,509.97	.	$302.00
15879	Suction assisted lipectomy		T	0137	22.1186	$1,509.97	.	$302.00
15920	Removal of tail bone ulcer		T	0019	4.9184	$335.76	.	$67.16
15922	Removal of tail bone ulcer		T	0137	22.1186	$1,509.97	.	$302.00

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15931	Remove sacrum pressure sore		T	0022	24.1269	$1,647.07	$354.45	$329.42
15933	Remove sacrum pressure sore		T	0022	24.1269	$1,647.07	$354.45	$329.42
15934	Remove sacrum pressure sore		T	0137	22.1186	$1,509.97	.	$302.00
15935	Remove sacrum pressure sore		T	0137	22.1186	$1,509.97	.	$302.00
15936	Remove sacrum pressure sore		T	0136	17.1353	$1,169.78	.	$233.96
15937	Remove sacrum pressure sore		T	0137	22.1186	$1,509.97	.	$302.00
15940	Remove hip pressure sore		T	0022	24.1269	$1,647.07	$354.45	$329.42
15941	Remove hip pressure sore		T	0022	24.1269	$1,647.07	$354.45	$329.42
15944	Remove hip pressure sore		T	0137	22.1186	$1,509.97	.	$302.00
15945	Remove hip pressure sore		T	0137	22.1186	$1,509.97	.	$302.00
15946	Remove hip pressure sore		T	0137	22.1186	$1,509.97	.	$302.00
15950	Remove thigh pressure sore		T	0022	24.1269	$1,647.07	$354.45	$329.42
15951	Remove thigh pressure sore		T	0022	24.1269	$1,647.07	$354.45	$329.42
15952	Remove thigh pressure sore		T	0136	17.1353	$1,169.78	.	$233.96
15953	Remove thigh pressure sore		T	0136	17.1353	$1,169.78	.	$233.96
15956	Remove thigh pressure sore		T	0136	17.1353	$1,169.78	.	$233.96
15958	Remove thigh pressure sore		T	0136	17.1353	$1,169.78	.	$233.96
15999	Removal of pressure sore		T	0019	4.9184	$335.76	.	$67.16
16000	Initial treatment of burn(s)		T	0013	0.8782	$59.95	.	$11.99
16020	Dress/debrid p-thick burn, s		T	0015	1.5303	$104.47	.	$20.90
16025	Dress/debrid p-thick burn, m		T	0015	1.5303	$104.47	.	$20.90
16030	Dress/debrid p-thick burn, l		T	0015	1.5303	$104.47	.	$20.90
16035	Incision of burn scab, initi		T	0015	1.5303	$104.47	.	$20.90
16036	Escharotomy; addl incision		C					
17000	Destruct premalg lesion		T	0013	0.8782	$59.95	.	$11.99
17003	Destruct premalg les, 2-14		T	0012	0.4253	$29.03	.	$5.81
17004	Destroy premlg lesions 15+		T	0016	2.8176	$192.35	.	$38.47
17106	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17107	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
17108	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17110	Destruct b9 lesion, 1-14		T	0013	0.8782	$59.95	.	$11.99
17111	Destruct lesion, 15 or more		T	0015	1.5303	$104.47	.	$20.90
17250	Chemical cautery, tissue		T	0015	1.5303	$104.47	.	$20.90
17260	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17261	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17262	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17263	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17264	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17266	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17270	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17271	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17272	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17273	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17274	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17276	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17280	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17281	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17282	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17283	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17284	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17286	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17311	Mohs, 1 stage, h/n/hf/g		T	0694	5.0842	$347.08	$91.69	$69.42
17312	Mohs addl stage		T	0694	5.0842	$347.08	$91.69	$69.42
17313	Mohs, 1 stage, t/a/l		T	0694	5.0842	$347.08	$91.69	$69.42
17314	Mohs, addl stage, t/a/l		T	0694	5.0842	$347.08	$91.69	$69.42
17315	Mohs surg, addl block		T	0694	5.0842	$347.08	$91.69	$69.42
17340	Cryotherapy of skin		T	0013	0.8782	$59.95	.	$11.99
17360	Skin peel therapy		T	0013	0.8782	$59.95	.	$11.99

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
17380	Hair removal by electrolysis		T	0013	0.8782	$59.95	.	$11.99
17999	Skin tissue procedure		T	0012	0.4253	$29.03	.	$5.81
19000	Drainage of breast lesion		T	0004	4.6624	$318.29	.	$63.66
19001	Drain breast lesion add-on		T	0002	1.7752	$121.19	.	$24.24
19020	Incision of breast lesion		T	0008	20.2481	$1,382.28	.	$276.46
19030	Injection for breast x-ray		N					
19100	Bx breast percut w/o image		T	0004	4.6624	$318.29	.	$63.66
19101	Biopsy of breast, open		T	0028	25.7651	$1,758.91	.	$351.79
19102	Bx breast percut w/image		T	0005	8.16	$557.06	.	$111.42
19103	Bx breast percut w/device		T	0037	15.764	$1,076.16	$228.76	$215.24
19105	Cryosurg ablate fa, each		T	0029	34.3618	$2,345.78	$581.52	$469.16
19110	Nipple exploration		T	0028	25.7651	$1,758.91	.	$351.79
19112	Excise breast duct fistula		T	0028	25.7651	$1,758.91	.	$351.79
19120	Removal of breast lesion		T	0028	25.7651	$1,758.91	.	$351.79
19125	Excision, breast lesion		T	0028	25.7651	$1,758.91	.	$351.79
19126	Excision, addl breast lesion		T	0028	25.7651	$1,758.91	.	$351.79
19260	Removal of chest wall lesion		T	0021	18.2223	$1,243.98	.	$248.80
19271	Revision of chest wall		C					
19272	Extensive chest wall surgery		C					
19290	Place needle wire, breast		N					
19291	Place needle wire, breast		N					
19295	Place breast clip, percut		N					
19296	Place po breast cath for rad		T	0648	62.9	$4,293.99	.	$858.80
19297	Place breast cath for rad		T	0648	62.9	$4,293.99	.	$858.80
19298	Place breast rad tube/caths		T	0648	62.9	$4,293.99	.	$858.80
19300	Removal of breast tissue		T	0028	25.7651	$1,758.91	.	$351.79
19301	Partical mastectomy		T	0028	25.7651	$1,758.91	.	$351.79
19302	P-mastectomy w/ln removal		T	0030	45.1924	$3,085.15	$747.07	$617.03
19303	Mast, simple, complete		T	0029	34.3618	$2,345.78	$581.52	$469.16

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
19304	Mast, subq		T	0029	34.3618	$2,345.78	$581.52	$469.16
19305	Mast, radical		C					
19306	Mast, rad, urban type		C					
19307	Mast, mod rad		T	0030	45.1924	$3,085.15	$747.07	$617.03
19316	Suspension of breast		T	0029	34.3618	$2,345.78	$581.52	$469.16
19318	Reduction of large breast		T	0030	45.1924	$3,085.15	$747.07	$617.03
19324	Enlarge breast		T	0030	45.1924	$3,085.15	$747.07	$617.03
19325	Enlarge breast with implant		T	0648	62.9	$4,293.99	.	$858.80
19328	Removal of breast implant		T	0029	34.3618	$2,345.78	$581.52	$469.16
19330	Removal of implant material		T	0029	34.3618	$2,345.78	$581.52	$469.16
19340	Immediate breast prosthesis		T	0030	45.1924	$3,085.15	$747.07	$617.03
19342	Delayed breast prosthesis		T	0648	62.9	$4,293.99	.	$858.80
19350	Breast reconstruction		T	0028	25.7651	$1,758.91	.	$351.79
19355	Correct inverted nipple(s)		T	0029	34.3618	$2,345.78	$581.52	$469.16
19357	Breast reconstruction		T	0648	62.9	$4,293.99	.	$858.80
19361	Breast reconstr w/lat flap		C					
19364	Breast reconstruction		C					
19366	Breast reconstruction		T	0029	34.3618	$2,345.78	$581.52	$469.16
19367	Breast reconstruction		C					
19368	Breast reconstruction		C					
19369	Breast reconstruction		C					
19370	Surgery of breast capsule		T	0029	34.3618	$2,345.78	$581.52	$469.16
19371	Removal of breast capsule		T	0029	34.3618	$2,345.78	$581.52	$469.16
19380	Revise breast reconstruction		T	0030	45.1924	$3,085.15	$747.07	$617.03
19396	Design custom breast implant		T	0029	34.3618	$2,345.78	$581.52	$469.16
19499	Breast surgery procedure		T	0028	25.7651	$1,758.91	.	$351.79
20000	Incision of abscess		T	0006	1.4939	$101.98	.	$20.40
20005	Incision of deep abscess		T	0049	23.2249	$1,585.49	.	$317.10
20100	Explore wound, neck		T	0252	7.8743	$537.55	$109.16	$107.51

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20101	Explore wound, chest		T	0137	22.1186	$1,509.97	.	$302.00
20102	Explore wound, abdomen		T	0137	22.1186	$1,509.97	.	$302.00
20103	Explore wound, extremity		T	0007	13.3268	$909.78	.	$181.96
20150	Excise epiphyseal bar		T	0051	47.3761	$3,234.22	.	$646.85
20200	Muscle biopsy		T	0021	18.2223	$1,243.98	.	$248.80
20205	Deep muscle biopsy		T	0021	18.2223	$1,243.98	.	$248.80
20206	Needle biopsy, muscle		T	0005	8.16	$557.06	.	$111.42
20220	Bone biopsy, trocar/needle		T	0020	8.7772	$599.19	.	$119.84
20225	Bone biopsy, trocar/needle		T	0021	18.2223	$1,243.98	.	$248.80
20240	Bone biopsy, excisional		T	0022	24.1269	$1,647.07	$354.45	$329.42
20245	Bone biopsy, excisional		T	0022	24.1269	$1,647.07	$354.45	$329.42
20250	Open bone biopsy		T	0049	23.2249	$1,585.49	.	$317.10
20251	Open bone biopsy		T	0049	23.2249	$1,585.49	.	$317.10
20500	Injection of sinus tract		T	0252	7.8743	$537.55	$109.16	$107.51
20501	Inject sinus tract for x-ray		N					
20520	Removal of foreign body		T	0019	4.9184	$335.76	.	$67.16
20525	Removal of foreign body		T	0022	24.1269	$1,647.07	$354.45	$329.42
20526	Ther injection, carp tunnel		T	0204	2.666	$182.00	$40.13	$36.40
20550	Inj tendon sheath/ligament		T	0204	2.666	$182.00	$40.13	$36.40
20551	Inj tendon origin/insertion		T	0204	2.666	$182.00	$40.13	$36.40
20552	Inj trigger point, 1/2 muscl		T	0204	2.666	$182.00	$40.13	$36.40
20553	Inject trigger points, =/> 3		T	0204	2.666	$182.00	$40.13	$36.40
20555	Place ndl musc/tis for rt		T	0050	32.4253	$2,213.58	.	$442.72
20600	Drain/inject, joint/bursa		T	0204	2.666	$182.00	$40.13	$36.40
20605	Drain/inject, joint/bursa		T	0204	2.666	$182.00	$40.13	$36.40
20610	Drain/inject, joint/bursa		T	0204	2.666	$182.00	$40.13	$36.40
20612	Aspirate/inj ganglion cyst		T	0204	2.666	$182.00	$40.13	$36.40
20615	Treatment of bone cyst		T	0004	4.6624	$318.29	.	$63.66
20650	Insert and remove bone pin		T	0049	23.2249	$1,585.49	.	$317.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20660	Apply, rem fixation device		T	0138	5.2593	$359.04	.	$71.81
20661	Application of head brace		C					
20662	Application of pelvis brace		T	0049	23.2249	$1,585.49	.	$317.10
20663	Application of thigh brace		T	0049	23.2249	$1,585.49	.	$317.10
20664	Halo brace application		C					
20665	Removal of fixation device		X	0340	0.6899	$47.10	.	$9.42
20670	Removal of support implant		T	0021	18.2223	$1,243.98	.	$248.80
20680	Removal of support implant		T	0022	24.1269	$1,647.07	$354.45	$329.42
20690	Apply bone fixation device		T	0050	32.4253	$2,213.58	.	$442.72
20692	Apply bone fixation device		T	0050	32.4253	$2,213.58	.	$442.72
20693	Adjust bone fixation device		T	0049	23.2249	$1,585.49	.	$317.10
20694	Remove bone fixation device		T	0049	23.2249	$1,585.49	.	$317.10
20696	Comp multiplane ext fixation		T	0050	32.4253	$2,213.58	.	$442.72
20697	Comp ext fixate strut change		T	0139	20.9892	$1,432.87	.	$286.58
20802	Replantation, arm, complete		C					
20805	Replant forearm, complete		C					
20808	Replantation hand, complete		C					
20816	Replantation digit, complete		C					
20822	Replantation digit, complete		T	0054	29.8184	$2,035.61	.	$407.13
20824	Replantation thumb, complete		C					
20827	Replantation thumb, complete		C					
20838	Replantation foot, complete		C					
20900	Removal of bone for graft		T	0050	32.4253	$2,213.58	.	$442.72
20902	Removal of bone for graft		T	0050	32.4253	$2,213.58	.	$442.72
20910	Remove cartilage for graft		T	0137	22.1186	$1,509.97	.	$302.00
20912	Remove cartilage for graft		T	0137	22.1186	$1,509.97	.	$302.00
20920	Removal of fascia for graft		T	0136	17.1353	$1,169.78	.	$233.96
20922	Removal of fascia for graft		T	0136	17.1353	$1,169.78	.	$233.96
20924	Removal of tendon for graft		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20926	Removal of tissue for graft		T	0135	4.6616	$318.23	.	$63.65
20930	Sp bone algrft morsel add-on		C					
20931	Sp bone algrft struct add-on		C					
20936	Sp bone agrft local add-on		C					
20937	Sp bone agrft morsel add-on		C					
20938	Sp bone agrft struct add-on		C					
20950	Fluid pressure, muscle		T	0006	1.4939	$101.98	.	$20.40
20955	Fibula bone graft, microvasc		C					
20956	Iliac bone graft, microvasc		C					
20957	Mt bone graft, microvasc		C					
20962	Other bone graft, microvasc		C					
20969	Bone/skin graft, microvasc		C					
20970	Bone/skin graft, iliac crest		C					
20972	Bone/skin graft, metatarsal		T	0056	55.5064	$3,789.26	.	$757.86
20973	Bone/skin graft, great toe		T	0056	55.5064	$3,789.26	.	$757.86
20974	Electrical bone stimulation		A					
20975	Electrical bone stimulation		N					
20979	Us bone stimulation		X	0340	0.6899	$47.10	.	$9.42
20982	Ablate, bone tumor(s) perq		T	0051	47.3761	$3,234.22	.	$646.85
20985	Cptr-asst dir ms px		N					
20999	Musculoskeletal surgery		T	0049	23.2249	$1,585.49	.	$317.10
21010	Incision of jaw joint		T	0254	25.5397	$1,743.52	.	$348.71
21011	Exc face les sc < 2 cm		T	0020	8.7772	$599.19	.	$119.84
21012	Exc face les sc = 2 cm		T	0020	8.7772	$599.19	.	$119.84
21013	Exc face tum deep < 2 cm		T	0020	8.7772	$599.19	.	$119.84
21014	Exc face tum deep = 2 cm		T	0020	8.7772	$599.19	.	$119.84
21015	Resect face tum < 2 cm		T	0021	18.2223	$1,243.98	.	$248.80
21016	Resect face tum = 2 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21025	Excision of bone, lower jaw		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21026	Excision of facial bone(s)		T	0256	44.8441	$3,061.37	.	$612.28
21029	Contour of face bone lesion		T	0256	44.8441	$3,061.37	.	$612.28
21030	Excise max/zygoma b9 tumor		T	0254	25.5397	$1,743.52	.	$348.71
21031	Remove exostosis, mandible		T	0254	25.5397	$1,743.52	.	$348.71
21032	Remove exostosis, maxilla		T	0254	25.5397	$1,743.52	.	$348.71
21034	Excise max/zygoma mlg tumor		T	0256	44.8441	$3,061.37	.	$612.28
21040	Excise mandible lesion		T	0254	25.5397	$1,743.52	.	$348.71
21044	Removal of jaw bone lesion		T	0256	44.8441	$3,061.37	.	$612.28
21045	Extensive jaw surgery		C					
21046	Remove mandible cyst complex		T	0256	44.8441	$3,061.37	.	$612.28
21047	Excise lwr jaw cyst w/repair		T	0256	44.8441	$3,061.37	.	$612.28
21048	Remove maxilla cyst complex		T	0256	44.8441	$3,061.37	.	$612.28
21049	Excis uppr jaw cyst w/repair		T	0256	44.8441	$3,061.37	.	$612.28
21050	Removal of jaw joint		T	0256	44.8441	$3,061.37	.	$612.28
21060	Remove jaw joint cartilage		T	0256	44.8441	$3,061.37	.	$612.28
21070	Remove coronoid process		T	0256	44.8441	$3,061.37	.	$612.28
21073	Mnpj of tmj w/anesth		T	0252	7.8743	$537.55	$109.16	$107.51
21076	Prepare face/oral prosthesis		T	0254	25.5397	$1,743.52	.	$348.71
21077	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21079	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21080	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21081	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21082	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21083	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21084	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21085	Prepare face/oral prosthesis		T	0253	17.4151	$1,188.88	$282.29	$237.78
21086	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21087	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21088	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21089	Prepare face/oral prosthesis		T	0250	1.1743	$80.17	$25.10	$16.04
21100	Maxillofacial fixation		T	0256	44.8441	$3,061.37	.	$612.28
21110	Interdental fixation		T	0252	7.8743	$537.55	$109.16	$107.51
21116	Injection, jaw joint x-ray		N					
21120	Reconstruction of chin		T	0254	25.5397	$1,743.52	.	$348.71
21121	Reconstruction of chin		T	0254	25.5397	$1,743.52	.	$348.71
21122	Reconstruction of chin		T	0254	25.5397	$1,743.52	.	$348.71
21123	Reconstruction of chin		T	0254	25.5397	$1,743.52	.	$348.71
21125	Augmentation, lower jaw bone		T	0254	25.5397	$1,743.52	.	$348.71
21127	Augmentation, lower jaw bone		T	0256	44.8441	$3,061.37	.	$612.28
21137	Reduction of forehead		T	0254	25.5397	$1,743.52	.	$348.71
21138	Reduction of forehead		T	0256	44.8441	$3,061.37	.	$612.28
21139	Reduction of forehead		T	0256	44.8441	$3,061.37	.	$612.28
21141	Reconstruct midface, lefort		C					
21142	Reconstruct midface, lefort		C					
21143	Reconstruct midface, lefort		C					
21145	Reconstruct midface, lefort		C					
21146	Reconstruct midface, lefort		C					
21147	Reconstruct midface, lefort		C					
21150	Reconstruct midface, lefort		T	0256	44.8441	$3,061.37	.	$612.28
21151	Reconstruct midface, lefort		C					
21154	Reconstruct midface, lefort		C					
21155	Reconstruct midface, lefort		C					
21159	Reconstruct midface, lefort		C					
21160	Reconstruct midface, lefort		C					
21172	Reconstruct orbit/forehead		T	0256	44.8441	$3,061.37	.	$612.28
21175	Reconstruct orbit/forehead		T	0256	44.8441	$3,061.37	.	$612.28
21179	Reconstruct entire forehead		C					
21180	Reconstruct entire forehead		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21181	Contour cranial bone lesion		T	0254	25.5397	$1,743.52	.	$348.71
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	CH	T	0256	44.8441	$3,061.37	.	$612.28
21194	Reconst lwr jaw w/graft		C					
21195	Reconst lwr jaw w/o fixation		T	0256	44.8441	$3,061.37	.	$612.28
21196	Reconst lwr jaw w/fixation		C					
21198	Reconstr lwr jaw segment		T	0256	44.8441	$3,061.37	.	$612.28
21199	Reconstr lwr jaw w/advance		T	0256	44.8441	$3,061.37	.	$612.28
21206	Reconstruct upper jaw bone		T	0256	44.8441	$3,061.37	.	$612.28
21208	Augmentation of facial bones		T	0256	44.8441	$3,061.37	.	$612.28
21209	Reduction of facial bones		T	0256	44.8441	$3,061.37	.	$612.28
21210	Face bone graft		T	0256	44.8441	$3,061.37	.	$612.28
21215	Lower jaw bone graft		T	0256	44.8441	$3,061.37	.	$612.28
21230	Rib cartilage graft		T	0256	44.8441	$3,061.37	.	$612.28
21235	Ear cartilage graft		T	0254	25.5397	$1,743.52	.	$348.71
21240	Reconstruction of jaw joint		T	0256	44.8441	$3,061.37	.	$612.28
21242	Reconstruction of jaw joint		T	0256	44.8441	$3,061.37	.	$612.28
21243	Reconstruction of jaw joint		T	0256	44.8441	$3,061.37	.	$612.28
21244	Reconstruction of lower jaw		T	0256	44.8441	$3,061.37	.	$612.28
21245	Reconstruction of jaw		T	0256	44.8441	$3,061.37	.	$612.28
21246	Reconstruction of jaw		T	0256	44.8441	$3,061.37	.	$612.28
21247	Reconstruct lower jaw bone		C					
21248	Reconstruction of jaw		T	0256	44.8441	$3,061.37	.	$612.28
21249	Reconstruction of jaw		T	0256	44.8441	$3,061.37	.	$612.28
21255	Reconstruct lower jaw bone		C					
21256	Reconstruction of orbit		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21260	Revise eye sockets		T	0256	44.8441	$3,061.37	.	$612.28
21261	Revise eye sockets		T	0256	44.8441	$3,061.37	.	$612.28
21263	Revise eye sockets		T	0256	44.8441	$3,061.37	.	$612.28
21267	Revise eye sockets		T	0256	44.8441	$3,061.37	.	$612.28
21268	Revise eye sockets		C					
21270	Augmentation, cheek bone		T	0256	44.8441	$3,061.37	.	$612.28
21275	Revision, orbitofacial bones		T	0256	44.8441	$3,061.37	.	$612.28
21280	Revision of eyelid		T	0256	44.8441	$3,061.37	.	$612.28
21282	Revision of eyelid		T	0253	17.4151	$1,188.88	$282.29	$237.78
21295	Revision of jaw muscle/bone		T	0252	7.8743	$537.55	$109.16	$107.51
21296	Revision of jaw muscle/bone		T	0254	25.5397	$1,743.52	.	$348.71
21299	Cranio/maxillofacial surgery		T	0250	1.1743	$80.17	$25.10	$16.04
21310	Treatment of nose fracture		T	0250	1.1743	$80.17	$25.10	$16.04
21315	Treatment of nose fracture		T	0253	17.4151	$1,188.88	$282.29	$237.78
21320	Treatment of nose fracture		T	0253	17.4151	$1,188.88	$282.29	$237.78
21325	Treatment of nose fracture		T	0254	25.5397	$1,743.52	.	$348.71
21330	Treatment of nose fracture		T	0254	25.5397	$1,743.52	.	$348.71
21335	Treatment of nose fracture		T	0254	25.5397	$1,743.52	.	$348.71
21336	Treat nasal septal fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
21337	Treat nasal septal fracture		T	0253	17.4151	$1,188.88	$282.29	$237.78
21338	Treat nasoethmoid fracture		T	0254	25.5397	$1,743.52	.	$348.71
21339	Treat nasoethmoid fracture		T	0254	25.5397	$1,743.52	.	$348.71
21340	Treatment of nose fracture		T	0256	44.8441	$3,061.37	.	$612.28
21343	Treatment of sinus fracture		C					
21344	Treatment of sinus fracture		C					
21345	Treat nose/jaw fracture		T	0254	25.5397	$1,743.52	.	$348.71
21346	Treat nose/jaw fracture		C					
21347	Treat nose/jaw fracture		C					
21348	Treat nose/jaw fracture		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21355	Treat cheek bone fracture		T	0256	44.8441	$3,061.37	.	$612.28
21356	Treat cheek bone fracture		T	0254	25.5397	$1,743.52	.	$348.71
21360	Treat cheek bone fracture		T	0254	25.5397	$1,743.52	.	$348.71
21365	Treat cheek bone fracture		T	0256	44.8441	$3,061.37	.	$612.28
21366	Treat cheek bone fracture		C					
21385	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21386	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21387	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21390	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21395	Treat eye socket fracture	CH	T	0256	44.8441	$3,061.37	.	$612.28
21400	Treat eye socket fracture		T	0252	7.8743	$537.55	$109.16	$107.51
21401	Treat eye socket fracture		T	0253	17.4151	$1,188.88	$282.29	$237.78
21406	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21407	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21408	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21421	Treat mouth roof fracture		T	0254	25.5397	$1,743.52	.	$348.71
21422	Treat mouth roof fracture		C					
21423	Treat mouth roof fracture		C					
21431	Treat craniofacial fracture		C					
21432	Treat craniofacial fracture		C					
21433	Treat craniofacial fracture		C					
21435	Treat craniofacial fracture		C					
21436	Treat craniofacial fracture		C					
21440	Treat dental ridge fracture		T	0254	25.5397	$1,743.52	.	$348.71
21445	Treat dental ridge fracture		T	0254	25.5397	$1,743.52	.	$348.71
21450	Treat lower jaw fracture		T	0251	3.4369	$234.63	.	$46.93
21451	Treat lower jaw fracture		T	0252	7.8743	$537.55	$109.16	$107.51
21452	Treat lower jaw fracture		T	0253	17.4151	$1,188.88	$282.29	$237.78
21453	Treat lower jaw fracture		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21454	Treat lower jaw fracture		T	0254	25.5397	$1,743.52	.	$348.71
21461	Treat lower jaw fracture		T	0256	44.8441	$3,061.37	.	$612.28
21462	Treat lower jaw fracture		T	0256	44.8441	$3,061.37	.	$612.28
21465	Treat lower jaw fracture		T	0256	44.8441	$3,061.37	.	$612.28
21470	Treat lower jaw fracture		T	0256	44.8441	$3,061.37	.	$612.28
21480	Reset dislocated jaw		T	0250	1.1743	$80.17	$25.10	$16.04
21485	Reset dislocated jaw		T	0253	17.4151	$1,188.88	$282.29	$237.78
21490	Repair dislocated jaw		T	0256	44.8441	$3,061.37	.	$612.28
21495	Treat hyoid bone fracture		T	0253	17.4151	$1,188.88	$282.29	$237.78
21497	Interdental wiring		T	0253	17.4151	$1,188.88	$282.29	$237.78
21499	Head surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
21501	Drain neck/chest lesion		T	0008	20.2481	$1,382.28	.	$276.46
21502	Drain chest lesion		T	0049	23.2249	$1,585.49	.	$317.10
21510	Drainage of bone lesion		C					
21550	Biopsy of neck/chest		T	0021	18.2223	$1,243.98	.	$248.80
21552	Exc neck les sc = 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21554	Exc neck tum deep = 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21555	Exc neck les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
21556	Exc neck tum deep < 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21557	Resect neck tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
21558	Resect neck tum = 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21600	Partial removal of rib		T	0050	32.4253	$2,213.58	.	$442.72
21610	Partial removal of rib		T	0050	32.4253	$2,213.58	.	$442.72
21615	Removal of rib		C					
21616	Removal of rib and nerves		C					
21620	Partial removal of sternum		C					
21627	Sternal debridement		C					
21630	Extensive sternum surgery		C					
21632	Extensive sternum surgery		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21685	Hyoid myotomy & suspension		T	0252	7.8743	$537.55	$109.16	$107.51
21700	Revision of neck muscle		T	0049	23.2249	$1,585.49	.	$317.10
21705	Revision of neck muscle/rib		C					
21720	Revision of neck muscle		T	0049	23.2249	$1,585.49	.	$317.10
21725	Revision of neck muscle		T	0006	1.4939	$101.98	.	$20.40
21740	Reconstruction of sternum		C					
21742	Repair stern/nuss w/o scope		T	0051	47.3761	$3,234.22	.	$646.85
21743	Repair sternum/nuss w/scope		T	0051	47.3761	$3,234.22	.	$646.85
21750	Repair of sternum separation		C					
21800	Treatment of rib fracture		T	0129	1.6325	$111.45	.	$22.29
21805	Treatment of rib fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
21810	Treatment of rib fracture(s)		C					
21820	Treat sternum fracture		T	0129	1.6325	$111.45	.	$22.29
21825	Treat sternum fracture		C					
21899	Neck/chest surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
21920	Biopsy soft tissue of back		T	0020	8.7772	$599.19	.	$119.84
21925	Biopsy soft tissue of back		T	0022	24.1269	$1,647.07	$354.45	$329.42
21930	Exc back les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
21931	Exc back les sc = 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21932	Exc back tum deep < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
21933	Exc back tum deep = 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21935	Resect back tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
21936	Resect back tum = 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
22010	I&d, p-spine, c/t/cerv-thor		C					
22015	I&d, p-spine, l/s/ls		C					
22100	Remove part of neck vertebra		T	0208	51.7137	$3,530.34	.	$706.07
22101	Remove part, thorax vertebra		T	0208	51.7137	$3,530.34	.	$706.07
22102	Remove part, lumbar vertebra		T	0208	51.7137	$3,530.34	.	$706.07
22103	Remove extra spine segment		T	0208	51.7137	$3,530.34	.	$706.07

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22110	Remove part of neck vertebra		C					
22112	Remove part, thorax vertebra		C					
22114	Remove part, lumbar vertebra		C					
22116	Remove extra spine segment		C					
22206	Cut spine 3 col, thor		C					
22207	Cut spine 3 col, lumb		C					
22208	Cut spine 3 col, addl seg		C					
22210	Revision of neck spine		C					
22212	Revision of thorax spine		C					
22214	Revision of lumbar spine		C					
22216	Revise, extra spine segment		C					
22220	Revision of neck spine		C					
22222	Revision of thorax spine		T	0208	51.7137	$3,530.34	.	$706.07
22224	Revision of lumbar spine		C					
22226	Revise, extra spine segment		C					
22305	Treat spine process fracture		T	0129	1.6325	$111.45	.	$22.29
22310	Treat spine fracture		T	0138	5.2593	$359.04	.	$71.81
22315	Treat spine fracture		T	0139	20.9892	$1,432.87	.	$286.58
22318	Treat odontoid fx w/o graft		C					
22319	Treat odontoid fx w/graft		C					
22325	Treat spine fracture		C					
22326	Treat neck spine fracture		C					
22327	Treat thorax spine fracture		C					
22328	Treat each add spine fx		C					
22505	Manipulation of spine		T	0045	15.5647	$1,062.56	$268.44	$212.52
22520	Percut vertebroplasty thor		T	0050	32.4253	$2,213.58	.	$442.72
22521	Percut vertebroplasty lumb		T	0050	32.4253	$2,213.58	.	$442.72
22522	Percut vertebroplasty addl		T	0050	32.4253	$2,213.58	.	$442.72
22523	Percut kyphoplasty, thor		T	0052	88.5249	$6,043.33	.	$1,208.67

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22524	Percut kyphoplasty, lumbar		T	0052	88.5249	$6,043.33	.	$1,208.67
22525	Percut kyphoplasty, add-on		T	0052	88.5249	$6,043.33	.	$1,208.67
22526	Idet, single level		E					
22527	Idet, 1 or more levels		E					
22532	Lat thorax spine fusion		C					
22533	Lat lumbar spine fusion		C					
22534	Lat thor/lumb, addl seg		C					
22548	Neck spine fusion		C					
22554	Neck spine fusion		C					
22556	Thorax spine fusion		C					
22558	Lumbar spine fusion		C					
22585	Additional spinal fusion		C					
22590	Spine & skull spinal fusion		C					
22595	Neck spinal fusion		C					
22600	Neck spine fusion		C					
22610	Thorax spine fusion		C					
22612	Lumbar spine fusion		T	0208	51.7137	$3,530.34	.	$706.07
22614	Spine fusion, extra segment		T	0208	51.7137	$3,530.34	.	$706.07
22630	Lumbar spine fusion		C					
22632	Spine fusion, extra segment		C					
22800	Fusion of spine		C					
22802	Fusion of spine		C					
22804	Fusion of spine		C					
22808	Fusion of spine		C					
22810	Fusion of spine		C					
22812	Fusion of spine		C					
22818	Kyphectomy, 1-2 segments		C					
22819	Kyphectomy, 3 or more		C					
22830	Exploration of spinal fusion		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22840	Insert spine fixation device		C					
22841	Insert spine fixation device		C					
22842	Insert spine fixation device		C					
22843	Insert spine fixation device		C					
22844	Insert spine fixation device		C					
22845	Insert spine fixation device		C					
22846	Insert spine fixation device		C					
22847	Insert spine fixation device		C					
22848	Insert pelv fixation device		C					
22849	Reinsert spinal fixation		C					
22850	Remove spine fixation device		C					
22851	Apply spine prosth device		T	0049	23.2249	$1,585.49	.	$317.10
22852	Remove spine fixation device		C					
22855	Remove spine fixation device		C					
22856	Cerv artific diskectomy		C					
22857	Lumbar artif diskectomy		C					
22861	Revise cerv artific disc		C					
22862	Revise lumbar artif disc		C					
22864	Remove cerv artif disc		C					
22865	Remove lumb artif disc		C					
22899	Spine surgery procedure		T	0049	23.2249	$1,585.49	.	$317.10
22900	Exc back tum deep < 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
22901	Exc back tum deep = 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
22902	Exc abd les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
22903	Exc abd les sc > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
22904	Resect abd tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
22905	Resect abd tum > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
22999	Abdomen surgery procedure		T	0049	23.2249	$1,585.49	.	$317.10
23000	Removal of calcium deposits		T	0021	18.2223	$1,243.98	.	$248.80

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23020	Release shoulder joint		T	0051	47.3761	$3,234.22	.	$646.85
23030	Drain shoulder lesion		T	0008	20.2481	$1,382.28	.	$276.46
23031	Drain shoulder bursa		T	0008	20.2481	$1,382.28	.	$276.46
23035	Drain shoulder bone lesion		T	0049	23.2249	$1,585.49	.	$317.10
23040	Exploratory shoulder surgery		T	0050	32.4253	$2,213.58	.	$442.72
23044	Exploratory shoulder surgery		T	0050	32.4253	$2,213.58	.	$442.72
23065	Biopsy shoulder tissues		T	0020	8.7772	$599.19	.	$119.84
23066	Biopsy shoulder tissues		T	0022	24.1269	$1,647.07	$354.45	$329.42
23071	Exc shoulder les sc > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
23073	Exc shoulder tum deep > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
23075	Exc shoulder les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
23076	Exc shoulder tum deep < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
23077	Resect shoulder tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
23078	Resect shoulder tum > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
23100	Biopsy of shoulder joint		T	0049	23.2249	$1,585.49	.	$317.10
23101	Shoulder joint surgery		T	0050	32.4253	$2,213.58	.	$442.72
23105	Remove shoulder joint lining		T	0050	32.4253	$2,213.58	.	$442.72
23106	Incision of collarbone joint		T	0050	32.4253	$2,213.58	.	$442.72
23107	Explore treat shoulder joint		T	0050	32.4253	$2,213.58	.	$442.72
23120	Partial removal, collar bone		T	0050	32.4253	$2,213.58	.	$442.72
23125	Removal of collar bone		T	0050	32.4253	$2,213.58	.	$442.72
23130	Remove shoulder bone, part		T	0051	47.3761	$3,234.22	.	$646.85
23140	Removal of bone lesion		T	0049	23.2249	$1,585.49	.	$317.10
23145	Removal of bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
23146	Removal of bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
23150	Removal of humerus lesion		T	0050	32.4253	$2,213.58	.	$442.72
23155	Removal of humerus lesion		T	0050	32.4253	$2,213.58	.	$442.72
23156	Removal of humerus lesion		T	0050	32.4253	$2,213.58	.	$442.72
23170	Remove collar bone lesion		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23172	Remove shoulder blade lesion		T	0050	32.4253	$2,213.58	.	$442.72
23174	Remove humerus lesion		T	0050	32.4253	$2,213.58	.	$442.72
23180	Remove collar bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
23182	Remove shoulder blade lesion		T	0050	32.4253	$2,213.58	.	$442.72
23184	Remove humerus lesion		T	0050	32.4253	$2,213.58	.	$442.72
23190	Partial removal of scapula		T	0050	32.4253	$2,213.58	.	$442.72
23195	Removal of head of humerus		T	0050	32.4253	$2,213.58	.	$442.72
23200	Resect clavicle tumor		C					
23210	Resect scapula tumor		C					
23220	Resect prox humerus tumor		C					
23330	Remove shoulder foreign body		T	0020	8.7772	$599.19	.	$119.84
23331	Remove shoulder foreign body		T	0022	24.1269	$1,647.07	$354.45	$329.42
23332	Remove shoulder foreign body		C					
23350	Injection for shoulder x-ray		N					
23395	Muscle transfer,shoulder/arm		T	0051	47.3761	$3,234.22	.	$646.85
23397	Muscle transfers		T	0052	88.5249	$6,043.33	.	$1,208.67
23400	Fixation of shoulder blade		T	0050	32.4253	$2,213.58	.	$442.72
23405	Incision of tendon & muscle		T	0050	32.4253	$2,213.58	.	$442.72
23406	Incise tendon(s) & muscle(s)		T	0050	32.4253	$2,213.58	.	$442.72
23410	Repair rotator cuff, acute		T	0051	47.3761	$3,234.22	.	$646.85
23412	Repair rotator cuff, chronic		T	0051	47.3761	$3,234.22	.	$646.85
23415	Release of shoulder ligament		T	0051	47.3761	$3,234.22	.	$646.85
23420	Repair of shoulder		T	0051	47.3761	$3,234.22	.	$646.85
23430	Repair biceps tendon		T	0051	47.3761	$3,234.22	.	$646.85
23440	Remove/transplant tendon		T	0051	47.3761	$3,234.22	.	$646.85
23450	Repair shoulder capsule		T	0052	88.5249	$6,043.33	.	$1,208.67
23455	Repair shoulder capsule		T	0052	88.5249	$6,043.33	.	$1,208.67
23460	Repair shoulder capsule		T	0052	88.5249	$6,043.33	.	$1,208.67
23462	Repair shoulder capsule		T	0051	47.3761	$3,234.22	.	$646.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23465	Repair shoulder capsule		T	0052	88.5249	$6,043.33	.	$1,208.67
23466	Repair shoulder capsule		T	0051	47.3761	$3,234.22	.	$646.85
23470	Reconstruct shoulder joint		T	0425	122.1766	$8,340.63	.	$1,668.13
23472	Reconstruct shoulder joint		C					
23480	Revision of collar bone		T	0051	47.3761	$3,234.22	.	$646.85
23485	Revision of collar bone		T	0052	88.5249	$6,043.33	.	$1,208.67
23490	Reinforce clavicle	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
23491	Reinforce shoulder bones		T	0052	88.5249	$6,043.33	.	$1,208.67
23500	Treat clavicle fracture		T	0129	1.6325	$111.45	.	$22.29
23505	Treat clavicle fracture		T	0139	20.9892	$1,432.87	.	$286.58
23515	Treat clavicle fracture		T	0064	66.575	$4,544.88	.	$908.98
23520	Treat clavicle dislocation		T	0138	5.2593	$359.04	.	$71.81
23525	Treat clavicle dislocation		T	0138	5.2593	$359.04	.	$71.81
23530	Treat clavicle dislocation		T	0063	48.0827	$3,282.46	.	$656.50
23532	Treat clavicle dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
23540	Treat clavicle dislocation		T	0129	1.6325	$111.45	.	$22.29
23545	Treat clavicle dislocation		T	0138	5.2593	$359.04	.	$71.81
23550	Treat clavicle dislocation		T	0063	48.0827	$3,282.46	.	$656.50
23552	Treat clavicle dislocation		T	0063	48.0827	$3,282.46	.	$656.50
23570	Treat shoulder blade fx		T	0129	1.6325	$111.45	.	$22.29
23575	Treat shoulder blade fx		T	0138	5.2593	$359.04	.	$71.81
23585	Treat scapula fracture		T	0064	66.575	$4,544.88	.	$908.98
23600	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
23605	Treat humerus fracture		T	0139	20.9892	$1,432.87	.	$286.58
23615	Treat humerus fracture		T	0064	66.5750	$4,544.88	.	$908.98
23616	Treat humerus fracture		T	0064	66.5750	$4,544.88	.	$908.98
23620	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
23625	Treat humerus fracture		T	0139	20.9892	$1,432.87	.	$286.58
23630	Treat humerus fracture		T	0064	66.5750	$4,544.88	.	$908.98

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23650	Treat shoulder dislocation		T	0129	1.6325	$111.45	.	$22.29
23655	Treat shoulder dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
23660	Treat shoulder dislocation		T	0063	48.0827	$3,282.46	.	$656.50
23665	Treat dislocation/fracture		T	0138	5.2593	$359.04	.	$71.81
23670	Treat dislocation/fracture		T	0064	66.5750	$4,544.88	.	$908.98
23675	Treat dislocation/fracture		T	0129	1.6325	$111.45	.	$22.29
23680	Treat dislocation/fracture		T	0063	48.0827	$3,282.46	.	$656.50
23700	Fixation of shoulder		T	0045	15.5647	$1,062.56	$268.44	$212.52
23800	Fusion of shoulder joint		T	0052	88.5249	$6,043.33	.	$1,208.67
23802	Fusion of shoulder joint	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
23900	Amputation of arm & girdle		C					
23920	Amputation at shoulder joint		C					
23921	Amputation follow-up surgery		T	0136	17.1353	$1,169.78	.	$233.96
23929	Shoulder surgery procedure		T	0129	1.6325	$111.45	.	$22.29
23930	Drainage of arm lesion		T	0008	20.2481	$1,382.28	.	$276.46
23931	Drainage of arm bursa		T	0008	20.2481	$1,382.28	.	$276.46
23935	Drain arm/elbow bone lesion		T	0049	23.2249	$1,585.49	.	$317.10
24000	Exploratory elbow surgery		T	0050	32.4253	$2,213.58	.	$442.72
24006	Release elbow joint		T	0050	32.4253	$2,213.58	.	$442.72
24065	Biopsy arm/elbow soft tissue		T	0021	18.2223	$1,243.98	.	$248.80
24066	Biopsy arm/elbow soft tissue		T	0021	18.2223	$1,243.98	.	$248.80
24071	Exc arm/elbow les sc = 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
24073	Ex arm/elbow tum deep > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
24075	Exc arm/elbow les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
24076	Ex arm/elbow tum deep < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
24077	Resect arm/elbow tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
24079	Resect arm/elbow tum > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
24100	Biopsy elbow joint lining		T	0049	23.2249	$1,585.49	.	$317.10
24101	Explore/treat elbow joint		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24102	Remove elbow joint lining		T	0050	32.4253	$2,213.58	.	$442.72
24105	Removal of elbow bursa		T	0049	23.2249	$1,585.49	.	$317.10
24110	Remove humerus lesion		T	0049	23.2249	$1,585.49	.	$317.10
24115	Remove/graft bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24116	Remove/graft bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24120	Remove elbow lesion		T	0049	23.2249	$1,585.49	.	$317.10
24125	Remove/graft bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24126	Remove/graft bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24130	Removal of head of radius		T	0050	32.4253	$2,213.58	.	$442.72
24134	Removal of arm bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24136	Remove radius bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24138	Remove elbow bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24140	Partial removal of arm bone		T	0050	32.4253	$2,213.58	.	$442.72
24145	Partial removal of radius		T	0050	32.4253	$2,213.58	.	$442.72
24147	Partial removal of elbow		T	0050	32.4253	$2,213.58	.	$442.72
24149	Radical resection of elbow		T	0050	32.4253	$2,213.58	.	$442.72
24150	Resect distal humerus tumor		T	0051	47.3761	$3,234.22	.	$646.85
24152	Resect radius tumor		T	0051	47.3761	$3,234.22	.	$646.85
24155	Removal of elbow joint		T	0051	47.3761	$3,234.22	.	$646.85
24160	Remove elbow joint implant		T	0050	32.4253	$2,213.58	.	$442.72
24164	Remove radius head implant		T	0050	32.4253	$2,213.58	.	$442.72
24200	Removal of arm foreign body		T	0019	4.9184	$335.76	.	$67.16
24201	Removal of arm foreign body		T	0021	18.2223	$1,243.98	.	$248.80
24220	Injection for elbow x-ray		N					
24300	Manipulate elbow w/anesth		T	0045	15.5647	$1,062.56	$268.44	$212.52
24301	Muscle/tendon transfer		T	0050	32.4253	$2,213.58	.	$442.72
24305	Arm tendon lengthening		T	0050	32.4253	$2,213.58	.	$442.72
24310	Revision of arm tendon		T	0049	23.2249	$1,585.49	.	$317.10
24320	Repair of arm tendon		T	0051	47.3761	$3,234.22	.	$646.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24330	Revision of arm muscles		T	0052	88.5249	$6,043.33	.	$1,208.67
24331	Revision of arm muscles		T	0051	47.3761	$3,234.22	.	$646.85
24332	Tenolysis, triceps		T	0049	23.2249	$1,585.49	.	$317.10
24340	Repair of biceps tendon		T	0051	47.3761	$3,234.22	.	$646.85
24341	Repair arm tendon/muscle		T	0051	47.3761	$3,234.22	.	$646.85
24342	Repair of ruptured tendon		T	0051	47.3761	$3,234.22	.	$646.85
24343	Repr elbow lat ligmnt w/tiss		T	0050	32.4253	$2,213.58	.	$442.72
24344	Reconstruct elbow lat ligmnt		T	0052	88.5249	$6,043.33	.	$1,208.67
24345	Repr elbw med ligmnt w/tissu		T	0050	32.4253	$2,213.58	.	$442.72
24346	Reconstruct elbow med ligmnt	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
24357	Repair elbow, perc		T	0050	32.4253	$2,213.58	.	$442.72
24358	Repair elbow w/deb, open		T	0050	32.4253	$2,213.58	.	$442.72
24359	Repair elbow deb/attch open		T	0050	32.4253	$2,213.58	.	$442.72
24360	Reconstruct elbow joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
24361	Reconstruct elbow joint		T	0425	122.1766	$8,340.63	.	$1,668.13
24362	Reconstruct elbow joint		T	0048	60.2668	$4,114.23	.	$822.85
24363	Replace elbow joint		T	0425	122.1766	$8,340.63	.	$1,668.13
24365	Reconstruct head of radius		T	0047	39.0731	$2,667.40	$534.09	$533.48
24366	Reconstruct head of radius		T	0425	122.1766	$8,340.63	.	$1,668.13
24400	Revision of humerus	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
24410	Revision of humerus		T	0051	47.3761	$3,234.22	.	$646.85
24420	Revision of humerus		T	0051	47.3761	$3,234.22	.	$646.85
24430	Repair of humerus		T	0052	88.5249	$6,043.33	.	$1,208.67
24435	Repair humerus with graft		T	0052	88.5249	$6,043.33	.	$1,208.67
24470	Revision of elbow joint		T	0051	47.3761	$3,234.22	.	$646.85
24495	Decompression of forearm		T	0050	32.4253	$2,213.58	.	$442.72
24498	Reinforce humerus		T	0052	88.5249	$6,043.33	.	$1,208.67
24500	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
24505	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24515	Treat humerus fracture		T	0064	66.575	$4,544.88	.	$908.98
24516	Treat humerus fracture		T	0064	66.575	$4,544.88	.	$908.98
24530	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
24535	Treat humerus fracture		T	0138	5.2593	$359.04	.	$71.81
24538	Treat humerus fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
24545	Treat humerus fracture		T	0064	66.575	$4,544.88	.	$908.98
24546	Treat humerus fracture		T	0064	66.575	$4,544.88	.	$908.98
24560	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
24565	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
24566	Treat humerus fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
24575	Treat humerus fracture		T	0064	66.575	$4,544.88	.	$908.98
24576	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
24577	Treat humerus fracture		T	0138	5.2593	$359.04	.	$71.81
24579	Treat humerus fracture		T	0064	66.575	$4,544.88	.	$908.98
24582	Treat humerus fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
24586	Treat elbow fracture		T	0064	66.575	$4,544.88	.	$908.98
24587	Treat elbow fracture		T	0064	66.575	$4,544.88	.	$908.98
24600	Treat elbow dislocation		T	0129	1.6325	$111.45	.	$22.29
24605	Treat elbow dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
24615	Treat elbow dislocation		T	0064	66.575	$4,544.88	.	$908.98
24620	Treat elbow fracture		T	0139	20.9892	$1,432.87	.	$286.58
24635	Treat elbow fracture		T	0064	66.575	$4,544.88	.	$908.98
24640	Treat elbow dislocation		T	0129	1.6325	$111.45	.	$22.29
24650	Treat radius fracture		T	0129	1.6325	$111.45	.	$22.29
24655	Treat radius fracture		T	0138	5.2593	$359.04	.	$71.81
24665	Treat radius fracture		T	0063	48.0827	$3,282.46	.	$656.50
24666	Treat radius fracture		T	0064	66.575	$4,544.88	.	$908.98
24670	Treat ulnar fracture		T	0129	1.6325	$111.45	.	$22.29
24675	Treat ulnar fracture		T	0129	1.6325	$111.45	.	$22.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24685	Treat ulnar fracture		T	0063	48.0827	$3,282.46	.	$656.50
24800	Fusion of elbow joint		T	0051	47.3761	$3,234.22	.	$646.85
24802	Fusion/graft of elbow joint	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
24900	Amputation of upper arm		C					
24920	Amputation of upper arm		C					
24925	Amputation follow-up surgery		T	0049	23.2249	$1,585.49	.	$317.10
24930	Amputation follow-up surgery		C					
24931	Amputate upper arm & implant		C					
24935	Revision of amputation		T	0052	88.5249	$6,043.33	.	$1,208.67
24940	Revision of upper arm		C					
24999	Upper arm/elbow surgery		T	0129	1.6325	$111.45	.	$22.29
25000	Incision of tendon sheath		T	0049	23.2249	$1,585.49	.	$317.10
25001	Incise flexor carpi radialis		T	0049	23.2249	$1,585.49	.	$317.10
25020	Decompress forearm 1 space		T	0050	32.4253	$2,213.58	.	$442.72
25023	Decompress forearm 1 space		T	0050	32.4253	$2,213.58	.	$442.72
25024	Decompress forearm 2 spaces		T	0050	32.4253	$2,213.58	.	$442.72
25025	Decompress forearm 2 spaces		T	0050	32.4253	$2,213.58	.	$442.72
25028	Drainage of forearm lesion		T	0049	23.2249	$1,585.49	.	$317.10
25031	Drainage of forearm bursa		T	0049	23.2249	$1,585.49	.	$317.10
25035	Treat forearm bone lesion		T	0049	23.2249	$1,585.49	.	$317.10
25040	Explore/treat wrist joint		T	0050	32.4253	$2,213.58	.	$442.72
25065	Biopsy forearm soft tissues		T	0020	8.7772	$599.19	.	$119.84
25066	Biopsy forearm soft tissues		T	0022	24.1269	$1,647.07	$354.45	$329.42
25071	Exc forearm les sc > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
25073	Exc forearm tum deep = 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
25075	Exc forearm les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
25076	Exc forearm tum deep < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
25077	Resect forearm/wrist tum<3cm		T	0021	18.2223	$1,243.98	.	$248.80
25078	Resect forearm/wrist tum=3cm		T	0022	24.1269	$1,647.07	$354.45	$329.42

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25085	Incision of wrist capsule		T	0049	23.2249	$1,585.49	.	$317.10
25100	Biopsy of wrist joint		T	0049	23.2249	$1,585.49	.	$317.10
25101	Explore/treat wrist joint		T	0050	32.4253	$2,213.58	.	$442.72
25105	Remove wrist joint lining		T	0050	32.4253	$2,213.58	.	$442.72
25107	Remove wrist joint cartilage		T	0050	32.4253	$2,213.58	.	$442.72
25109	Excise tendon forearm/wrist		T	0049	23.2249	$1,585.49	.	$317.10
25110	Remove wrist tendon lesion		T	0049	23.2249	$1,585.49	.	$317.10
25111	Remove wrist tendon lesion		T	0049	23.2249	$1,585.49	.	$317.10
25112	Reremove wrist tendon lesion		T	0049	23.2249	$1,585.49	.	$317.10
25115	Remove wrist/forearm lesion		T	0049	23.2249	$1,585.49	.	$317.10
25116	Remove wrist/forearm lesion		T	0049	23.2249	$1,585.49	.	$317.10
25118	Excise wrist tendon sheath		T	0050	32.4253	$2,213.58	.	$442.72
25119	Partial removal of ulna		T	0050	32.4253	$2,213.58	.	$442.72
25120	Removal of forearm lesion		T	0050	32.4253	$2,213.58	.	$442.72
25125	Remove/graft forearm lesion		T	0050	32.4253	$2,213.58	.	$442.72
25126	Remove/graft forearm lesion		T	0050	32.4253	$2,213.58	.	$442.72
25130	Removal of wrist lesion		T	0050	32.4253	$2,213.58	.	$442.72
25135	Remove & graft wrist lesion		T	0050	32.4253	$2,213.58	.	$442.72
25136	Remove & graft wrist lesion		T	0050	32.4253	$2,213.58	.	$442.72
25145	Remove forearm bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
25150	Partial removal of ulna		T	0050	32.4253	$2,213.58	.	$442.72
25151	Partial removal of radius		T	0050	32.4253	$2,213.58	.	$442.72
25170	Resect radius/ulnar tumor		T	0051	47.3761	$3,234.22	.	$646.85
25210	Removal of wrist bone		T	0050	32.4253	$2,213.58	.	$442.72
25215	Removal of wrist bones		T	0050	32.4253	$2,213.58	.	$442.72
25230	Partial removal of radius		T	0050	32.4253	$2,213.58	.	$442.72
25240	Partial removal of ulna		T	0050	32.4253	$2,213.58	.	$442.72
25246	Injection for wrist x-ray		N					
25248	Remove forearm foreign body		T	0049	23.2249	$1,585.49	.	$317.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25250	Removal of wrist prosthesis		T	0050	32.4253	$2,213.58	.	$442.72
25251	Removal of wrist prosthesis		T	0050	32.4253	$2,213.58	.	$442.72
25259	Manipulate wrist w/anesthes		T	0139	20.9892	$1,432.87	.	$286.58
25260	Repair forearm tendon/muscle		T	0050	32.4253	$2,213.58	.	$442.72
25263	Repair forearm tendon/muscle		T	0050	32.4253	$2,213.58	.	$442.72
25265	Repair forearm tendon/muscle		T	0050	32.4253	$2,213.58	.	$442.72
25270	Repair forearm tendon/muscle		T	0050	32.4253	$2,213.58	.	$442.72
25272	Repair forearm tendon/muscle		T	0050	32.4253	$2,213.58	.	$442.72
25274	Repair forearm tendon/muscle		T	0050	32.4253	$2,213.58	.	$442.72
25275	Repair forearm tendon sheath		T	0050	32.4253	$2,213.58	.	$442.72
25280	Revise wrist/forearm tendon		T	0050	32.4253	$2,213.58	.	$442.72
25290	Incise wrist/forearm tendon		T	0050	32.4253	$2,213.58	.	$442.72
25295	Release wrist/forearm tendon		T	0049	23.2249	$1,585.49	.	$317.10
25300	Fusion of tendons at wrist		T	0050	32.4253	$2,213.58	.	$442.72
25301	Fusion of tendons at wrist		T	0050	32.4253	$2,213.58	.	$442.72
25310	Transplant forearm tendon		T	0051	47.3761	$3,234.22	.	$646.85
25312	Transplant forearm tendon		T	0051	47.3761	$3,234.22	.	$646.85
25315	Revise palsy hand tendon(s)		T	0051	47.3761	$3,234.22	.	$646.85
25316	Revise palsy hand tendon(s)		T	0052	88.5249	$6,043.33	.	$1,208.67
25320	Repair/revise wrist joint		T	0051	47.3761	$3,234.22	.	$646.85
25332	Revise wrist joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
25335	Realignment of hand		T	0051	47.3761	$3,234.22	.	$646.85
25337	Reconstruct ulna/radioulnar		T	0051	47.3761	$3,234.22	.	$646.85
25350	Revision of radius		T	0051	47.3761	$3,234.22	.	$646.85
25355	Revision of radius		T	0051	47.3761	$3,234.22	.	$646.85
25360	Revision of ulna		T	0051	47.3761	$3,234.22	.	$646.85
25365	Revise radius & ulna	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
25370	Revise radius or ulna		T	0051	47.3761	$3,234.22	.	$646.85
25375	Revise radius & ulna		T	0051	47.3761	$3,234.22	.	$646.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25390	Shorten radius or ulna		T	0051	47.3761	$3,234.22	.	$646.85
25391	Lengthen radius or ulna	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
25392	Shorten radius & ulna		T	0050	32.4253	$2,213.58	.	$442.72
25393	Lengthen radius & ulna		T	0051	47.3761	$3,234.22	.	$646.85
25394	Repair carpal bone, shorten		T	0051	47.3761	$3,234.22	.	$646.85
25400	Repair radius or ulna	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
25405	Repair/graft radius or ulna		T	0052	88.5249	$6,043.33	.	$1,208.67
25415	Repair radius & ulna		T	0052	88.5249	$6,043.33	.	$1,208.67
25420	Repair/graft radius & ulna		T	0052	88.5249	$6,043.33	.	$1,208.67
25425	Repair/graft radius or ulna	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
25426	Repair/graft radius & ulna		T	0051	47.3761	$3,234.22	.	$646.85
25430	Vasc graft into carpal bone		T	0051	47.3761	$3,234.22	.	$646.85
25431	Repair nonunion carpal bone		T	0051	47.3761	$3,234.22	.	$646.85
25440	Repair/graft wrist bone		T	0052	88.5249	$6,043.33	.	$1,208.67
25441	Reconstruct wrist joint		T	0425	122.1766	$8,340.63	.	$1,668.13
25442	Reconstruct wrist joint		T	0425	122.1766	$8,340.63	.	$1,668.13
25443	Reconstruct wrist joint		T	0048	60.2668	$4,114.23	.	$822.85
25444	Reconstruct wrist joint		T	0048	60.2668	$4,114.23	.	$822.85
25445	Reconstruct wrist joint		T	0048	60.2668	$4,114.23	.	$822.85
25446	Wrist replacement		T	0425	122.1766	$8,340.63	.	$1,668.13
25447	Repair wrist joint(s)		T	0047	39.0731	$2,667.40	$534.09	$533.48
25449	Remove wrist joint implant		T	0047	39.0731	$2,667.40	$534.09	$533.48
25450	Revision of wrist joint		T	0051	47.3761	$3,234.22	.	$646.85
25455	Revision of wrist joint		T	0051	47.3761	$3,234.22	.	$646.85
25490	Reinforce radius		T	0051	47.3761	$3,234.22	.	$646.85
25491	Reinforce ulna		T	0051	47.3761	$3,234.22	.	$646.85
25492	Reinforce radius and ulna		T	0051	47.3761	$3,234.22	.	$646.85
25500	Treat fracture of radius		T	0129	1.6325	$111.45	.	$22.29
25505	Treat fracture of radius		T	0138	5.2593	$359.04	.	$71.81

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25515	Treat fracture of radius		T	0063	48.0827	$3,282.46	.	$656.50
25520	Treat fracture of radius		T	0138	5.2593	$359.04	.	$71.81
25525	Treat fracture of radius		T	0063	48.0827	$3,282.46	.	$656.50
25526	Treat fracture of radius		T	0063	48.0827	$3,282.46	.	$656.50
25530	Treat fracture of ulna		T	0129	1.6325	$111.45	.	$22.29
25535	Treat fracture of ulna		T	0129	1.6325	$111.45	.	$22.29
25545	Treat fracture of ulna		T	0063	48.0827	$3,282.46	.	$656.50
25560	Treat fracture radius & ulna		T	0129	1.6325	$111.45	.	$22.29
25565	Treat fracture radius & ulna		T	0138	5.2593	$359.04	.	$71.81
25574	Treat fracture radius & ulna		T	0064	66.575	$4,544.88	.	$908.98
25575	Treat fracture radius/ulna		T	0064	66.575	$4,544.88	.	$908.98
25600	Treat fracture radius/ulna		T	0129	1.6325	$111.45	.	$22.29
25605	Treat fracture radius/ulna		T	0138	5.2593	$359.04	.	$71.81
25606	Treat fx distal radial		T	0062	26.6924	$1,822.21	$372.87	$364.45
25607	Treat fx rad extra-articul		T	0064	66.575	$4,544.88	.	$908.98
25608	Treat fx rad intra-articul		T	0064	66.575	$4,544.88	.	$908.98
25609	Treat fx radial 3+ frag		T	0064	66.575	$4,544.88	.	$908.98
25622	Treat wrist bone fracture		T	0129	1.6325	$111.45	.	$22.29
25624	Treat wrist bone fracture		T	0138	5.2593	$359.04	.	$71.81
25628	Treat wrist bone fracture		T	0063	48.0827	$3,282.46	.	$656.50
25630	Treat wrist bone fracture		T	0129	1.6325	$111.45	.	$22.29
25635	Treat wrist bone fracture		T	0138	5.2593	$359.04	.	$71.81
25645	Treat wrist bone fracture		T	0063	48.0827	$3,282.46	.	$656.50
25650	Treat wrist bone fracture		T	0129	1.6325	$111.45	.	$22.29
25651	Pin ulnar styloid fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
25652	Treat fracture ulnar styloid		T	0063	48.0827	$3,282.46	.	$656.50
25660	Treat wrist dislocation		T	0129	1.6325	$111.45	.	$22.29
25670	Treat wrist dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
25671	Pin radioulnar dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25675	Treat wrist dislocation		T	0129	1.6325	$111.45	.	$22.29
25676	Treat wrist dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
25680	Treat wrist fracture		T	0129	1.6325	$111.45	.	$22.29
25685	Treat wrist fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
25690	Treat wrist dislocation		T	0139	20.9892	$1,432.87	.	$286.58
25695	Treat wrist dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
25800	Fusion of wrist joint		T	0052	88.5249	$6,043.33	.	$1,208.67
25805	Fusion/graft of wrist joint	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
25810	Fusion/graft of wrist joint		T	0052	88.5249	$6,043.33	.	$1,208.67
25820	Fusion of hand bones		T	0051	47.3761	$3,234.22	.	$646.85
25825	Fuse hand bones with graft		T	0052	88.5249	$6,043.33	.	$1,208.67
25830	Fusion, radioulnar jnt/ulna		T	0052	88.5249	$6,043.33	.	$1,208.67
25900	Amputation of forearm		C					
25905	Amputation of forearm		C					
25907	Amputation follow-up surgery		T	0049	23.2249	$1,585.49	.	$317.10
25909	Amputation follow-up surgery	CH	T	0049	23.2249	$1,585.49	.	$317.10
25915	Amputation of forearm		C					
25920	Amputate hand at wrist		C					
25922	Amputate hand at wrist		T	0049	23.2249	$1,585.49	.	$317.10
25924	Amputation follow-up surgery		C					
25927	Amputation of hand		C					
25929	Amputation follow-up surgery		T	0136	17.1353	$1,169.78	.	$233.96
25931	Amputation follow-up surgery		T	0049	23.2249	$1,585.49	.	$317.10
25999	Forearm or wrist surgery		T	0129	1.6325	$111.45	.	$22.29
26010	Drainage of finger abscess		T	0006	1.4939	$101.98	.	$20.40
26011	Drainage of finger abscess		T	0007	13.3268	$909.78	.	$181.96
26020	Drain hand tendon sheath		T	0053	17.3655	$1,185.49	$253.49	$237.10
26025	Drainage of palm bursa		T	0053	17.3655	$1,185.49	$253.49	$237.10
26030	Drainage of palm bursa(s)		T	0053	17.3655	$1,185.49	$253.49	$237.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26034	Treat hand bone lesion		T	0053	17.3655	$1,185.49	$253.49	$237.10
26035	Decompress fingers/hand		T	0053	17.3655	$1,185.49	$253.49	$237.10
26037	Decompress fingers/hand		T	0053	17.3655	$1,185.49	$253.49	$237.10
26040	Release palm contracture	CH	T	0053	17.3655	$1,185.49	$253.49	$237.10
26045	Release palm contracture		T	0054	29.8184	$2,035.61	.	$407.13
26055	Incise finger tendon sheath		T	0053	17.3655	$1,185.49	$253.49	$237.10
26060	Incision of finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26070	Explore/treat hand joint		T	0053	17.3655	$1,185.49	$253.49	$237.10
26075	Explore/treat finger joint		T	0053	17.3655	$1,185.49	$253.49	$237.10
26080	Explore/treat finger joint		T	0053	17.3655	$1,185.49	$253.49	$237.10
26100	Biopsy hand joint lining		T	0053	17.3655	$1,185.49	$253.49	$237.10
26105	Biopsy finger joint lining		T	0053	17.3655	$1,185.49	$253.49	$237.10
26110	Biopsy finger joint lining		T	0053	17.3655	$1,185.49	$253.49	$237.10
26111	Exc hand les sc > 1.5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
26113	Exc hand tum deep > 1.5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
26115	Exc hand les sc < 1.5 cm		T	0021	18.2223	$1,243.98	.	$248.80
26116	Exc hand tum deep < 1.5 cm		T	0021	18.2223	$1,243.98	.	$248.80
26117	Exc hand tum ra < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
26118	Exc hand tum ra > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
26121	Release palm contracture		T	0054	29.8184	$2,035.61	.	$407.13
26123	Release palm contracture		T	0054	29.8184	$2,035.61	.	$407.13
26125	Release palm contracture		T	0053	17.3655	$1,185.49	$253.49	$237.10
26130	Remove wrist joint lining		T	0053	17.3655	$1,185.49	$253.49	$237.10
26135	Revise finger joint, each		T	0054	29.8184	$2,035.61	.	$407.13
26140	Revise finger joint, each		T	0053	17.3655	$1,185.49	$253.49	$237.10
26145	Tendon excision, palm/finger		T	0053	17.3655	$1,185.49	$253.49	$237.10
26160	Remove tendon sheath lesion		T	0053	17.3655	$1,185.49	$253.49	$237.10
26170	Removal of palm tendon, each		T	0053	17.3655	$1,185.49	$253.49	$237.10
26180	Removal of finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26185	Remove finger bone		T	0053	17.3655	$1,185.49	$253.49	$237.10
26200	Remove hand bone lesion		T	0053	17.3655	$1,185.49	$253.49	$237.10
26205	Remove/graft bone lesion		T	0054	29.8184	$2,035.61	.	$407.13
26210	Removal of finger lesion		T	0053	17.3655	$1,185.49	$253.49	$237.10
26215	Remove/graft finger lesion		T	0053	17.3655	$1,185.49	$253.49	$237.10
26230	Partial removal of hand bone		T	0053	17.3655	$1,185.49	$253.49	$237.10
26235	Partial removal, finger bone		T	0053	17.3655	$1,185.49	$253.49	$237.10
26236	Partial removal, finger bone		T	0053	17.3655	$1,185.49	$253.49	$237.10
26250	Extensive hand surgery		T	0053	17.3655	$1,185.49	$253.49	$237.10
26260	Resect prox finger tumor		T	0053	17.3655	$1,185.49	$253.49	$237.10
26262	Resect distal finger tumor		T	0053	17.3655	$1,185.49	$253.49	$237.10
26320	Removal of implant from hand		T	0021	18.2223	$1,243.98	.	$248.80
26340	Manipulate finger w/anesth		T	0138	5.2593	$359.04	.	$71.81
26350	Repair finger/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26352	Repair/graft hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26356	Repair finger/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26357	Repair finger/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26358	Repair/graft hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26370	Repair finger/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26372	Repair/graft hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26373	Repair finger/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26390	Revise hand/finger tendon		T	0054	29.8184	$2,035.61	.	$407.13
26392	Repair/graft hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26410	Repair hand tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26412	Repair/graft hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26415	Excision, hand/finger tendon		T	0054	29.8184	$2,035.61	.	$407.13
26416	Graft hand or finger tendon		T	0054	29.8184	$2,035.61	.	$407.13
26418	Repair finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26420	Repair/graft finger tendon		T	0054	29.8184	$2,035.61	.	$407.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26426	Repair finger/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26428	Repair/graft finger tendon		T	0054	29.8184	$2,035.61	.	$407.13
26432	Repair finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26433	Repair finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26434	Repair/graft finger tendon		T	0054	29.8184	$2,035.61	.	$407.13
26437	Realignment of tendons		T	0053	17.3655	$1,185.49	$253.49	$237.10
26440	Release palm/finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26442	Release palm & finger tendon		T	0054	29.8184	$2,035.61	.	$407.13
26445	Release hand/finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26449	Release forearm/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26450	Incision of palm tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26455	Incision of finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26460	Incise hand/finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26471	Fusion of finger tendons		T	0053	17.3655	$1,185.49	$253.49	$237.10
26474	Fusion of finger tendons		T	0053	17.3655	$1,185.49	$253.49	$237.10
26476	Tendon lengthening		T	0053	17.3655	$1,185.49	$253.49	$237.10
26477	Tendon shortening		T	0053	17.3655	$1,185.49	$253.49	$237.10
26478	Lengthening of hand tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26479	Shortening of hand tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26480	Transplant hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26483	Transplant/graft hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26485	Transplant palm tendon		T	0054	29.8184	$2,035.61	.	$407.13
26489	Transplant/graft palm tendon		T	0054	29.8184	$2,035.61	.	$407.13
26490	Revise thumb tendon		T	0054	29.8184	$2,035.61	.	$407.13
26492	Tendon transfer with graft		T	0054	29.8184	$2,035.61	.	$407.13
26494	Hand tendon/muscle transfer		T	0054	29.8184	$2,035.61	.	$407.13
26496	Revise thumb tendon		T	0054	29.8184	$2,035.61	.	$407.13
26497	Finger tendon transfer		T	0054	29.8184	$2,035.61	.	$407.13
26498	Finger tendon transfer		T	0054	29.8184	$2,035.61	.	$407.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26499	Revision of finger		T	0054	29.8184	$2,035.61	.	$407.13
26500	Hand tendon reconstruction		T	0053	17.3655	$1,185.49	$253.49	$237.10
26502	Hand tendon reconstruction		T	0054	29.8184	$2,035.61	.	$407.13
26508	Release thumb contracture		T	0053	17.3655	$1,185.49	$253.49	$237.10
26510	Thumb tendon transfer		T	0054	29.8184	$2,035.61	.	$407.13
26516	Fusion of knuckle joint		T	0054	29.8184	$2,035.61	.	$407.13
26517	Fusion of knuckle joints		T	0054	29.8184	$2,035.61	.	$407.13
26518	Fusion of knuckle joints		T	0054	29.8184	$2,035.61	.	$407.13
26520	Release knuckle contracture		T	0053	17.3655	$1,185.49	$253.49	$237.10
26525	Release finger contracture		T	0053	17.3655	$1,185.49	$253.49	$237.10
26530	Revise knuckle joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
26531	Revise knuckle with implant		T	0048	60.2668	$4,114.23	.	$822.85
26535	Revise finger joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
26536	Revise/implant finger joint		T	0048	60.2668	$4,114.23	.	$822.85
26540	Repair hand joint		T	0053	17.3655	$1,185.49	$253.49	$237.10
26541	Repair hand joint with graft		T	0054	29.8184	$2,035.61	.	$407.13
26542	Repair hand joint with graft		T	0053	17.3655	$1,185.49	$253.49	$237.10
26545	Reconstruct finger joint		T	0054	29.8184	$2,035.61	.	$407.13
26546	Repair nonunion hand		T	0054	29.8184	$2,035.61	.	$407.13
26548	Reconstruct finger joint		T	0054	29.8184	$2,035.61	.	$407.13
26550	Construct thumb replacement		T	0054	29.8184	$2,035.61	.	$407.13
26551	Great toe-hand transfer		C					
26553	Single transfer, toe-hand		C					
26554	Double transfer, toe-hand		C					
26555	Positional change of finger		T	0054	29.8184	$2,035.61	.	$407.13
26556	Toe joint transfer		C					
26560	Repair of web finger		T	0053	17.3655	$1,185.49	$253.49	$237.10
26561	Repair of web finger		T	0054	29.8184	$2,035.61	.	$407.13
26562	Repair of web finger		T	0054	29.8184	$2,035.61	.	$407.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26565	Correct metacarpal flaw		T	0054	29.8184	$2,035.61	.	$407.13
26567	Correct finger deformity		T	0054	29.8184	$2,035.61	.	$407.13
26568	Lengthen metacarpal/finger		T	0054	29.8184	$2,035.61	.	$407.13
26580	Repair hand deformity		T	0053	17.3655	$1,185.49	$253.49	$237.10
26587	Reconstruct extra finger		T	0053	17.3655	$1,185.49	$253.49	$237.10
26590	Repair finger deformity		T	0053	17.3655	$1,185.49	$253.49	$237.10
26591	Repair muscles of hand		T	0054	29.8184	$2,035.61	.	$407.13
26593	Release muscles of hand		T	0053	17.3655	$1,185.49	$253.49	$237.10
26596	Excision constricting tissue		T	0053	17.3655	$1,185.49	$253.49	$237.10
26600	Treat metacarpal fracture		T	0129	1.6325	$111.45	.	$22.29
26605	Treat metacarpal fracture		T	0129	1.6325	$111.45	.	$22.29
26607	Treat metacarpal fracture		T	0139	20.9892	$1,432.87	.	$286.58
26608	Treat metacarpal fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
26615	Treat metacarpal fracture		T	0063	48.0827	$3,282.46	.	$656.50
26641	Treat thumb dislocation		T	0129	1.6325	$111.45	.	$22.29
26645	Treat thumb fracture		T	0138	5.2593	$359.04	.	$71.81
26650	Treat thumb fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
26665	Treat thumb fracture		T	0063	48.0827	$3,282.46	.	$656.50
26670	Treat hand dislocation		T	0129	1.6325	$111.45	.	$22.29
26675	Treat hand dislocation		T	0138	5.2593	$359.04	.	$71.81
26676	Pin hand dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
26685	Treat hand dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
26686	Treat hand dislocation		T	0064	66.575	$4,544.88	.	$908.98
26700	Treat knuckle dislocation		T	0129	1.6325	$111.45	.	$22.29
26705	Treat knuckle dislocation		T	0129	1.6325	$111.45	.	$22.29
26706	Pin knuckle dislocation		T	0139	20.9892	$1,432.87	.	$286.58
26715	Treat knuckle dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
26720	Treat finger fracture, each		T	0129	1.6325	$111.45	.	$22.29
26725	Treat finger fracture, each		T	0129	1.6325	$111.45	.	$22.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26727	Treat finger fracture, each		T	0062	26.6924	$1,822.21	$372.87	$364.45
26735	Treat finger fracture, each		T	0062	26.6924	$1,822.21	$372.87	$364.45
26740	Treat finger fracture, each		T	0129	1.6325	$111.45	.	$22.29
26742	Treat finger fracture, each		T	0129	1.6325	$111.45	.	$22.29
26746	Treat finger fracture, each		T	0062	26.6924	$1,822.21	$372.87	$364.45
26750	Treat finger fracture, each		T	0129	1.6325	$111.45	.	$22.29
26755	Treat finger fracture, each		T	0129	1.6325	$111.45	.	$22.29
26756	Pin finger fracture, each		T	0062	26.6924	$1,822.21	$372.87	$364.45
26765	Treat finger fracture, each		T	0062	26.6924	$1,822.21	$372.87	$364.45
26770	Treat finger dislocation		T	0129	1.6325	$111.45	.	$22.29
26775	Treat finger dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
26776	Pin finger dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
26785	Treat finger dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
26820	Thumb fusion with graft		T	0054	29.8184	$2,035.61	.	$407.13
26841	Fusion of thumb		T	0054	29.8184	$2,035.61	.	$407.13
26842	Thumb fusion with graft		T	0054	29.8184	$2,035.61	.	$407.13
26843	Fusion of hand joint		T	0054	29.8184	$2,035.61	.	$407.13
26844	Fusion/graft of hand joint		T	0054	29.8184	$2,035.61	.	$407.13
26850	Fusion of knuckle		T	0054	29.8184	$2,035.61	.	$407.13
26852	Fusion of knuckle with graft		T	0054	29.8184	$2,035.61	.	$407.13
26860	Fusion of finger joint		T	0054	29.8184	$2,035.61	.	$407.13
26861	Fusion of finger jnt, add-on		T	0054	29.8184	$2,035.61	.	$407.13
26862	Fusion/graft of finger joint		T	0054	29.8184	$2,035.61	.	$407.13
26863	Fuse/graft added joint		T	0054	29.8184	$2,035.61	.	$407.13
26910	Amputate metacarpal bone		T	0054	29.8184	$2,035.61	.	$407.13
26951	Amputation of finger/thumb		T	0053	17.3655	$1,185.49	$253.49	$237.10
26952	Amputation of finger/thumb		T	0053	17.3655	$1,185.49	$253.49	$237.10
26989	Hand/finger surgery		T	0129	1.6325	$111.45	.	$22.29
26990	Drainage of pelvis lesion		T	0049	23.2249	$1,585.49	.	$317.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26991	Drainage of pelvis bursa		T	0049	23.2249	$1,585.49	.	$317.10
26992	Drainage of bone lesion		C					
27000	Incision of hip tendon		T	0049	23.2249	$1,585.49	.	$317.10
27001	Incision of hip tendon		T	0050	32.4253	$2,213.58	.	$442.72
27003	Incision of hip tendon		T	0050	32.4253	$2,213.58	.	$442.72
27005	Incision of hip tendon		C					
27006	Incision of hip tendons		T	0050	32.4253	$2,213.58	.	$442.72
27025	Incision of hip/thigh fascia		C					
27027	Buttock fasciotomy		T	0049	23.2249	$1,585.49	.	$317.10
27030	Drainage of hip joint		C					
27033	Exploration of hip joint		T	0051	47.3761	$3,234.22	.	$646.85
27035	Denervation of hip joint		T	0051	47.3761	$3,234.22	.	$646.85
27036	Excision of hip joint/muscle		C					
27040	Biopsy of soft tissues		T	0020	8.7772	$599.19	.	$119.84
27041	Biopsy of soft tissues		T	0020	8.7772	$599.19	.	$119.84
27043	Exc hip pelvis les sc > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27045	Exc hip/pelv tum deep > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27047	Exc hip/pelvis les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
27048	Exc hip/pelv tum deep < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
27049	Resect hip/pelv tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
27050	Biopsy of sacroiliac joint		T	0049	23.2249	$1,585.49	.	$317.10
27052	Biopsy of hip joint		T	0049	23.2249	$1,585.49	.	$317.10
27054	Removal of hip joint lining		C					
27057	Buttock fasciotomy w/dbrdmt		T	0049	23.2249	$1,585.49	.	$317.10
27059	Resect hip/pelv tum > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27060	Removal of ischial bursa		T	0049	23.2249	$1,585.49	.	$317.10
27062	Remove femur lesion/bursa		T	0049	23.2249	$1,585.49	.	$317.10
27065	Removal of hip bone lesion		T	0049	23.2249	$1,585.49	.	$317.10
27066	Removal of hip bone lesion		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27067	Remove/graft hip bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
27070	Partial removal of hip bone		C					
27071	Partial removal of hip bone		C					
27075	Resect hip tumor		C					
27076	Resect hip tum incl acetabul		C					
27077	Resect hip tum w/innom bone		C					
27078	Rsect hip tum incl femur		C					
27080	Removal of tail bone		T	0050	32.4253	$2,213.58	.	$442.72
27086	Remove hip foreign body		T	0020	8.7772	$599.19	.	$119.84
27087	Remove hip foreign body		T	0049	23.2249	$1,585.49	.	$317.10
27090	Removal of hip prosthesis		C					
27091	Removal of hip prosthesis		C					
27093	Injection for hip x-ray		N					
27095	Injection for hip x-ray		N					
27096	Inject sacroiliac joint		B					
27097	Revision of hip tendon		T	0050	32.4253	$2,213.58	.	$442.72
27098	Transfer tendon to pelvis		T	0050	32.4253	$2,213.58	.	$442.72
27100	Transfer of abdominal muscle		T	0051	47.3761	$3,234.22	.	$646.85
27105	Transfer of spinal muscle		T	0051	47.3761	$3,234.22	.	$646.85
27110	Transfer of iliopsoas muscle		T	0051	47.3761	$3,234.22	.	$646.85
27111	Transfer of iliopsoas muscle		T	0051	47.3761	$3,234.22	.	$646.85
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		T	0052	88.5249	$6,043.33	.	$1,208.67
27181	Treat slipped epiphysis		C					
27185	Revision of femur epiphysis		C					
27187	Reinforce hip bones		C					
27193	Treat pelvic ring fracture		T	0129	1.6325	$111.45	.	$22.29
27194	Treat pelvic ring fracture		T	0045	15.5647	$1,062.56	$268.44	$212.52
27200	Treat tail bone fracture		T	0129	1.6325	$111.45	.	$22.29
27202	Treat tail bone fracture		T	0063	48.0827	$3,282.46	.	$656.50
27215	Treat pelvic fracture(s)		E					
27216	Treat pelvic ring fracture		E					
27217	Treat pelvic ring fracture		E					
27218	Treat pelvic ring fracture		E					
27220	Treat hip socket fracture		T	0129	1.6325	$111.45	.	$22.29
27222	Treat hip socket fracture		C					
27226	Treat hip wall fracture		C					
27227	Treat hip fracture(s)		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27228	Treat hip fracture(s)		C					
27230	Treat thigh fracture		T	0129	1.6325	$111.45	.	$22.29
27232	Treat thigh fracture		C					
27235	Treat thigh fracture		T	0050	32.4253	$2,213.58	.	$442.72
27236	Treat thigh fracture		C					
27238	Treat thigh fracture		T	0138	5.2593	$359.04	.	$71.81
27240	Treat thigh fracture		C					
27244	Treat thigh fracture		C					
27245	Treat thigh fracture		C					
27246	Treat thigh fracture		T	0138	5.2593	$359.04	.	$71.81
27248	Treat thigh fracture		C					
27250	Treat hip dislocation		T	0129	1.6325	$111.45	.	$22.29
27252	Treat hip dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
27253	Treat hip dislocation		C					
27254	Treat hip dislocation		C					
27256	Treat hip dislocation		T	0129	1.6325	$111.45	.	$22.29
27257	Treat hip dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
27258	Treat hip dislocation		C					
27259	Treat hip dislocation		C					
27265	Treat hip dislocation		T	0129	1.6325	$111.45	.	$22.29
27266	Treat hip dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
27267	Cltx thigh fx		T	0129	1.6325	$111.45	.	$22.29
27268	Cltx thigh fx w/mnpj		C					
27269	Optx thigh fx		C					
27275	Manipulation of hip joint		T	0045	15.5647	$1,062.56	$268.44	$212.52
27280	Fusion of sacroiliac joint		C					
27282	Fusion of pubic bones		C					
27284	Fusion of hip joint		C					
27286	Fusion of hip joint		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27290	Amputation of leg at hip		C					
27295	Amputation of leg at hip		C					
27299	Pelvis/hip joint surgery		T	0129	1.6325	$111.45	.	$22.29
27301	Drain thigh/knee lesion		T	0008	20.2481	$1,382.28	.	$276.46
27303	Drainage of bone lesion		C					
27305	Incise thigh tendon & fascia		T	0049	23.2249	$1,585.49	.	$317.10
27306	Incision of thigh tendon		T	0049	23.2249	$1,585.49	.	$317.10
27307	Incision of thigh tendons		T	0049	23.2249	$1,585.49	.	$317.10
27310	Exploration of knee joint		T	0050	32.4253	$2,213.58	.	$442.72
27323	Biopsy, thigh soft tissues		T	0020	8.7772	$599.19	.	$119.84
27324	Biopsy, thigh soft tissues		T	0022	24.1269	$1,647.07	$354.45	$329.42
27325	Neurectomy, hamstring		T	0220	19.3535	$1,321.21	.	$264.25
27326	Neurectomy, popliteal		T	0220	19.3535	$1,321.21	.	$264.25
27327	Exc thigh/knee les sc < 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27328	Exc thigh/knee tum deep <5cm		T	0021	18.2223	$1,243.98	.	$248.80
27329	Resect thigh/knee tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
27330	Biopsy, knee joint lining		T	0050	32.4253	$2,213.58	.	$442.72
27331	Explore/treat knee joint		T	0050	32.4253	$2,213.58	.	$442.72
27332	Removal of knee cartilage		T	0050	32.4253	$2,213.58	.	$442.72
27333	Removal of knee cartilage		T	0050	32.4253	$2,213.58	.	$442.72
27334	Remove knee joint lining		T	0050	32.4253	$2,213.58	.	$442.72
27335	Remove knee joint lining		T	0050	32.4253	$2,213.58	.	$442.72
27337	Exc thigh/knee les sc > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27339	Exc thigh/knee tum deep >5cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27340	Removal of kneecap bursa		T	0049	23.2249	$1,585.49	.	$317.10
27345	Removal of knee cyst		T	0049	23.2249	$1,585.49	.	$317.10
27347	Remove knee cyst		T	0049	23.2249	$1,585.49	.	$317.10
27350	Removal of kneecap		T	0050	32.4253	$2,213.58	.	$442.72
27355	Remove femur lesion		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27356	Remove femur lesion/graft		T	0050	32.4253	$2,213.58	.	$442.72
27357	Remove femur lesion/graft		T	0050	32.4253	$2,213.58	.	$442.72
27358	Remove femur lesion/fixation		T	0050	32.4253	$2,213.58	.	$442.72
27360	Partial removal, leg bone(s)		T	0050	32.4253	$2,213.58	.	$442.72
27364	Resect thigh/knee tum >5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27365	Resect femur/knee tumor		C					
27370	Injection for knee x-ray		N					
27372	Removal of foreign body		T	0022	24.1269	$1,647.07	$354.45	$329.42
27380	Repair of kneecap tendon		T	0049	23.2249	$1,585.49	.	$317.10
27381	Repair/graft kneecap tendon		T	0049	23.2249	$1,585.49	.	$317.10
27385	Repair of thigh muscle		T	0049	23.2249	$1,585.49	.	$317.10
27386	Repair/graft of thigh muscle		T	0049	23.2249	$1,585.49	.	$317.10
27390	Incision of thigh tendon		T	0049	23.2249	$1,585.49	.	$317.10
27391	Incision of thigh tendons		T	0049	23.2249	$1,585.49	.	$317.10
27392	Incision of thigh tendons		T	0049	23.2249	$1,585.49	.	$317.10
27393	Lengthening of thigh tendon		T	0050	32.4253	$2,213.58	.	$442.72
27394	Lengthening of thigh tendons		T	0050	32.4253	$2,213.58	.	$442.72
27395	Lengthening of thigh tendons		T	0051	47.3761	$3,234.22	.	$646.85
27396	Transplant of thigh tendon		T	0050	32.4253	$2,213.58	.	$442.72
27397	Transplants of thigh tendons		T	0051	47.3761	$3,234.22	.	$646.85
27400	Revise thigh muscles/tendons		T	0051	47.3761	$3,234.22	.	$646.85
27403	Repair of knee cartilage		T	0050	32.4253	$2,213.58	.	$442.72
27405	Repair of knee ligament		T	0051	47.3761	$3,234.22	.	$646.85
27407	Repair of knee ligament		T	0052	88.5249	$6,043.33	.	$1,208.67
27409	Repair of knee ligaments	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
27412	Autochondrocyte implant knee		T	0052	88.5249	$6,043.33	.	$1,208.67
27415	Osteochondral knee allograft		T	0052	88.5249	$6,043.33	.	$1,208.67
27416	Osteochondral knee autograft		T	0051	47.3761	$3,234.22	.	$646.85
27418	Repair degenerated kneecap		T	0051	47.3761	$3,234.22	.	$646.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27420	Revision of unstable kneecap		T	0051	47.3761	$3,234.22	.	$646.85
27422	Revision of unstable kneecap		T	0051	47.3761	$3,234.22	.	$646.85
27424	Revision/removal of kneecap		T	0051	47.3761	$3,234.22	.	$646.85
27425	Lat retinacular release open		T	0050	32.4253	$2,213.58	.	$442.72
27427	Reconstruction, knee	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
27428	Reconstruction, knee		T	0052	88.5249	$6,043.33	.	$1,208.67
27429	Reconstruction, knee		T	0052	88.5249	$6,043.33	.	$1,208.67
27430	Revision of thigh muscles		T	0051	47.3761	$3,234.22	.	$646.85
27435	Incision of knee joint		T	0051	47.3761	$3,234.22	.	$646.85
27437	Revise kneecap		T	0047	39.0731	$2,667.40	$534.09	$533.48
27438	Revise kneecap with implant		T	0048	60.2668	$4,114.23	.	$822.85
27440	Revision of knee joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
27441	Revision of knee joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
27442	Revision of knee joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
27443	Revision of knee joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
27445	Revision of knee joint		C					
27446	Revision of knee joint		T	0425	122.1766	$8,340.63	.	$1,668.13
27447	Total knee arthroplasty		C					
27448	Incision of thigh		C					
27450	Incision of thigh		C					
27454	Realignment of thigh bone		C					
27455	Realignment of knee		C					
27457	Realignment of knee		C					
27465	Shortening of thigh bone		C					
27466	Lengthening of thigh bone		C					
27468	Shorten/lengthen thighs		C					
27470	Repair of thigh		C					
27472	Repair/graft of thigh		C					
27475	Surgery to stop leg growth		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27477	Surgery to stop leg growth		C					
27479	Surgery to stop leg growth		T	0050	32.4253	$2,213.58	.	$442.72
27485	Surgery to stop leg growth		C					
27486	Revise/replace knee joint		C					
27487	Revise/replace knee joint		C					
27488	Removal of knee prosthesis		C					
27495	Reinforce thigh		C					
27496	Decompression of thigh/knee		T	0050	32.4253	$2,213.58	.	$442.72
27497	Decompression of thigh/knee		T	0049	23.2249	$1,585.49	.	$317.10
27498	Decompression of thigh/knee		T	0050	32.4253	$2,213.58	.	$442.72
27499	Decompression of thigh/knee		T	0050	32.4253	$2,213.58	.	$442.72
27500	Treatment of thigh fracture		T	0138	5.2593	$359.04	.	$71.81
27501	Treatment of thigh fracture		T	0129	1.6325	$111.45	.	$22.29
27502	Treatment of thigh fracture		T	0139	20.9892	$1,432.87	.	$286.58
27503	Treatment of thigh fracture		T	0129	1.6325	$111.45	.	$22.29
27506	Treatment of thigh fracture		C					
27507	Treatment of thigh fracture		C					
27508	Treatment of thigh fracture		T	0129	1.6325	$111.45	.	$22.29
27509	Treatment of thigh fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
27510	Treatment of thigh fracture		T	0138	5.2593	$359.04	.	$71.81
27511	Treatment of thigh fracture		C					
27513	Treatment of thigh fracture		C					
27514	Treatment of thigh fracture		C					
27516	Treat thigh fx growth plate		T	0129	1.6325	$111.45	.	$22.29
27517	Treat thigh fx growth plate		T	0129	1.6325	$111.45	.	$22.29
27519	Treat thigh fx growth plate		C					
27520	Treat kneecap fracture		T	0129	1.6325	$111.45	.	$22.29
27524	Treat kneecap fracture		T	0063	48.0827	$3,282.46	.	$656.50
27530	Treat knee fracture		T	0129	1.6325	$111.45	.	$22.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27532	Treat knee fracture		T	0139	20.9892	$1,432.87	.	$286.58
27535	Treat knee fracture		C					
27536	Treat knee fracture		C					
27538	Treat knee fracture(s)		T	0129	1.6325	$111.45	.	$22.29
27540	Treat knee fracture		C					
27550	Treat knee dislocation		T	0129	1.6325	$111.45	.	$22.29
27552	Treat knee dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
27556	Treat knee dislocation		C					
27557	Treat knee dislocation		C					
27558	Treat knee dislocation		C					
27560	Treat kneecap dislocation		T	0129	1.6325	$111.45	.	$22.29
27562	Treat kneecap dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
27566	Treat kneecap dislocation		T	0063	48.0827	$3,282.46	.	$656.50
27570	Fixation of knee joint		T	0045	15.5647	$1,062.56	$268.44	$212.52
27580	Fusion of knee		C					
27590	Amputate leg at thigh		C					
27591	Amputate leg at thigh		C					
27592	Amputate leg at thigh		C					
27594	Amputation follow-up surgery		T	0049	23.2249	$1,585.49	.	$317.10
27596	Amputation follow-up surgery		C					
27598	Amputate lower leg at knee		C					
27599	Leg surgery procedure		T	0129	1.6325	$111.45	.	$22.29
27600	Decompression of lower leg		T	0049	23.2249	$1,585.49	.	$317.10
27601	Decompression of lower leg		T	0049	23.2249	$1,585.49	.	$317.10
27602	Decompression of lower leg		T	0049	23.2249	$1,585.49	.	$317.10
27603	Drain lower leg lesion		T	0008	20.2481	$1,382.28	.	$276.46
27604	Drain lower leg bursa		T	0049	23.2249	$1,585.49	.	$317.10
27605	Incision of achilles tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
27606	Incision of achilles tendon		T	0049	23.2249	$1,585.49	.	$317.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27607	Treat lower leg bone lesion		T	0049	23.2249	$1,585.49	.	$317.10
27610	Explore/treat ankle joint		T	0050	32.4253	$2,213.58	.	$442.72
27612	Exploration of ankle joint		T	0050	32.4253	$2,213.58	.	$442.72
27613	Biopsy lower leg soft tissue		T	0020	8.7772	$599.19	.	$119.84
27614	Biopsy lower leg soft tissue		T	0022	24.1269	$1,647.07	$354.45	$329.42
27615	Resect leg/ankle tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
27616	Resect leg/ankle tum > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27618	Exc leg/ankle tum < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
27619	Exc leg/ankle tum deep <5 cm		T	0021	18.2223	$1,243.98	.	$248.80
27620	Explore/treat ankle joint		T	0050	32.4253	$2,213.58	.	$442.72
27625	Remove ankle joint lining		T	0050	32.4253	$2,213.58	.	$442.72
27626	Remove ankle joint lining		T	0050	32.4253	$2,213.58	.	$442.72
27630	Removal of tendon lesion		T	0049	23.2249	$1,585.49	.	$317.10
27632	Exc leg/ankle les sc > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27634	Exc leg/ankle tum deep >5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27635	Remove lower leg bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
27637	Remove/graft leg bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
27638	Remove/graft leg bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
27640	Partial removal of tibia		T	0051	47.3761	$3,234.22	.	$646.85
27641	Partial removal of fibula		T	0050	32.4253	$2,213.58	.	$442.72
27645	Resect tibia tumor		C					
27646	Resect fibula tumor		C					
27647	Resect talus/calcaneus tum		T	0051	47.3761	$3,234.22	.	$646.85
27648	Injection for ankle x-ray		N					
27650	Repair achilles tendon		T	0051	47.3761	$3,234.22	.	$646.85
27652	Repair/graft achilles tendon		T	0052	88.5249	$6,043.33	.	$1,208.67
27654	Repair of achilles tendon		T	0051	47.3761	$3,234.22	.	$646.85
27656	Repair leg fascia defect		T	0049	23.2249	$1,585.49	.	$317.10
27658	Repair of leg tendon, each		T	0049	23.2249	$1,585.49	.	$317.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27659	Repair of leg tendon, each		T	0049	23.2249	$1,585.49	.	$317.10
27664	Repair of leg tendon, each		T	0050	32.4253	$2,213.58	.	$442.72
27665	Repair of leg tendon, each		T	0050	32.4253	$2,213.58	.	$442.72
27675	Repair lower leg tendons		T	0049	23.2249	$1,585.49	.	$317.10
27676	Repair lower leg tendons		T	0050	32.4253	$2,213.58	.	$442.72
27680	Release of lower leg tendon		T	0050	32.4253	$2,213.58	.	$442.72
27681	Release of lower leg tendons		T	0050	32.4253	$2,213.58	.	$442.72
27685	Revision of lower leg tendon		T	0050	32.4253	$2,213.58	.	$442.72
27686	Revise lower leg tendons		T	0050	32.4253	$2,213.58	.	$442.72
27687	Revision of calf tendon		T	0050	32.4253	$2,213.58	.	$442.72
27690	Revise lower leg tendon		T	0051	47.3761	$3,234.22	.	$646.85
27691	Revise lower leg tendon		T	0051	47.3761	$3,234.22	.	$646.85
27692	Revise additional leg tendon		T	0051	47.3761	$3,234.22	.	$646.85
27695	Repair of ankle ligament		T	0050	32.4253	$2,213.58	.	$442.72
27696	Repair of ankle ligaments		T	0050	32.4253	$2,213.58	.	$442.72
27698	Repair of ankle ligament		T	0050	32.4253	$2,213.58	.	$442.72
27700	Revision of ankle joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
27702	Reconstruct ankle joint		C					
27703	Reconstruction, ankle joint		C					
27704	Removal of ankle implant		T	0049	23.2249	$1,585.49	.	$317.10
27705	Incision of tibia		T	0051	47.3761	$3,234.22	.	$646.85
27707	Incision of fibula		T	0049	23.2249	$1,585.49	.	$317.10
27709	Incision of tibia & fibula		T	0050	32.4253	$2,213.58	.	$442.72
27712	Realignment of lower leg		C					
27715	Revision of lower leg		C					
27720	Repair of tibia		T	0063	48.0827	$3,282.46	.	$656.50
27722	Repair/graft of tibia		T	0064	66.575	$4,544.88	.	$908.98
27724	Repair/graft of tibia		C					
27725	Repair of lower leg		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27726	Repair fibula nonunion		T	0063	48.0827	$3,282.46	.	$656.50
27727	Repair of lower leg		C					
27730	Repair of tibia epiphysis		T	0050	32.4253	$2,213.58	.	$442.72
27732	Repair of fibula epiphysis		T	0050	32.4253	$2,213.58	.	$442.72
27734	Repair lower leg epiphyses		T	0050	32.4253	$2,213.58	.	$442.72
27740	Repair of leg epiphyses		T	0050	32.4253	$2,213.58	.	$442.72
27742	Repair of leg epiphyses		T	0051	47.3761	$3,234.22	.	$646.85
27745	Reinforce tibia		T	0052	88.5249	$6,043.33	.	$1,208.67
27750	Treatment of tibia fracture		T	0129	1.6325	$111.45	.	$22.29
27752	Treatment of tibia fracture		T	0139	20.9892	$1,432.87	.	$286.58
27756	Treatment of tibia fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
27758	Treatment of tibia fracture		T	0063	48.0827	$3,282.46	.	$656.50
27759	Treatment of tibia fracture		T	0064	66.575	$4,544.88	.	$908.98
27760	Cltx medial ankle fx		T	0129	1.6325	$111.45	.	$22.29
27762	Cltx med ankle fx w/mnpj		T	0139	20.9892	$1,432.87	.	$286.58
27766	Optx medial ankle fx		T	0063	48.0827	$3,282.46	.	$656.50
27767	Cltx post ankle fx		T	0129	1.6325	$111.45	.	$22.29
27768	Cltx post ankle fx w/mnpj		T	0129	1.6325	$111.45	.	$22.29
27769	Optx post ankle fx		T	0063	48.0827	$3,282.46	.	$656.50
27780	Treatment of fibula fracture		T	0129	1.6325	$111.45	.	$22.29
27781	Treatment of fibula fracture		T	0139	20.9892	$1,432.87	.	$286.58
27784	Treatment of fibula fracture		T	0063	48.0827	$3,282.46	.	$656.50
27786	Treatment of ankle fracture		T	0129	1.6325	$111.45	.	$22.29
27788	Treatment of ankle fracture		T	0129	1.6325	$111.45	.	$22.29
27792	Treatment of ankle fracture		T	0063	48.0827	$3,282.46	.	$656.50
27808	Treatment of ankle fracture		T	0129	1.6325	$111.45	.	$22.29
27810	Treatment of ankle fracture		T	0138	5.2593	$359.04	.	$71.81
27814	Treatment of ankle fracture		T	0063	48.0827	$3,282.46	.	$656.50
27816	Treatment of ankle fracture		T	0129	1.6325	$111.45	.	$22.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27818	Treatment of ankle fracture		T	0138	5.2593	$359.04	.	$71.81
27822	Treatment of ankle fracture		T	0063	48.0827	$3,282.46	.	$656.50
27823	Treatment of ankle fracture		T	0064	66.575	$4,544.88	.	$908.98
27824	Treat lower leg fracture		T	0129	1.6325	$111.45	.	$22.29
27825	Treat lower leg fracture		T	0139	20.9892	$1,432.87	.	$286.58
27826	Treat lower leg fracture		T	0063	48.0827	$3,282.46	.	$656.50
27827	Treat lower leg fracture		T	0064	66.575	$4,544.88	.	$908.98
27828	Treat lower leg fracture		T	0064	66.575	$4,544.88	.	$908.98
27829	Treat lower leg joint		T	0063	48.0827	$3,282.46	.	$656.50
27830	Treat lower leg dislocation		T	0129	1.6325	$111.45	.	$22.29
27831	Treat lower leg dislocation		T	0139	20.9892	$1,432.87	.	$286.58
27832	Treat lower leg dislocation		T	0063	48.0827	$3,282.46	.	$656.50
27840	Treat ankle dislocation		T	0138	5.2593	$359.04	.	$71.81
27842	Treat ankle dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
27846	Treat ankle dislocation		T	0063	48.0827	$3,282.46	.	$656.50
27848	Treat ankle dislocation		T	0063	48.0827	$3,282.46	.	$656.50
27860	Fixation of ankle joint		T	0045	15.5647	$1,062.56	$268.44	$212.52
27870	Fusion of ankle joint, open		T	0052	88.5249	$6,043.33	.	$1,208.67
27871	Fusion of tibiofibular joint		T	0052	88.5249	$6,043.33	.	$1,208.67
27880	Amputation of lower leg		C					
27881	Amputation of lower leg		C					
27882	Amputation of lower leg		C					
27884	Amputation follow-up surgery		T	0049	23.2249	$1,585.49	.	$317.10
27886	Amputation follow-up surgery		C					
27888	Amputation of foot at ankle		C					
27889	Amputation of foot at ankle		T	0050	32.4253	$2,213.58	.	$442.72
27892	Decompression of leg		T	0050	32.4253	$2,213.58	.	$442.72
27893	Decompression of leg		T	0050	32.4253	$2,213.58	.	$442.72
27894	Decompression of leg		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27899	Leg/ankle surgery procedure		T	0129	1.6325	$111.45	.	$22.29
28001	Drainage of bursa of foot		T	0007	13.3268	$909.78	.	$181.96
28002	Treatment of foot infection		T	0049	23.2249	$1,585.49	.	$317.10
28003	Treatment of foot infection		T	0049	23.2249	$1,585.49	.	$317.10
28005	Treat foot bone lesion		T	0055	22.6974	$1,549.48	$355.34	$309.90
28008	Incision of foot fascia		T	0055	22.6974	$1,549.48	$355.34	$309.90
28010	Incision of toe tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28011	Incision of toe tendons		T	0055	22.6974	$1,549.48	$355.34	$309.90
28020	Exploration of foot joint		T	0055	22.6974	$1,549.48	$355.34	$309.90
28022	Exploration of foot joint		T	0055	22.6974	$1,549.48	$355.34	$309.90
28024	Exploration of toe joint		T	0055	22.6974	$1,549.48	$355.34	$309.90
28035	Decompression of tibia nerve		T	0220	19.3535	$1,321.21	.	$264.25
28039	Exc foot/toe tum sc > 1.5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
28041	Exc foot/toe tum deep >1.5cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
28043	Exc foot/toe tum sc < 1.5 cm		T	0021	18.2223	$1,243.98	.	$248.80
28045	Exc foot/toe tum deep <1.5cm		T	0021	18.2223	$1,243.98	.	$248.80
28046	Resect foot/toe tumor < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
28047	Resect foot/toe tumor > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
28050	Biopsy of foot joint lining		T	0055	22.6974	$1,549.48	$355.34	$309.90
28052	Biopsy of foot joint lining		T	0055	22.6974	$1,549.48	$355.34	$309.90
28054	Biopsy of toe joint lining		T	0055	22.6974	$1,549.48	$355.34	$309.90
28055	Neurectomy, foot		T	0220	19.3535	$1,321.21	.	$264.25
28060	Partial removal, foot fascia		T	0055	22.6974	$1,549.48	$355.34	$309.90
28062	Removal of foot fascia		T	0055	22.6974	$1,549.48	$355.34	$309.90
28070	Removal of foot joint lining		T	0055	22.6974	$1,549.48	$355.34	$309.90
28072	Removal of foot joint lining		T	0055	22.6974	$1,549.48	$355.34	$309.90
28080	Removal of foot lesion		T	0055	22.6974	$1,549.48	$355.34	$309.90
28086	Excise foot tendon sheath		T	0055	22.6974	$1,549.48	$355.34	$309.90
28088	Excise foot tendon sheath		T	0055	22.6974	$1,549.48	$355.34	$309.90

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28090	Removal of foot lesion		T	0055	22.6974	$1,549.48	$355.34	$309.90
28092	Removal of toe lesions		T	0055	22.6974	$1,549.48	$355.34	$309.90
28100	Removal of ankle/heel lesion		T	0055	22.6974	$1,549.48	$355.34	$309.90
28102	Remove/graft foot lesion		T	0056	55.5064	$3,789.26	.	$757.86
28103	Remove/graft foot lesion		T	0056	55.5064	$3,789.26	.	$757.86
28104	Removal of foot lesion		T	0055	22.6974	$1,549.48	$355.34	$309.90
28106	Remove/graft foot lesion		T	0056	55.5064	$3,789.26	.	$757.86
28107	Remove/graft foot lesion		T	0056	55.5064	$3,789.26	.	$757.86
28108	Removal of toe lesions		T	0055	22.6974	$1,549.48	$355.34	$309.90
28110	Part removal of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28111	Part removal of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28112	Part removal of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28113	Part removal of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28114	Removal of metatarsal heads		T	0055	22.6974	$1,549.48	$355.34	$309.90
28116	Revision of foot		T	0055	22.6974	$1,549.48	$355.34	$309.90
28118	Removal of heel bone		T	0055	22.6974	$1,549.48	$355.34	$309.90
28119	Removal of heel spur		T	0055	22.6974	$1,549.48	$355.34	$309.90
28120	Part removal of ankle/heel		T	0055	22.6974	$1,549.48	$355.34	$309.90
28122	Partial removal of foot bone		T	0055	22.6974	$1,549.48	$355.34	$309.90
28124	Partial removal of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28126	Partial removal of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28130	Removal of ankle bone		T	0055	22.6974	$1,549.48	$355.34	$309.90
28140	Removal of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28150	Removal of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28153	Partial removal of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28160	Partial removal of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28171	Resect tarsal tumor		T	0055	22.6974	$1,549.48	$355.34	$309.90
28173	Resect metatarsal tumor		T	0055	22.6974	$1,549.48	$355.34	$309.90
28175	Resect phalanx of toe tumor		T	0055	22.6974	$1,549.48	$355.34	$309.90

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28190	Removal of foot foreign body		T	0020	8.7772	$599.19	.	$119.84
28192	Removal of foot foreign body		T	0021	18.2223	$1,243.98	.	$248.80
28193	Removal of foot foreign body		T	0020	8.7772	$599.19	.	$119.84
28200	Repair of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28202	Repair/graft of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28208	Repair of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28210	Repair/graft of foot tendon		T	0056	55.5064	$3,789.26	.	$757.86
28220	Release of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28222	Release of foot tendons		T	0055	22.6974	$1,549.48	$355.34	$309.90
28225	Release of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28226	Release of foot tendons		T	0055	22.6974	$1,549.48	$355.34	$309.90
28230	Incision of foot tendon(s)		T	0055	22.6974	$1,549.48	$355.34	$309.90
28232	Incision of toe tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28234	Incision of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28238	Revision of foot tendon		T	0056	55.5064	$3,789.26	.	$757.86
28240	Release of big toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28250	Revision of foot fascia		T	0055	22.6974	$1,549.48	$355.34	$309.90
28260	Release of midfoot joint		T	0055	22.6974	$1,549.48	$355.34	$309.90
28261	Revision of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28262	Revision of foot and ankle		T	0055	22.6974	$1,549.48	$355.34	$309.90
28264	Release of midfoot joint		T	0056	55.5064	$3,789.26	.	$757.86
28270	Release of foot contracture		T	0055	22.6974	$1,549.48	$355.34	$309.90
28272	Release of toe joint, each		T	0055	22.6974	$1,549.48	$355.34	$309.90
28280	Fusion of toes		T	0055	22.6974	$1,549.48	$355.34	$309.90
28285	Repair of hammertoe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28286	Repair of hammertoe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28288	Partial removal of foot bone		T	0055	22.6974	$1,549.48	$355.34	$309.90
28289	Repair hallux rigidus		T	0055	22.6974	$1,549.48	$355.34	$309.90
28290	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28292	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28293	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28294	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28296	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28297	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28298	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28299	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28300	Incision of heel bone		T	0056	55.5064	$3,789.26	.	$757.86
28302	Incision of ankle bone		T	0055	22.6974	$1,549.48	$355.34	$309.90
28304	Incision of midfoot bones		T	0056	55.5064	$3,789.26	.	$757.86
28305	Incise/graft midfoot bones		T	0056	55.5064	$3,789.26	.	$757.86
28306	Incision of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28307	Incision of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28308	Incision of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28309	Incision of metatarsals		T	0056	55.5064	$3,789.26	.	$757.86
28310	Revision of big toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28312	Revision of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28313	Repair deformity of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28315	Removal of sesamoid bone		T	0055	22.6974	$1,549.48	$355.34	$309.90
28320	Repair of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28322	Repair of metatarsals		T	0056	55.5064	$3,789.26	.	$757.86
28340	Resect enlarged toe tissue		T	0055	22.6974	$1,549.48	$355.34	$309.90
28341	Resect enlarged toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28344	Repair extra toe(s)		T	0055	22.6974	$1,549.48	$355.34	$309.90
28345	Repair webbed toe(s)		T	0055	22.6974	$1,549.48	$355.34	$309.90
28360	Reconstruct cleft foot		T	0056	55.5064	$3,789.26	.	$757.86
28400	Treatment of heel fracture		T	0129	1.6325	$111.45	.	$22.29
28405	Treatment of heel fracture		T	0139	20.9892	$1,432.87	.	$286.58
28406	Treatment of heel fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28415	Treat heel fracture		T	0064	66.575	$4,544.88	.	$908.98
28420	Treat/graft heel fracture		T	0063	48.0827	$3,282.46	.	$656.50
28430	Treatment of ankle fracture		T	0129	1.6325	$111.45	.	$22.29
28435	Treatment of ankle fracture		T	0129	1.6325	$111.45	.	$22.29
28436	Treatment of ankle fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28445	Treat ankle fracture		T	0063	48.0827	$3,282.46	.	$656.50
28446	Osteochondral talus autogrft		T	0056	55.5064	$3,789.26	.	$757.86
28450	Treat midfoot fracture, each		T	0129	1.6325	$111.45	.	$22.29
28455	Treat midfoot fracture, each		T	0129	1.6325	$111.45	.	$22.29
28456	Treat midfoot fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28465	Treat midfoot fracture, each		T	0063	48.0827	$3,282.46	.	$656.50
28470	Treat metatarsal fracture		T	0129	1.6325	$111.45	.	$22.29
28475	Treat metatarsal fracture		T	0129	1.6325	$111.45	.	$22.29
28476	Treat metatarsal fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28485	Treat metatarsal fracture		T	0063	48.0827	$3,282.46	.	$656.50
28490	Treat big toe fracture		T	0129	1.6325	$111.45	.	$22.29
28495	Treat big toe fracture		T	0129	1.6325	$111.45	.	$22.29
28496	Treat big toe fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28505	Treat big toe fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28510	Treatment of toe fracture		T	0129	1.6325	$111.45	.	$22.29
28515	Treatment of toe fracture		T	0129	1.6325	$111.45	.	$22.29
28525	Treat toe fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28530	Treat sesamoid bone fracture		T	0129	1.6325	$111.45	.	$22.29
28531	Treat sesamoid bone fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28540	Treat foot dislocation		T	0129	1.6325	$111.45	.	$22.29
28545	Treat foot dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28546	Treat foot dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28555	Repair foot dislocation		T	0063	48.0827	$3,282.46	.	$656.50
28570	Treat foot dislocation		T	0138	5.2593	$359.04	.	$71.81

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28575	Treat foot dislocation		T	0139	20.9892	$1,432.87	.	$286.58
28576	Treat foot dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28585	Repair foot dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28600	Treat foot dislocation		T	0129	1.6325	$111.45	.	$22.29
28605	Treat foot dislocation		T	0129	1.6325	$111.45	.	$22.29
28606	Treat foot dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28615	Repair foot dislocation		T	0063	48.0827	$3,282.46	.	$656.50
28630	Treat toe dislocation		T	0129	1.6325	$111.45	.	$22.29
28635	Treat toe dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
28636	Treat toe dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28645	Repair toe dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28660	Treat toe dislocation		T	0129	1.6325	$111.45	.	$22.29
28665	Treat toe dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
28666	Treat toe dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28675	Repair of toe dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28705	Fusion of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28715	Fusion of foot bones		T	0052	88.5249	$6,043.33	.	$1,208.67
28725	Fusion of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28730	Fusion of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28735	Fusion of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28737	Revision of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28740	Fusion of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28750	Fusion of big toe joint		T	0056	55.5064	$3,789.26	.	$757.86
28755	Fusion of big toe joint		T	0055	22.6974	$1,549.48	$355.34	$309.90
28760	Fusion of big toe joint		T	0056	55.5064	$3,789.26	.	$757.86
28800	Amputation of midfoot		C					
28805	Amputation thru metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28810	Amputation toe & metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28820	Amputation of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28825	Partial amputation of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28890	High energy eswt, plantar f		T	0050	32.4253	$2,213.58	.	$442.72
28899	Foot/toes surgery procedure		T	0129	1.6325	$111.45	.	$22.29
29000	Application of body cast		S	0058	1.1409	$77.89	.	$15.58
29010	Application of body cast		S	0426	2.4913	$170.07	.	$34.02
29015	Application of body cast		S	0426	2.4913	$170.07	.	$34.02
29020	Application of body cast		S	0058	1.1409	$77.89	.	$15.58
29025	Application of body cast		S	0058	1.1409	$77.89	.	$15.58
29035	Application of body cast		S	0426	2.4913	$170.07	.	$34.02
29040	Application of body cast		S	0058	1.1409	$77.89	.	$15.58
29044	Application of body cast		S	0426	2.4913	$170.07	.	$34.02
29046	Application of body cast		S	0426	2.4913	$170.07	.	$34.02
29049	Application of figure eight		S	0058	1.1409	$77.89	.	$15.58
29055	Application of shoulder cast		S	0426	2.4913	$170.07	.	$34.02
29058	Application of shoulder cast		S	0058	1.1409	$77.89	.	$15.58
29065	Application of long arm cast		S	0426	2.4913	$170.07	.	$34.02
29075	Application of forearm cast		S	0426	2.4913	$170.07	.	$34.02
29085	Apply hand/wrist cast		S	0058	1.1409	$77.89	.	$15.58
29086	Apply finger cast		S	0058	1.1409	$77.89	.	$15.58
29105	Apply long arm splint		S	0058	1.1409	$77.89	.	$15.58
29125	Apply forearm splint		S	0058	1.1409	$77.89	.	$15.58
29126	Apply forearm splint		S	0058	1.1409	$77.89	.	$15.58
29130	Application of finger splint		S	0058	1.1409	$77.89	.	$15.58
29131	Application of finger splint		S	0058	1.1409	$77.89	.	$15.58
29200	Strapping of chest		S	0058	1.1409	$77.89	.	$15.58
29240	Strapping of shoulder		S	0058	1.1409	$77.89	.	$15.58
29260	Strapping of elbow or wrist		S	0058	1.1409	$77.89	.	$15.58
29280	Strapping of hand or finger		S	0058	1.1409	$77.89	.	$15.58
29305	Application of hip cast		S	0426	2.4913	$170.07	.	$34.02

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29325	Application of hip casts		S	0426	2.4913	$170.07	.	$34.02
29345	Application of long leg cast		S	0426	2.4913	$170.07	.	$34.02
29355	Application of long leg cast		S	0426	2.4913	$170.07	.	$34.02
29358	Apply long leg cast brace		S	0426	2.4913	$170.07	.	$34.02
29365	Application of long leg cast		S	0426	2.4913	$170.07	.	$34.02
29405	Apply short leg cast		S	0426	2.4913	$170.07	.	$34.02
29425	Apply short leg cast		S	0426	2.4913	$170.07	.	$34.02
29435	Apply short leg cast		S	0426	2.4913	$170.07	.	$34.02
29440	Addition of walker to cast		S	0058	1.1409	$77.89	.	$15.58
29445	Apply rigid leg cast		S	0426	2.4913	$170.07	.	$34.02
29450	Application of leg cast		S	0058	1.1409	$77.89	.	$15.58
29505	Application, long leg splint		S	0058	1.1409	$77.89	.	$15.58
29515	Application lower leg splint		S	0058	1.1409	$77.89	.	$15.58
29520	Strapping of hip		S	0058	1.1409	$77.89	.	$15.58
29530	Strapping of knee		S	0058	1.1409	$77.89	.	$15.58
29540	Strapping of ankle and/or ft		S	0058	1.1409	$77.89	.	$15.58
29550	Strapping of toes		S	0058	1.1409	$77.89	.	$15.58
29580	Application of paste boot		S	0058	1.1409	$77.89	.	$15.58
29581	Apply multlay comprs lwr leg		S	0058	1.1409	$77.89	.	$15.58
29590	Application of foot splint		S	0058	1.1409	$77.89	.	$15.58
29700	Removal/revision of cast		S	0058	1.1409	$77.89	.	$15.58
29705	Removal/revision of cast		S	0058	1.1409	$77.89	.	$15.58
29710	Removal/revision of cast		S	0426	2.4913	$170.07	.	$34.02
29715	Removal/revision of cast		S	0058	1.1409	$77.89	.	$15.58
29720	Repair of body cast		S	0058	1.1409	$77.89	.	$15.58
29730	Windowing of cast		S	0058	1.1409	$77.89	.	$15.58
29740	Wedging of cast		S	0058	1.1409	$77.89	.	$15.58
29750	Wedging of clubfoot cast		S	0058	1.1409	$77.89	.	$15.58
29799	Casting/strapping procedure		S	0058	1.1409	$77.89	.	$15.58

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29800	Jaw arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29804	Jaw arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29805	Shoulder arthroscopy, dx		T	0041	30.3175	$2,069.68	.	$413.94
29806	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29807	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29819	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29820	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29821	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29822	Shoulder arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29823	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29824	Shoulder arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29825	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29826	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29827	Arthroscop rotator cuff repr		T	0042	48.2063	$3,290.90	$804.74	$658.18
29828	Arthroscopy biceps tenodesis		T	0042	48.2063	$3,290.90	$804.74	$658.18
29830	Elbow arthroscopy		T	0041	30.3175	$2,069.68	.	$413.94
29834	Elbow arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29835	Elbow arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29836	Elbow arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29837	Elbow arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29838	Elbow arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29840	Wrist arthroscopy		T	0041	30.3175	$2,069.68	.	$413.94
29843	Wrist arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29844	Wrist arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29845	Wrist arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29846	Wrist arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29847	Wrist arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29848	Wrist endoscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29850	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29851	Knee arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29855	Tibial arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29856	Tibial arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29860	Hip arthroscopy, dx		T	0042	48.2063	$3,290.90	$804.74	$658.18
29861	Hip arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29862	Hip arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29863	Hip arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29866	Autgrft implnt, knee w/scope		T	0042	48.2063	$3,290.90	$804.74	$658.18
29867	Allgrft implnt, knee w/scope		T	0042	48.2063	$3,290.90	$804.74	$658.18
29868	Meniscal trnspl, knee w/scpe		T	0042	48.2063	$3,290.90	$804.74	$658.18
29870	Knee arthroscopy, dx		T	0041	30.3175	$2,069.68	.	$413.94
29871	Knee arthroscopy/drainage		T	0041	30.3175	$2,069.68	.	$413.94
29873	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29874	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29875	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29876	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29877	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29879	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29880	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29881	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29882	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29883	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29884	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29885	Knee arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29886	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29887	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29888	Knee arthroscopy/surgery		T	0052	88.5249	$6,043.33	.	$1,208.67
29889	Knee arthroscopy/surgery		T	0052	88.5249	$6,043.33	.	$1,208.67
29891	Ankle arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29892	Ankle arthroscopy/surgery		T	0052	88.5249	$6,043.33	.	$1,208.67
29893	Scope, plantar fasciotomy		T	0055	22.6974	$1,549.48	$355.34	$309.90
29894	Ankle arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29895	Ankle arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29897	Ankle arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29898	Ankle arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29899	Ankle arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29900	Mcp joint arthroscopy, dx		T	0041	30.3175	$2,069.68	.	$413.94
29901	Mcp joint arthroscopy, surg		T	0041	30.3175	$2,069.68	.	$413.94
29902	Mcp joint arthroscopy, surg		T	0041	30.3175	$2,069.68	.	$413.94
29904	Subtalar arthro w/fb rmvl		T	0041	30.3175	$2,069.68	.	$413.94
29905	Subtalar arthro w/exc		T	0041	30.3175	$2,069.68	.	$413.94
29906	Subtalar arthro w/deb		T	0041	30.3175	$2,069.68	.	$413.94
29907	Subtalar arthro w/fusion		T	0042	48.2063	$3,290.90	$804.74	$658.18
29999	Arthroscopy of joint		T	0041	30.3175	$2,069.68	.	$413.94
30000	Drainage of nose lesion		T	0251	3.4369	$234.63	.	$46.93
30020	Drainage of nose lesion		T	0251	3.4369	$234.63	.	$46.93
30100	Intranasal biopsy		T	0252	7.8743	$537.55	$109.16	$107.51
30110	Removal of nose polyp(s)		T	0253	17.4151	$1,188.88	$282.29	$237.78
30115	Removal of nose polyp(s)		T	0253	17.4151	$1,188.88	$282.29	$237.78
30117	Removal of intranasal lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
30118	Removal of intranasal lesion		T	0254	25.5397	$1,743.52	.	$348.71
30120	Revision of nose		T	0254	25.5397	$1,743.52	.	$348.71
30124	Removal of nose lesion		T	0252	7.8743	$537.55	$109.16	$107.51
30125	Removal of nose lesion		T	0256	44.8441	$3,061.37	.	$612.28
30130	Excise inferior turbinate		T	0253	17.4151	$1,188.88	$282.29	$237.78
30140	Resect inferior turbinate		T	0254	25.5397	$1,743.52	.	$348.71
30150	Partial removal of nose		T	0256	44.8441	$3,061.37	.	$612.28
30160	Removal of nose		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
30200	Injection treatment of nose		T	0252	7.8743	$537.55	$109.16	$107.51
30210	Nasal sinus therapy		T	0252	7.8743	$537.55	$109.16	$107.51
30220	Insert nasal septal button		T	0252	7.8743	$537.55	$109.16	$107.51
30300	Remove nasal foreign body		X	0340	0.6899	$47.10	.	$9.42
30310	Remove nasal foreign body		T	0253	17.4151	$1,188.88	$282.29	$237.78
30320	Remove nasal foreign body		T	0253	17.4151	$1,188.88	$282.29	$237.78
30400	Reconstruction of nose		T	0256	44.8441	$3,061.37	.	$612.28
30410	Reconstruction of nose		T	0256	44.8441	$3,061.37	.	$612.28
30420	Reconstruction of nose		T	0256	44.8441	$3,061.37	.	$612.28
30430	Revision of nose		T	0254	25.5397	$1,743.52	.	$348.71
30435	Revision of nose		T	0256	44.8441	$3,061.37	.	$612.28
30450	Revision of nose		T	0256	44.8441	$3,061.37	.	$612.28
30460	Revision of nose		T	0256	44.8441	$3,061.37	.	$612.28
30462	Revision of nose		T	0256	44.8441	$3,061.37	.	$612.28
30465	Repair nasal stenosis		T	0256	44.8441	$3,061.37	.	$612.28
30520	Repair of nasal septum		T	0254	25.5397	$1,743.52	.	$348.71
30540	Repair nasal defect		T	0256	44.8441	$3,061.37	.	$612.28
30545	Repair nasal defect		T	0256	44.8441	$3,061.37	.	$612.28
30560	Release of nasal adhesions		T	0251	3.4369	$234.63	.	$46.93
30580	Repair upper jaw fistula		T	0256	44.8441	$3,061.37	.	$612.28
30600	Repair mouth/nose fistula		T	0256	44.8441	$3,061.37	.	$612.28
30620	Intranasal reconstruction		T	0256	44.8441	$3,061.37	.	$612.28
30630	Repair nasal septum defect		T	0254	25.5397	$1,743.52	.	$348.71
30801	Ablate inf turbinate, superf		T	0252	7.8743	$537.55	$109.16	$107.51
30802	Ablate inf turbinate submuc		T	0253	17.4151	$1,188.88	$282.29	$237.78
30901	Control of nosebleed		T	0250	1.1743	$80.17	$25.10	$16.04
30903	Control of nosebleed		T	0250	1.1743	$80.17	$25.10	$16.04
30905	Control of nosebleed		T	0250	1.1743	$80.17	$25.10	$16.04
30906	Repeat control of nosebleed		T	0250	1.1743	$80.17	$25.10	$16.04

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
30915	Ligation, nasal sinus artery		T	0092	27.5456	$1,880.46	.	$376.10
30920	Ligation, upper jaw artery		T	0092	27.5456	$1,880.46	.	$376.10
30930	Ther fx, nasal inf turbinate		T	0253	17.4151	$1,188.88	$282.29	$237.78
30999	Nasal surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
31000	Irrigation, maxillary sinus		T	0251	3.4369	$234.63	.	$46.93
31002	Irrigation, sphenoid sinus		T	0252	7.8743	$537.55	$109.16	$107.51
31020	Exploration, maxillary sinus		T	0254	25.5397	$1,743.52	.	$348.71
31030	Exploration, maxillary sinus		T	0256	44.8441	$3,061.37	.	$612.28
31032	Explore sinus, remove polyps		T	0256	44.8441	$3,061.37	.	$612.28
31040	Exploration behind upper jaw		T	0254	25.5397	$1,743.52	.	$348.71
31050	Exploration, sphenoid sinus		T	0256	44.8441	$3,061.37	.	$612.28
31051	Sphenoid sinus surgery		T	0256	44.8441	$3,061.37	.	$612.28
31070	Exploration of frontal sinus		T	0254	25.5397	$1,743.52	.	$348.71
31075	Exploration of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31080	Removal of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31081	Removal of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31084	Removal of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31085	Removal of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31086	Removal of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31087	Removal of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31090	Exploration of sinuses		T	0256	44.8441	$3,061.37	.	$612.28
31200	Removal of ethmoid sinus		T	0256	44.8441	$3,061.37	.	$612.28
31201	Removal of ethmoid sinus		T	0256	44.8441	$3,061.37	.	$612.28
31205	Removal of ethmoid sinus		T	0256	44.8441	$3,061.37	.	$612.28
31225	Removal of upper jaw		C					
31230	Removal of upper jaw		C					
31231	Nasal endoscopy, dx		T	0072	1.8778	$128.19	.	$25.64
31233	Nasal/sinus endoscopy, dx		T	0072	1.8778	$128.19	.	$25.64
31235	Nasal/sinus endoscopy, dx		T	0074	21.9959	$1,501.59	.	$300.32

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31237	Nasal/sinus endoscopy, surg		T	0074	21.9959	$1,501.59	.	$300.32
31238	Nasal/sinus endoscopy, surg		T	0074	21.9959	$1,501.59	.	$300.32
31239	Nasal/sinus endoscopy, surg		T	0075	31.4168	$2,144.73	$445.92	$428.95
31240	Nasal/sinus endoscopy, surg		T	0074	21.9959	$1,501.59	.	$300.32
31254	Revision of ethmoid sinus		T	0075	31.4168	$2,144.73	$445.92	$428.95
31255	Removal of ethmoid sinus		T	0075	31.4168	$2,144.73	$445.92	$428.95
31256	Exploration maxillary sinus		T	0075	31.4168	$2,144.73	$445.92	$428.95
31267	Endoscopy, maxillary sinus		T	0075	31.4168	$2,144.73	$445.92	$428.95
31276	Sinus endoscopy, surgical		T	0075	31.4168	$2,144.73	$445.92	$428.95
31287	Nasal/sinus endoscopy, surg		T	0075	31.4168	$2,144.73	$445.92	$428.95
31288	Nasal/sinus endoscopy, surg		T	0075	31.4168	$2,144.73	$445.92	$428.95
31290	Nasal/sinus endoscopy, surg		C					
31291	Nasal/sinus endoscopy, surg		C					
31292	Nasal/sinus endoscopy, surg		T	0075	31.4168	$2,144.73	$445.92	$428.95
31293	Nasal/sinus endoscopy, surg		T	0075	31.4168	$2,144.73	$445.92	$428.95
31294	Nasal/sinus endoscopy, surg		T	0075	31.4168	$2,144.73	$445.92	$428.95
31299	Sinus surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
31300	Removal of larynx lesion		T	0254	25.5397	$1,743.52	.	$348.71
31320	Diagnostic incision, larynx		T	0256	44.8441	$3,061.37	.	$612.28
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31400	Revision of larynx		T	0256	44.8441	$3,061.37	.	$612.28
31420	Removal of epiglottis		T	0256	44.8441	$3,061.37	.	$612.28
31500	Insert emergency airway		S	0094	2.4281	$165.76	$46.29	$33.16
31502	Change of windpipe airway		S	0078	1.4237	$97.19	.	$19.44
31505	Diagnostic laryngoscopy		T	0071	0.9225	$62.98	.	$12.60
31510	Laryngoscopy with biopsy		T	0074	21.9959	$1,501.59	.	$300.32
31511	Remove foreign body, larynx		T	0072	1.8778	$128.19	.	$25.64
31512	Removal of larynx lesion		T	0074	21.9959	$1,501.59	.	$300.32
31513	Injection into vocal cord		T	0072	1.8778	$128.19	.	$25.64
31515	Laryngoscopy for aspiration		T	0074	21.9959	$1,501.59	.	$300.32
31520	Dx laryngoscopy, newborn		T	0072	1.8778	$128.19	.	$25.64
31525	Dx laryngoscopy excl nb		T	0074	21.9959	$1,501.59	.	$300.32
31526	Dx laryngoscopy w/oper scope		T	0074	21.9959	$1,501.59	.	$300.32
31527	Laryngoscopy for treatment		T	0075	31.4168	$2,144.73	$445.92	$428.95
31528	Laryngoscopy and dilation		T	0074	21.9959	$1,501.59	.	$300.32
31529	Laryngoscopy and dilation		T	0074	21.9959	$1,501.59	.	$300.32
31530	Laryngoscopy w/fb removal		T	0074	21.9959	$1,501.59	.	$300.32
31531	Laryngoscopy w/fb & op scope		T	0074	21.9959	$1,501.59	.	$300.32
31535	Laryngoscopy w/biopsy		T	0074	21.9959	$1,501.59	.	$300.32
31536	Laryngoscopy w/bx & op scope		T	0074	21.9959	$1,501.59	.	$300.32
31540	Laryngoscopy w/exc of tumor		T	0074	21.9959	$1,501.59	.	$300.32
31541	Larynscop w/tumr exc + scope		T	0074	21.9959	$1,501.59	.	$300.32
31545	Remove vc lesion w/scope		T	0075	31.4168	$2,144.73	$445.92	$428.95
31546	Remove vc lesion scope/graft		T	0075	31.4168	$2,144.73	$445.92	$428.95
31560	Laryngoscop w/arytenoidectom		T	0075	31.4168	$2,144.73	$445.92	$428.95
31561	Larynscop, remve cart + scop		T	0075	31.4168	$2,144.73	$445.92	$428.95
31570	Laryngoscope w/vc inj		T	0074	21.9959	$1,501.59	.	$300.32
31571	Laryngoscop w/vc inj + scope		T	0075	31.4168	$2,144.73	$445.92	$428.95
31575	Diagnostic laryngoscopy		T	0072	1.8778	$128.19	.	$25.64

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31576	Laryngoscopy with biopsy		T	0074	21.9959	$1,501.59	.	$300.32
31577	Remove foreign body, larynx		T	0073	4.0416	$275.91	$64.31	$55.19
31578	Removal of larynx lesion		T	0075	31.4168	$2,144.73	$445.92	$428.95
31579	Diagnostic laryngoscopy		T	0073	4.0416	$275.91	$64.31	$55.19
31580	Revision of larynx		T	0256	44.8441	$3,061.37	.	$612.28
31582	Revision of larynx		T	0256	44.8441	$3,061.37	.	$612.28
31584	Treat larynx fracture		C					
31587	Revision of larynx		C					
31588	Revision of larynx		T	0256	44.8441	$3,061.37	.	$612.28
31590	Reinnervate larynx		T	0256	44.8441	$3,061.37	.	$612.28
31595	Larynx nerve surgery		T	0256	44.8441	$3,061.37	.	$612.28
31599	Larynx surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
31600	Incision of windpipe		T	0254	25.5397	$1,743.52	.	$348.71
31601	Incision of windpipe		T	0254	25.5397	$1,743.52	.	$348.71
31603	Incision of windpipe		T	0252	7.8743	$537.55	$109.16	$107.51
31605	Incision of windpipe		T	0252	7.8743	$537.55	$109.16	$107.51
31610	Incision of windpipe		T	0254	25.5397	$1,743.52	.	$348.71
31611	Surgery/speech prosthesis		T	0254	25.5397	$1,743.52	.	$348.71
31612	Puncture/clear windpipe		T	0254	25.5397	$1,743.52	.	$348.71
31613	Repair windpipe opening		T	0254	25.5397	$1,743.52	.	$348.71
31614	Repair windpipe opening		T	0256	44.8441	$3,061.37	.	$612.28
31615	Visualization of windpipe		T	0252	7.8743	$537.55	$109.16	$107.51
31620	Endobronchial us add-on		N					
31622	Dx bronchoscope/wash		T	0076	10.5445	$719.84	$189.82	$143.97
31623	Dx bronchoscope/brush		T	0076	10.5445	$719.84	$189.82	$143.97
31624	Dx bronchoscope/lavage		T	0076	10.5445	$719.84	$189.82	$143.97
31625	Bronchoscopy w/biopsy(s)		T	0076	10.5445	$719.84	$189.82	$143.97
31626	Bronchoscopy w/markers		T	0076	10.5445	$719.84	$189.82	$143.97
31627	Navigational bronchoscopy		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31628	Bronchoscopy/lung bx, each		T	0076	10.5445	$719.84	$189.82	$143.97
31629	Bronchoscopy/needle bx, each		T	0076	10.5445	$719.84	$189.82	$143.97
31630	Bronchoscopy dilate/fx repr		T	0415	28.518	$1,946.84	$459.92	$389.37
31631	Bronchoscopy, dilate w/stent		T	0415	28.518	$1,946.84	$459.92	$389.37
31632	Bronchoscopy/lung bx, addl		T	0076	10.5445	$719.84	$189.82	$143.97
31633	Bronchoscopy/needle bx addl		T	0076	10.5445	$719.84	$189.82	$143.97
31635	Bronchoscopy w/fb removal		T	0076	10.5445	$719.84	$189.82	$143.97
31636	Bronchoscopy, bronch stents		T	0415	28.518	$1,946.84	$459.92	$389.37
31637	Bronchoscopy, stent add-on		T	0076	10.5445	$719.84	$189.82	$143.97
31638	Bronchoscopy, revise stent		T	0415	28.518	$1,946.84	$459.92	$389.37
31640	Bronchoscopy w/tumor excise		T	0415	28.518	$1,946.84	$459.92	$389.37
31641	Bronchoscopy, treat blockage		T	0415	28.518	$1,946.84	$459.92	$389.37
31643	Diag bronchoscope/catheter		T	0076	10.5445	$719.84	$189.82	$143.97
31645	Bronchoscopy, clear airways		T	0076	10.5445	$719.84	$189.82	$143.97
31646	Bronchoscopy, reclear airway		T	0076	10.5445	$719.84	$189.82	$143.97
31656	Bronchoscopy, inj for x-ray		T	0076	10.5445	$719.84	$189.82	$143.97
31715	Injection for bronchus x-ray		N					
31717	Bronchial brush biopsy		T	0073	4.0416	$275.91	$64.31	$55.19
31720	Clearance of airways		S	0077	0.418	$28.54	$7.74	$5.71
31725	Clearance of airways		C					
31730	Intro, windpipe wire/tube		T	0073	4.0416	$275.91	$64.31	$55.19
31750	Repair of windpipe		T	0256	44.8441	$3,061.37	.	$612.28
31755	Repair of windpipe		T	0256	44.8441	$3,061.37	.	$612.28
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31785	Remove windpipe lesion		T	0254	25.5397	$1,743.52	.	$348.71
31786	Remove windpipe lesion		C					
31800	Repair of windpipe injury		C					
31805	Repair of windpipe injury		C					
31820	Closure of windpipe lesion		T	0254	25.5397	$1,743.52	.	$348.71
31825	Repair of windpipe defect		T	0254	25.5397	$1,743.52	.	$348.71
31830	Revise windpipe scar		T	0254	25.5397	$1,743.52	.	$348.71
31899	Airways surgical procedure		T	0076	10.5445	$719.84	$189.82	$143.97
32035	Exploration of chest		C					
32036	Exploration of chest		C					
32095	Biopsy through chest wall		C					
32100	Exploration/biopsy of chest		C					
32110	Explore/repair chest		C					
32120	Re-exploration of chest		C					
32124	Explore chest free adhesions		C					
32140	Removal of lung lesion(s)		C					
32141	Remove/treat lung lesions		C					
32150	Removal of lung lesion(s)		C					
32151	Remove lung foreign body		C					
32160	Open chest heart massage		C					
32200	Drain, open, lung lesion		C					
32201	Drain, percut, lung lesion		T	0070	5.6491	$385.65	.	$77.13
32215	Treat chest lining		C					
32220	Release of lung		C					
32225	Partial release of lung		C					
32310	Removal of chest lining		C					
32320	Free/remove chest lining		C					
32400	Needle biopsy chest lining		T	0685	9.9046	$676.16	.	$135.24
32402	Open biopsy chest lining		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32405	Biopsy, lung or mediastinum		T	0685	9.9046	$676.16	.	$135.24
32420	Puncture/clear lung		T	0070	5.6491	$385.65	.	$77.13
32421	Thoracentesis for aspiration		T	0070	5.6491	$385.65	.	$77.13
32422	Thoracentesis w/tube insert		T	0070	5.6491	$385.65	.	$77.13
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					
32550	Insert pleural cath		T	0652	31.1286	$2,125.06	.	$425.02
32551	Insertion of chest tube		T	0070	5.6491	$385.65	.	$77.13
32552	Remove lung catheter		S	0078	1.4237	$97.19	.	$19.44
32553	Ins mark thor for rt perq		X	0310	13.5651	$926.05	$325.27	$185.21
32560	Treat pleurodesis w/agent		T	0070	5.6491	$385.65	.	$77.13
32561	Lyse chest fibrin init day		T	0070	5.6491	$385.65	.	$77.13
32562	Lyse chest fibrin subq day		T	0070	5.6491	$385.65	.	$77.13
32601	Thoracoscopy, diagnostic		T	0069	35.4455	$2,419.76	$591.64	$483.96
32602	Thoracoscopy, diagnostic		T	0069	35.4455	$2,419.76	$591.64	$483.96
32603	Thoracoscopy, diagnostic		T	0069	35.4455	$2,419.76	$591.64	$483.96
32604	Thoracoscopy, diagnostic		T	0069	35.4455	$2,419.76	$591.64	$483.96

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32605	Thoracoscopy, diagnostic		T	0069	35.4455	$2,419.76	$591.64	$483.96
32606	Thoracoscopy, diagnostic		T	0069	35.4455	$2,419.76	$591.64	$483.96
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 B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32900	Removal of rib(s)		C					
32905	Revise & repair chest wall		C					
32906	Revise & repair chest wall		C					
32940	Revision of lung		C					
32960	Therapeutic pneumothorax		T	0070	5.6491	$385.65	.	$77.13
32997	Total lung lavage		C					
32998	Perq rf ablate tx, pul tumor		T	0423	57.2089	$3,905.48	.	$781.10
32999	Chest surgery procedure		T	0070	5.6491	$385.65	.	$77.13
33010	Drainage of heart sac		T	0070	5.6491	$385.65	.	$77.13
33011	Repeat drainage of heart sac		T	0070	5.6491	$385.65	.	$77.13
33015	Incision of heart sac		C					
33020	Incision of heart sac		C					
33025	Incision of heart sac		C					
33030	Partial removal of heart sac		C					
33031	Partial removal of heart sac		C					
33050	Removal of heart sac lesion		C					
33120	Removal of heart lesion		C					
33130	Removal of heart lesion		C					
33140	Heart revascularize (tmr)		C					
33141	Heart tmr w/other procedure		C					
33202	Insert epicard eltrd, open		C					
33203	Insert epicard eltrd, endo		C					
33206	Insertion of heart pacemaker		T	0089	112.4202	$7,674.59	$1,615.11	$1,534.92
33207	Insertion of heart pacemaker		T	0089	112.4202	$7,674.59	$1,615.11	$1,534.92
33208	Insertion of heart pacemaker		T	0655	138.0708	$9,425.68	.	$1,885.14
33210	Insertion of heart electrode		T	0106	52.6182	$3,592.09	.	$718.42
33211	Insertion of heart electrode		T	0106	52.6182	$3,592.09	.	$718.42
33212	Insertion of pulse generator		T	0090	92.6057	$6,321.91	$1,530.07	$1,264.39
33213	Insertion of pulse generator		T	0654	108.1716	$7,384.55	.	$1,476.91

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33214	Upgrade of pacemaker system		T	0655	138.0708	$9,425.68	.	$1,885.14
33215	Reposition pacing-defib lead		T	0105	23.2281	$1,585.71	.	$317.15
33216	Insert 1 electrode pm-defib		T	0106	52.6182	$3,592.09	.	$718.42
33217	Insert 2 electrode pm-defib		T	0106	52.6182	$3,592.09	.	$718.42
33218	Repair lead pace-defib, one		T	0105	23.2281	$1,585.71	.	$317.15
33220	Repair lead pace-defib, dual		T	0105	23.2281	$1,585.71	.	$317.15
33222	Revise pocket, pacemaker		T	0136	17.1353	$1,169.78	.	$233.96
33223	Revise pocket for defib		T	0136	17.1353	$1,169.78	.	$233.96
33224	Insert pacing lead & connect		T	0418	143.1583	$9,772.99	.	$1,954.60
33225	L ventric pacing lead add-on		T	0418	143.1583	$9,772.99	.	$1,954.60
33226	Reposition l ventric lead		T	0105	23.2281	$1,585.71	.	$317.15
33233	Removal of pacemaker system		T	0105	23.2281	$1,585.71	.	$317.15
33234	Removal of pacemaker system		T	0105	23.2281	$1,585.71	.	$317.15
33235	Removal pacemaker electrode		T	0105	23.2281	$1,585.71	.	$317.15
33236	Remove electrode/thoracotomy		C					
33237	Remove electrode/thoracotomy		C					
33238	Remove electrode/thoracotomy		C					
33240	Insert pulse generator		T	0107	335.0724	$22,874.39	.	$4,574.88
33241	Remove pulse generator		T	0105	23.2281	$1,585.71	.	$317.15
33243	Remove eltrd/thoracotomy		C					
33244	Remove eltrd, transven		T	0105	23.2281	$1,585.71	.	$317.15
33249	Eltrd/insert pace-defib		T	0108	389.7128	$26,604.52	.	$5,320.91
33250	Ablate heart dysrhythm focus		C					
33251	Ablate heart dysrhythm focus		C					
33254	Ablate atria, lmtd		C					
33255	Ablate atria w/o bypass, ext		C					
33256	Ablate atria w/bypass, exten		C					
33257	Ablate atria, lmtd, add-on		C					
33258	Ablate atria, x10sv, add-on		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33259	Ablate atria w/bypass add-on		C					
33261	Ablate heart dysrhythm focus		C					
33265	Ablate atria, lmtd, endo		C					
33266	Ablate atria, x10sv, endo		C					
33282	Implant pat-active ht record		S	0680	78.5933	$5,365.33	.	$1,073.07
33284	Remove pat-active ht record		T	0020	8.7772	$599.19	.	$119.84
33300	Repair of heart wound		C					
33305	Repair of heart wound		C					
33310	Exploratory heart surgery		C					
33315	Exploratory heart surgery		C					
33320	Repair major blood vessel(s)		C					
33321	Repair major vessel		C					
33322	Repair major blood vessel(s)		C					
33330	Insert major vessel graft		C					
33332	Insert major vessel graft		C					
33335	Insert major vessel graft		C					
33400	Repair of aortic valve		C					
33401	Valvuloplasty, open		C					
33403	Valvuloplasty, w/cp bypass		C					
33404	Prepare heart-aorta conduit		C					
33405	Replacement of aortic valve		C					
33406	Replacement of aortic valve		C					
33410	Replacement of aortic valve		C					
33411	Replacement of aortic valve		C					
33412	Replacement of aortic valve		C					
33413	Replacement of aortic valve		C					
33414	Repair of aortic valve		C					
33415	Revision, subvalvular tissue		C					
33416	Revise ventricle muscle		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33417	Repair of aortic valve		C					
33420	Revision of mitral valve		C					
33422	Revision of mitral valve		C					
33425	Repair of mitral valve		C					
33426	Repair of mitral valve		C					
33427	Repair of mitral valve		C					
33430	Replacement of mitral valve		C					
33460	Revision of tricuspid valve		C					
33463	Valvuloplasty, tricuspid		C					
33464	Valvuloplasty, tricuspid		C					
33465	Replace tricuspid valve		C					
33468	Revision of tricuspid valve		C					
33470	Revision of pulmonary valve		C					
33471	Valvotomy, pulmonary valve		C					
33472	Revision of pulmonary valve		C					
33474	Revision of pulmonary valve		C					
33475	Replacement, pulmonary valve		C					
33476	Revision of heart chamber		C					
33478	Revision of heart chamber		C					
33496	Repair, prosth valve clot		C					
33500	Repair heart vessel fistula		C					
33501	Repair heart vessel fistula		C					
33502	Coronary artery correction		C					
33503	Coronary artery graft		C					
33504	Coronary artery graft		C					
33505	Repair artery w/tunnel		C					
33506	Repair artery, translocation		C					
33507	Repair art, intramural		C					
33508	Endoscopic vein harvest		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
33782	Nikaidoh proc		C					
33783	Nikaidoh proc w/ostia implt		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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33840	Remove aorta constriction		C					
33845	Remove aorta constriction		C					
33851	Remove aorta constriction		C					
33852	Repair septal defect		C					
33853	Repair septal defect		C					
33860	Ascending aortic graft		C					
33861	Ascending aortic graft		C					
33863	Ascending aortic graft		C					
33864	Ascending aortic graft		C					
33870	Transverse aortic arch graft		C					
33875	Thoracic aortic graft		C					
33877	Thoracoabdominal graft		C					
33880	Endovasc taa repr incl subcl		C					
33881	Endovasc taa repr w/o subcl		C					
33883	Insert endovasc prosth, taa		C					
33884	Endovasc prosth, taa, add-on		C					
33886	Endovasc prosth, delayed		C					
33889	Artery transpose/endovas taa		C					
33891	Car-car bp grft/endovas taa		C					
33910	Remove lung artery emboli		C					
33915	Remove lung artery emboli		C					
33916	Surgery of great vessel		C					
33917	Repair pulmonary artery		C					
33920	Repair pulmonary atresia		C					
33922	Transect pulmonary artery		C					
33924	Remove pulmonary shunt		C					
33925	Rpr pul art unifocal w/o cpb		C					
33926	Repr pul art, unifocal w/cpb		C					
33930	Removal of donor heart/lung		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
33981	Replace vad pump ext		C					
33982	Replace vad intra w/o bp		C					
33983	Replace vad intra w/bp		C					
33999	Cardiac surgery procedure		T	0070	5.6491	$385.65	.	$77.13
34001	Removal of artery clot		C					
34051	Removal of artery clot		C					
34101	Removal of artery clot		T	0088	41.8116	$2,854.35	$655.22	$570.87
34111	Removal of arm artery clot		T	0088	41.8116	$2,854.35	$655.22	$570.87
34151	Removal of artery clot		C					
34201	Removal of artery clot		T	0088	41.8116	$2,854.35	$655.22	$570.87

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
34203	Removal of leg artery clot		T	0088	41.8116	$2,854.35	$655.22	$570.87
34401	Removal of vein clot		C					
34421	Removal of vein clot		T	0088	41.8116	$2,854.35	$655.22	$570.87
34451	Removal of vein clot		C					
34471	Removal of vein clot		T	0088	41.8116	$2,854.35	$655.22	$570.87
34490	Removal of vein clot		T	0088	41.8116	$2,854.35	$655.22	$570.87
34501	Repair valve, femoral vein		T	0088	41.8116	$2,854.35	$655.22	$570.87
34502	Reconstruct vena cava		C					
34510	Transposition of vein valve		T	0088	41.8116	$2,854.35	$655.22	$570.87
34520	Cross-over vein graft		T	0088	41.8116	$2,854.35	$655.22	$570.87
34530	Leg vein fusion		T	0088	41.8116	$2,854.35	$655.22	$570.87
34800	Endovas aaa repr w/sm tube		C					
34802	Endovas aaa repr w/2-p part		C					
34803	Endovas aaa repr w/3-p part		C					
34804	Endovas aaa repr w/1-p part		C					
34805	Endovas aaa repr w/long tube		C					
34806	Aneurysm press sensor add-on		C					
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, addl		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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35001	Repair defect of artery		C					
35002	Repair artery rupture, neck		C					
35005	Repair defect of artery		C					
35011	Repair defect of artery		T	0653	44.7437	$3,054.52	.	$610.91
35013	Repair artery rupture, arm		C					
35021	Repair defect of artery		C					
35022	Repair artery rupture, chest		C					
35045	Repair defect of arm artery		C					
35081	Repair defect of artery		C					
35082	Repair artery rupture, aorta		C					
35091	Repair defect of artery		C					
35092	Repair artery rupture, aorta		C					
35102	Repair defect of artery		C					
35103	Repair artery rupture, groin		C					
35111	Repair defect of artery		C					
35112	Repair artery rupture,spleen		C					
35121	Repair defect of artery		C					
35122	Repair artery rupture, belly		C					
35131	Repair defect of artery		C					
35132	Repair artery rupture, groin		C					
35141	Repair defect of artery		C					
35142	Repair artery rupture, thigh		C					
35151	Repair defect of artery		C					
35152	Repair artery rupture, knee		C					
35180	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35182	Repair blood vessel lesion		C					
35184	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35188	Repair blood vessel lesion		T	0088	41.8116	$2,854.35	$655.22	$570.87
35189	Repair blood vessel lesion		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35190	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35201	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35206	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35207	Repair blood vessel lesion		T	0088	41.8116	$2,854.35	$655.22	$570.87
35211	Repair blood vessel lesion		C					
35216	Repair blood vessel lesion		C					
35221	Repair blood vessel lesion		C					
35226	Repair blood vessel lesion		T	0020	8.7772	$599.19	.	$119.84
35231	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35236	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35241	Repair blood vessel lesion		C					
35246	Repair blood vessel lesion		C					
35251	Repair blood vessel lesion		C					
35256	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35261	Repair blood vessel lesion		T	0653	44.7437	$3,054.52	.	$610.91
35266	Repair blood vessel lesion		T	0653	44.7437	$3,054.52	.	$610.91
35271	Repair blood vessel lesion		C					
35276	Repair blood vessel lesion		C					
35281	Repair blood vessel lesion		C					
35286	Repair blood vessel lesion		T	0653	44.7437	$3,054.52	.	$610.91
35301	Rechanneling of artery		C					
35302	Rechanneling of artery		C					
35303	Rechanneling of artery		C					
35304	Rechanneling of artery		C					
35305	Rechanneling of artery		C					
35306	Rechanneling of artery		C					
35311	Rechanneling of artery		C					
35321	Rechanneling of artery		T	0093	36.5266	$2,493.56	.	$498.72
35331	Rechanneling of artery		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35341	Rechanneling of artery		C					
35351	Rechanneling of artery		C					
35355	Rechanneling of artery		C					
35361	Rechanneling of artery		C					
35363	Rechanneling of artery		C					
35371	Rechanneling of artery		C					
35372	Rechanneling of artery		C					
35390	Reoperation, carotid add-on		C					
35400	Angioscopy		C					
35450	Repair arterial blockage		C					
35452	Repair arterial blockage		C					
35454	Repair arterial blockage		C					
35456	Repair arterial blockage		C					
35458	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35459	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35460	Repair venous blockage		T	0083	52.1947	$3,563.18	.	$712.64
35470	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35471	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35472	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35473	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35474	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35475	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35476	Repair venous blockage		T	0083	52.1947	$3,563.18	.	$712.64
35480	Atherectomy, open		C					
35481	Atherectomy, open		C					
35482	Atherectomy, open		C					
35483	Atherectomy, open		C					
35484	Atherectomy, open		T	0082	97.8929	$6,682.85	.	$1,336.57
35485	Atherectomy, open		T	0082	97.8929	$6,682.85	.	$1,336.57

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35490	Atherectomy, percutaneous		T	0082	97.8929	$6,682.85	.	$1,336.57
35491	Atherectomy, percutaneous		T	0082	97.8929	$6,682.85	.	$1,336.57
35492	Atherectomy, percutaneous		T	0082	97.8929	$6,682.85	.	$1,336.57
35493	Atherectomy, percutaneous		T	0082	97.8929	$6,682.85	.	$1,336.57
35494	Atherectomy, percutaneous		T	0082	97.8929	$6,682.85	.	$1,336.57
35495	Atherectomy, percutaneous		T	0082	97.8929	$6,682.85	.	$1,336.57
35500	Harvest vein for bypass		T	0103	19.1796	$1,309.33	.	$261.87
35501	Artery bypass graft		C					
35506	Artery bypass graft		C					
35508	Artery bypass graft		C					
35509	Artery bypass graft		C					
35510	Artery bypass graft		C					
35511	Artery bypass graft		C					
35512	Artery bypass graft		C					
35515	Artery bypass graft		C					
35516	Artery bypass graft		C					
35518	Artery bypass graft		C					
35521	Artery bypass graft		C					
35522	Artery bypass graft		C					
35523	Artery bypass graft		C					
35525	Artery bypass graft		C					
35526	Artery bypass graft		C					
35531	Artery bypass graft		C					
35533	Artery bypass graft		C					
35535	Artery bypass graft		C					
35536	Artery bypass graft		C					
35537	Artery bypass graft		C					
35538	Artery bypass graft		C					
35539	Artery bypass graft		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35540	Artery bypass graft		C					
35548	Artery bypass graft		C					
35549	Artery bypass graft		C					
35551	Artery bypass graft		C					
35556	Artery bypass graft		C					
35558	Artery bypass graft		C					
35560	Artery bypass graft		C					
35563	Artery bypass graft		C					
35565	Artery bypass graft		C					
35566	Artery bypass graft		C					
35570	Artery bypass graft		C					
35571	Artery bypass graft		C					
35572	Harvest femoropopliteal vein		N					
35583	Vein bypass graft		C					
35585	Vein bypass graft		C					
35587	Vein bypass graft		C					
35600	Harvest art for cabg add-on		C					
35601	Artery bypass graft		C					
35606	Artery bypass graft		C					
35612	Artery bypass graft		C					
35616	Artery bypass graft		C					
35621	Artery bypass graft		C					
35623	Bypass graft, not vein		C					
35626	Artery bypass graft		C					
35631	Artery bypass graft		C					
35632	Artery bypass graft		C					
35633	Artery bypass graft		C					
35634	Artery bypass graft		C					
35636	Artery bypass graft		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35637	Artery bypass graft		C					
35638	Artery bypass graft		C					
35642	Artery bypass graft		C					
35645	Artery bypass graft		C					
35646	Artery bypass graft		C					
35647	Artery bypass graft		C					
35650	Artery bypass graft		C					
35651	Artery bypass graft		C					
35654	Artery bypass graft		C					
35656	Artery bypass graft		C					
35661	Artery bypass graft		C					
35663	Artery bypass graft		C					
35665	Artery bypass graft		C					
35666	Artery bypass graft		C					
35671	Artery bypass graft		C					
35681	Composite bypass graft		C					
35682	Composite bypass graft		C					
35683	Composite bypass graft		C					
35685	Bypass graft patency/patch		T	0093	36.5266	$2,493.56	.	$498.72
35686	Bypass graft/av fist patency		T	0093	36.5266	$2,493.56	.	$498.72
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35761	Exploration of artery/vein		T	0093	36.5266	$2,493.56	.	$498.72
35800	Explore neck vessels		C					
35820	Explore chest vessels		C					
35840	Explore abdominal vessels		C					
35860	Explore limb vessels		T	0093	36.5266	$2,493.56	.	$498.72
35870	Repair vessel graft defect		C					
35875	Removal of clot in graft		T	0088	41.8116	$2,854.35	$655.22	$570.87
35876	Removal of clot in graft		T	0088	41.8116	$2,854.35	$655.22	$570.87
35879	Revise graft w/vein		T	0088	41.8116	$2,854.35	$655.22	$570.87
35881	Revise graft w/vein		T	0088	41.8116	$2,854.35	$655.22	$570.87
35883	Revise graft w/nonauto graft		T	0088	41.8116	$2,854.35	$655.22	$570.87
35884	Revise graft w/vein		T	0088	41.8116	$2,854.35	$655.22	$570.87
35901	Excision, graft, neck		C					
35903	Excision, graft, extremity		T	0093	36.5266	$2,493.56	.	$498.72
35905	Excision, graft, thorax		C					
35907	Excision, graft, abdomen		C					
36000	Place needle in vein		N					
36002	Pseudoaneurysm injection trt		S	0267	2.2748	$155.29	$60.50	$31.06
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					
36147	Access av dial grft for eval		T	0676	2.3844	$162.78	.	$32.56

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36148	Access av dial grft for proc		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	30.8594	$2,106.68	.	$421.34
36261	Revision of infusion pump		T	0105	23.2281	$1,585.71	.	$317.15
36262	Removal of infusion pump		T	0105	23.2281	$1,585.71	.	$317.15
36299	Vessel injection procedure		N					
36400	Bl draw < 3 yrs fem/jugular		N					
36405	Bl draw < 3 yrs scalp vein		N					
36406	Bl draw < 3 yrs other vein		N					
36410	Non-routine bl draw > 3 yrs		N					
36415	Routine venipuncture		A					
36416	Capillary blood draw		N					
36420	Vein access cutdown < 1 yr		X	0035	0.2446	$16.70	.	$3.34
36425	Vein access cutdown > 1 yr		X	0035	0.2446	$16.70	.	$3.34
36430	Blood transfusion service		S	0110	3.4107	$232.84	.	$46.57
36440	Bl push transfuse, 2 yr or <		S	0110	3.4107	$232.84	.	$46.57
36450	Bl exchange/transfuse, nb		S	0110	3.4107	$232.84	.	$46.57
36455	Bl exchange/transfuse non-nb		S	0110	3.4107	$232.84	.	$46.57
36460	Transfusion service, fetal		S	0110	3.4107	$232.84	.	$46.57
36468	Injection(s), spider veins		T	0013	0.8782	$59.95	.	$11.99

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36469	Injection(s), spider veins		T	0013	0.8782	$59.95	.	$11.99
36470	Injection therapy of vein		T	0013	0.8782	$59.95	.	$11.99
36471	Injection therapy of veins		T	0013	0.8782	$59.95	.	$11.99
36475	Endovenous rf, 1st vein		T	0091	44.4254	$3,032.79	.	$606.56
36476	Endovenous rf, vein add-on		T	0092	27.5456	$1,880.46	.	$376.10
36478	Endovenous laser, 1st vein		T	0092	27.5456	$1,880.46	.	$376.10
36479	Endovenous laser vein addon		T	0092	27.5456	$1,880.46	.	$376.10
36481	Insertion of catheter, vein		N					
36500	Insertion of catheter, vein		N					
36510	Insertion of catheter, vein		N					
36511	Apheresis wbc		S	0111	12.5247	$855.02	$198.40	$171.01
36512	Apheresis rbc		S	0111	12.5247	$855.02	$198.40	$171.01
36513	Apheresis platelets		S	0111	12.5247	$855.02	$198.40	$171.01
36514	Apheresis plasma		S	0111	12.5247	$855.02	$198.40	$171.01
36515	Apheresis, adsorp/reinfuse		S	0112	33.8904	$2,313.60	.	$462.72
36516	Apheresis, selective		S	0112	33.8904	$2,313.60	.	$462.72
36522	Photopheresis		S	0112	33.8904	$2,313.60	.	$462.72
36555	Insert non-tunnel cv cath		T	0621	11.4058	$778.64	.	$155.73
36556	Insert non-tunnel cv cath		T	0621	11.4058	$778.64	.	$155.73
36557	Insert tunneled cv cath		T	0622	25.693	$1,753.98	.	$350.80
36558	Insert tunneled cv cath		T	0622	25.693	$1,753.98	.	$350.80
36560	Insert tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36561	Insert tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36563	Insert tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36565	Insert tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36566	Insert tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36568	Insert picc cath		T	0621	11.4058	$778.64	.	$155.73
36569	Insert picc cath		T	0621	11.4058	$778.64	.	$155.73
36570	Insert picvad cath		T	0622	25.693	$1,753.98	.	$350.80

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36571	Insert picvad cath		T	0622	25.693	$1,753.98	.	$350.80
36575	Repair tunneled cv cath		T	0121	6.3264	$431.88	.	$86.38
36576	Repair tunneled cv cath		T	0621	11.4058	$778.64	.	$155.73
36578	Replace tunneled cv cath		T	0622	25.693	$1,753.98	.	$350.80
36580	Replace cvad cath		T	0621	11.4058	$778.64	.	$155.73
36581	Replace tunneled cv cath		T	0622	25.693	$1,753.98	.	$350.80
36582	Replace tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36583	Replace tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36584	Replace picc cath		T	0621	11.4058	$778.64	.	$155.73
36585	Replace picvad cath		T	0622	25.693	$1,753.98	.	$350.80
36589	Removal tunneled cv cath		T	0121	6.3264	$431.88	.	$86.38
36590	Removal tunneled cv cath		T	0621	11.4058	$778.64	.	$155.73
36591	Draw blood off venous device		Q1	0624	0.6338	$43.27	$12.65	$8.66
36592	Collect blood from picc		Q1	0624	0.6338	$43.27	$12.65	$8.66
36593	Declot vascular device		T	0676	2.3844	$162.78	.	$32.56
36595	Mech remov tunneled cv cath		T	0622	25.693	$1,753.98	.	$350.80
36596	Mech remov tunneled cv cath		T	0621	11.4058	$778.64	.	$155.73
36597	Reposition venous catheter		T	0621	11.4058	$778.64	.	$155.73
36598	Inj w/fluor, eval cv device		T	0676	2.3844	$162.78	.	$32.56
36600	Withdrawal of arterial blood		Q1	0035	0.2446	$16.70	.	$3.34
36620	Insertion catheter, artery		N					
36625	Insertion catheter, artery		N					
36640	Insertion catheter, artery		T	0623	30.8594	$2,106.68	.	$421.34
36660	Insertion catheter, artery		C					
36680	Insert needle, bone cavity		T	0002	1.7752	$121.19	.	$24.24
36800	Insertion of cannula		T	0115	33.3074	$2,273.80	.	$454.76
36810	Insertion of cannula		T	0115	33.3074	$2,273.80	.	$454.76
36815	Insertion of cannula		T	0115	33.3074	$2,273.80	.	$454.76
36818	Av fuse, uppr arm, cephalic		T	0088	41.8116	$2,854.35	$655.22	$570.87

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36819	Av fuse, uppr arm, basilic		T	0088	41.8116	$2,854.35	$655.22	$570.87
36820	Av fusion/forearm vein		T	0088	41.8116	$2,854.35	$655.22	$570.87
36821	Av fusion direct any site		T	0088	41.8116	$2,854.35	$655.22	$570.87
36822	Insertion of cannula(s)		C					
36823	Insertion of cannula(s)		C					
36825	Artery-vein autograft		T	0088	41.8116	$2,854.35	$655.22	$570.87
36830	Artery-vein nonautograft		T	0088	41.8116	$2,854.35	$655.22	$570.87
36831	Open thrombect av fistula		T	0088	41.8116	$2,854.35	$655.22	$570.87
36832	Av fistula revision, open		T	0088	41.8116	$2,854.35	$655.22	$570.87
36833	Av fistula revision		T	0088	41.8116	$2,854.35	$655.22	$570.87
36835	Artery to vein shunt		T	0115	33.3074	$2,273.80	.	$454.76
36838	Dist revas ligation, hemo		T	0088	41.8116	$2,854.35	$655.22	$570.87
36860	External cannula declotting		T	0676	2.3844	$162.78	.	$32.56
36861	Cannula declotting		T	0115	33.3074	$2,273.80	.	$454.76
36870	Percut thrombect av fistula		T	0653	44.7437	$3,054.52	.	$610.91
37140	Revision of circulation		C					
37145	Revision of circulation		C					
37160	Revision of circulation		C					
37180	Revision of circulation		C					
37181	Splice spleen/kidney veins		C					
37182	Insert hepatic shunt (tips)		C					
37183	Remove hepatic shunt (tips)		T	0229	96.8443	$6,611.27	.	$1,322.26
37184	Prim art mech thrombectomy		T	0088	41.8116	$2,854.35	$655.22	$570.87
37185	Prim art m-thrombect add-on		T	0088	41.8116	$2,854.35	$655.22	$570.87
37186	Sec art m-thrombect add-on		T	0088	41.8116	$2,854.35	$655.22	$570.87
37187	Venous mech thrombectomy		T	0088	41.8116	$2,854.35	$655.22	$570.87
37188	Venous m-thrombectomy add-on		T	0088	41.8116	$2,854.35	$655.22	$570.87
37195	Thrombolytic therapy, stroke		T	0676	2.3844	$162.78	.	$32.56
37200	Transcatheter biopsy		T	0623	30.8594	$2,106.68	.	$421.34

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
37201	Transcatheter therapy infuse		T	0103	19.1796	$1,309.33	.	$261.87
37202	Transcatheter therapy infuse		T	0103	19.1796	$1,309.33	.	$261.87
37203	Transcatheter retrieval		T	0623	30.8594	$2,106.68	.	$421.34
37204	Transcatheter occlusion		T	0082	97.8929	$6,682.85	.	$1,336.57
37205	Transcath iv stent, percut		T	0229	96.8443	$6,611.27	.	$1,322.26
37206	Transcath iv stent/perc addl		T	0229	96.8443	$6,611.27	.	$1,322.26
37207	Transcath iv stent, open		T	0229	96.8443	$6,611.27	.	$1,322.26
37208	Transcath iv stent/open addl		T	0229	96.8443	$6,611.27	.	$1,322.26
37209	Change iv cath at thromb tx		T	0623	30.8594	$2,106.68	.	$421.34
37210	Embolization uterine fibroid		T	0229	96.8443	$6,611.27	.	$1,322.26
37215	Transcath stent, cca w/eps		C					
37216	Transcath stent, cca w/o eps		E					
37250	Iv us first vessel add-on		N					
37251	Iv us each add vessel add-on		N					
37500	Endoscopy ligate perf veins		T	0091	44.4254	$3,032.79	.	$606.56
37501	Vascular endoscopy procedure		T	0092	27.5456	$1,880.46	.	$376.10
37565	Ligation of neck vein		T	0093	36.5266	$2,493.56	.	$498.72
37600	Ligation of neck artery		T	0093	36.5266	$2,493.56	.	$498.72
37605	Ligation of neck artery		T	0091	44.4254	$3,032.79	.	$606.56
37606	Ligation of neck artery		T	0092	27.5456	$1,880.46	.	$376.10
37607	Ligation of a-v fistula		T	0092	27.5456	$1,880.46	.	$376.10
37609	Temporal artery procedure		T	0021	18.2223	$1,243.98	.	$248.80
37615	Ligation of neck artery		T	0092	27.5456	$1,880.46	.	$376.10
37616	Ligation of chest artery		C					
37617	Ligation of abdomen artery		C					
37618	Ligation of extremity artery		C					
37620	Revision of major vein		T	0091	44.4254	$3,032.79	.	$606.56
37650	Revision of major vein		T	0092	27.5456	$1,880.46	.	$376.10
37660	Revision of major vein		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
37700	Revise leg vein		T	0092	27.5456	$1,880.46	.	$376.10
37718	Ligate/strip short leg vein		T	0092	27.5456	$1,880.46	.	$376.10
37722	Ligate/strip long leg vein		T	0091	44.4254	$3,032.79	.	$606.56
37735	Removal of leg veins/lesion		T	0091	44.4254	$3,032.79	.	$606.56
37760	Ligate leg veins radical		T	0092	27.5456	$1,880.46	.	$376.10
37761	Ligate leg veins open		T	0092	27.5456	$1,880.46	.	$376.10
37765	Phleb veins - extrem - to 20		T	0092	27.5456	$1,880.46	.	$376.10
37766	Phleb veins - extrem 20+		T	0092	27.5456	$1,880.46	.	$376.10
37780	Revision of leg vein		T	0092	27.5456	$1,880.46	.	$376.10
37785	Ligate/divide/excise vein		T	0092	27.5456	$1,880.46	.	$376.10
37788	Revascularization, penis		C					
37790	Penile venous occlusion		T	0181	36.4186	$2,486.19	$620.84	$497.24
37799	Vascular surgery procedure		X	0624	0.6338	$43.27	$12.65	$8.66
38100	Removal of spleen, total		C					
38101	Removal of spleen, partial		C					
38102	Removal of spleen, total		C					
38115	Repair of ruptured spleen		C					
38120	Laparoscopy, splenectomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
38129	Laparoscope proc, spleen		T	0130	38.7195	$2,643.26	$659.53	$528.66
38200	Injection for spleen x-ray		N					
38204	Bl donor search management		N					
38205	Harvest allogenic stem cells		B					
38206	Harvest auto stem cells		S	0111	12.5247	$855.02	$198.40	$171.01
38207	Cryopreserve stem cells		S	0110	3.4107	$232.84	.	$46.57
38208	Thaw preserved stem cells		S	0110	3.4107	$232.84	.	$46.57
38209	Wash harvest stem cells		S	0110	3.4107	$232.84	.	$46.57
38210	T-cell depletion of harvest		S	0393	5.877	$401.21	.	$80.25
38211	Tumor cell deplete of harvst		S	0393	5.877	$401.21	.	$80.25
38212	Rbc depletion of harvest		S	0393	5.877	$401.21	.	$80.25

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
38213	Platelet deplete of harvest		S	0393	5.877	$401.21	.	$80.25
38214	Volume deplete of harvest		S	0393	5.877	$401.21	.	$80.25
38215	Harvest stem cell concentrte		S	0393	5.877	$401.21	.	$80.25
38220	Bone marrow aspiration		T	0003	3.6353	$248.17	.	$49.64
38221	Bone marrow biopsy		T	0003	3.6353	$248.17	.	$49.64
38230	Bone marrow collection		S	0112	33.8904	$2,313.60	.	$462.72
38240	Bone marrow/stem transplant		S	0112	33.8904	$2,313.60	.	$462.72
38241	Bone marrow/stem transplant		S	0112	33.8904	$2,313.60	.	$462.72
38242	Lymphocyte infuse transplant		S	0111	12.5247	$855.02	$198.40	$171.01
38300	Drainage, lymph node lesion		T	0007	13.3268	$909.78	.	$181.96
38305	Drainage, lymph node lesion		T	0008	20.2481	$1,382.28	.	$276.46
38308	Incision of lymph channels		T	0113	25.2939	$1,726.74	.	$345.35
38380	Thoracic duct procedure		C					
38381	Thoracic duct procedure		C					
38382	Thoracic duct procedure		C					
38500	Biopsy/removal, lymph nodes		T	0113	25.2939	$1,726.74	.	$345.35
38505	Needle biopsy, lymph nodes		T	0005	8.16	$557.06	.	$111.42
38510	Biopsy/removal, lymph nodes		T	0113	25.2939	$1,726.74	.	$345.35
38520	Biopsy/removal, lymph nodes		T	0113	25.2939	$1,726.74	.	$345.35
38525	Biopsy/removal, lymph nodes		T	0113	25.2939	$1,726.74	.	$345.35
38530	Biopsy/removal, lymph nodes		T	0113	25.2939	$1,726.74	.	$345.35
38542	Explore deep node(s), neck		T	0114	50.9844	$3,480.55	.	$696.11
38550	Removal, neck/armpit lesion		T	0113	25.2939	$1,726.74	.	$345.35
38555	Removal, neck/armpit lesion		T	0113	25.2939	$1,726.74	.	$345.35
38562	Removal, pelvic lymph nodes		C					
38564	Removal, abdomen lymph nodes		C					
38570	Laparoscopy, lymph node biop		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
38571	Laparoscopy, lymphadenectomy		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
38572	Laparoscopy, lymphadenectomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
38589	Laparoscope proc, lymphatic		T	0130	38.7195	$2,643.26	$659.53	$528.66
38700	Removal of lymph nodes, neck		T	0113	25.2939	$1,726.74	.	$345.35
38720	Removal of lymph nodes, neck		T	0113	25.2939	$1,726.74	.	$345.35
38724	Removal of lymph nodes, neck		C					
38740	Remove armpit lymph nodes		T	0114	50.9844	$3,480.55	.	$696.11
38745	Remove armpit lymph nodes		T	0114	50.9844	$3,480.55	.	$696.11
38746	Remove thoracic lymph nodes		C					
38747	Remove abdominal lymph nodes		C					
38760	Remove groin lymph nodes		T	0113	25.2939	$1,726.74	.	$345.35
38765	Remove groin lymph nodes		C					
38770	Remove pelvis lymph nodes		C					
38780	Remove abdomen lymph nodes		C					
38790	Inject for lymphatic x-ray		N					
38792	Identify sentinel node		Q1	0392	2.6029	$177.69	$43.31	$35.54
38794	Access thoracic lymph duct		N					
38999	Blood/lymph system procedure		S	0110	3.4107	$232.84	.	$46.57
39000	Exploration of chest		C					
39010	Exploration of chest		C					
39200	Removal chest lesion		C					
39220	Removal chest lesion		C					
39400	Visualization of chest		T	0069	35.4455	$2,419.76	$591.64	$483.96
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
40490	Biopsy of lip		T	0251	3.4369	$234.63	.	$46.93
40500	Partial excision of lip		T	0253	17.4151	$1,188.88	$282.29	$237.78
40510	Partial excision of lip		T	0254	25.5397	$1,743.52	.	$348.71
40520	Partial excision of lip		T	0253	17.4151	$1,188.88	$282.29	$237.78
40525	Reconstruct lip with flap		T	0254	25.5397	$1,743.52	.	$348.71
40527	Reconstruct lip with flap		T	0254	25.5397	$1,743.52	.	$348.71
40530	Partial removal of lip		T	0254	25.5397	$1,743.52	.	$348.71
40650	Repair lip		T	0252	7.8743	$537.55	$109.16	$107.51
40652	Repair lip		T	0252	7.8743	$537.55	$109.16	$107.51
40654	Repair lip		T	0252	7.8743	$537.55	$109.16	$107.51
40700	Repair cleft lip/nasal		T	0256	44.8441	$3,061.37	.	$612.28
40701	Repair cleft lip/nasal		T	0256	44.8441	$3,061.37	.	$612.28
40702	Repair cleft lip/nasal		T	0256	44.8441	$3,061.37	.	$612.28
40720	Repair cleft lip/nasal		T	0256	44.8441	$3,061.37	.	$612.28
40761	Repair cleft lip/nasal		T	0256	44.8441	$3,061.37	.	$612.28
40799	Lip surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
40800	Drainage of mouth lesion		T	0006	1.4939	$101.98	.	$20.40
40801	Drainage of mouth lesion		T	0252	7.8743	$537.55	$109.16	$107.51
40804	Removal, foreign body, mouth		X	0340	0.6899	$47.10	.	$9.42
40805	Removal, foreign body, mouth		T	0252	7.8743	$537.55	$109.16	$107.51
40806	Incision of lip fold		T	0251	3.4369	$234.63	.	$46.93
40808	Biopsy of mouth lesion		T	0251	3.4369	$234.63	.	$46.93
40810	Excision of mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
40812	Excise/repair mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
40814	Excise/repair mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
40816	Excision of mouth lesion		T	0254	25.5397	$1,743.52	.	$348.71
40818	Excise oral mucosa for graft		T	0251	3.4369	$234.63	.	$46.93
40819	Excise lip or cheek fold		T	0252	7.8743	$537.55	$109.16	$107.51
40820	Treatment of mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
40830	Repair mouth laceration		T	0251	3.4369	$234.63	.	$46.93
40831	Repair mouth laceration		T	0252	7.8743	$537.55	$109.16	$107.51
40840	Reconstruction of mouth		T	0254	25.5397	$1,743.52	.	$348.71
40842	Reconstruction of mouth		T	0254	25.5397	$1,743.52	.	$348.71
40843	Reconstruction of mouth		T	0254	25.5397	$1,743.52	.	$348.71
40844	Reconstruction of mouth		T	0256	44.8441	$3,061.37	.	$612.28
40845	Reconstruction of mouth		T	0256	44.8441	$3,061.37	.	$612.28
40899	Mouth surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
41000	Drainage of mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41005	Drainage of mouth lesion		T	0251	3.4369	$234.63	.	$46.93
41006	Drainage of mouth lesion		T	0254	25.5397	$1,743.52	.	$348.71
41007	Drainage of mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41008	Drainage of mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41009	Drainage of mouth lesion		T	0251	3.4369	$234.63	.	$46.93
41010	Incision of tongue fold		T	0252	7.8743	$537.55	$109.16	$107.51
41015	Drainage of mouth lesion		T	0251	3.4369	$234.63	.	$46.93
41016	Drainage of mouth lesion		T	0252	7.8743	$537.55	$109.16	$107.51
41017	Drainage of mouth lesion		T	0252	7.8743	$537.55	$109.16	$107.51
41018	Drainage of mouth lesion		T	0252	7.8743	$537.55	$109.16	$107.51
41019	Place needles h&n for rt		T	0254	25.5397	$1,743.52	.	$348.71
41100	Biopsy of tongue		T	0252	7.8743	$537.55	$109.16	$107.51
41105	Biopsy of tongue		T	0253	17.4151	$1,188.88	$282.29	$237.78
41108	Biopsy of floor of mouth		T	0019	4.9184	$335.76	.	$67.16
41110	Excision of tongue lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
41112	Excision of tongue lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41113	Excision of tongue lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41114	Excision of tongue lesion		T	0254	25.5397	$1,743.52	.	$348.71
41115	Excision of tongue fold		T	0252	7.8743	$537.55	$109.16	$107.51
41116	Excision of mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41120	Partial removal of tongue		T	0254	25.5397	$1,743.52	.	$348.71
41130	Partial removal of tongue		C					
41135	Tongue and neck surgery		C					
41140	Removal of tongue		C					
41145	Tongue removal, neck surgery		C					
41150	Tongue, mouth, jaw surgery		C					
41153	Tongue, mouth, neck surgery		C					
41155	Tongue, jaw, & neck surgery		C					
41250	Repair tongue laceration		T	0250	1.1743	$80.17	$25.10	$16.04
41251	Repair tongue laceration		T	0251	3.4369	$234.63	.	$46.93
41252	Repair tongue laceration		T	0252	7.8743	$537.55	$109.16	$107.51
41500	Fixation of tongue		T	0254	25.5397	$1,743.52	.	$348.71
41510	Tongue to lip surgery		T	0253	17.4151	$1,188.88	$282.29	$237.78
41512	Tongue suspension		T	0252	7.8743	$537.55	$109.16	$107.51
41520	Reconstruction, tongue fold		T	0252	7.8743	$537.55	$109.16	$107.51
41530	Tongue base vol reduction		T	0254	25.5397	$1,743.52	.	$348.71
41599	Tongue and mouth surgery		T	0250	1.1743	$80.17	$25.10	$16.04
41800	Drainage of gum lesion		T	0006	1.4939	$101.98	.	$20.40
41805	Removal foreign body, gum		T	0254	25.5397	$1,743.52	.	$348.71
41806	Removal foreign body,jawbone		T	0253	17.4151	$1,188.88	$282.29	$237.78
41820	Excision, gum, each quadrant		T	0252	7.8743	$537.55	$109.16	$107.51
41821	Excision of gum flap		T	0252	7.8743	$537.55	$109.16	$107.51
41822	Excision of gum lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41823	Excision of gum lesion		T	0254	25.5397	$1,743.52	.	$348.71

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
41825	Excision of gum lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41826	Excision of gum lesion		T	0254	25.5397	$1,743.52	.	$348.71
41827	Excision of gum lesion		T	0254	25.5397	$1,743.52	.	$348.71
41828	Excision of gum lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41830	Removal of gum tissue		T	0253	17.4151	$1,188.88	$282.29	$237.78
41850	Treatment of gum lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41870	Gum graft		T	0254	25.5397	$1,743.52	.	$348.71
41872	Repair gum		T	0253	17.4151	$1,188.88	$282.29	$237.78
41874	Repair tooth socket		T	0254	25.5397	$1,743.52	.	$348.71
41899	Dental surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
42000	Drainage mouth roof lesion		T	0251	3.4369	$234.63	.	$46.93
42100	Biopsy roof of mouth		T	0252	7.8743	$537.55	$109.16	$107.51
42104	Excision lesion, mouth roof		T	0253	17.4151	$1,188.88	$282.29	$237.78
42106	Excision lesion, mouth roof		T	0253	17.4151	$1,188.88	$282.29	$237.78
42107	Excision lesion, mouth roof		T	0254	25.5397	$1,743.52	.	$348.71
42120	Remove palate/lesion		T	0256	44.8441	$3,061.37	.	$612.28
42140	Excision of uvula		T	0252	7.8743	$537.55	$109.16	$107.51
42145	Repair palate, pharynx/uvula		T	0254	25.5397	$1,743.52	.	$348.71
42160	Treatment mouth roof lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
42180	Repair palate		T	0251	3.4369	$234.63	.	$46.93
42182	Repair palate		T	0256	44.8441	$3,061.37	.	$612.28
42200	Reconstruct cleft palate		T	0256	44.8441	$3,061.37	.	$612.28
42205	Reconstruct cleft palate		T	0256	44.8441	$3,061.37	.	$612.28
42210	Reconstruct cleft palate		T	0256	44.8441	$3,061.37	.	$612.28
42215	Reconstruct cleft palate		T	0256	44.8441	$3,061.37	.	$612.28
42220	Reconstruct cleft palate		T	0256	44.8441	$3,061.37	.	$612.28
42225	Reconstruct cleft palate		T	0256	44.8441	$3,061.37	.	$612.28
42226	Lengthening of palate		T	0256	44.8441	$3,061.37	.	$612.28
42227	Lengthening of palate		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42235	Repair palate		T	0253	17.4151	$1,188.88	$282.29	$237.78
42260	Repair nose to lip fistula		T	0254	25.5397	$1,743.52	.	$348.71
42280	Preparation, palate mold		T	0251	3.4369	$234.63	.	$46.93
42281	Insertion, palate prosthesis		T	0253	17.4151	$1,188.88	$282.29	$237.78
42299	Palate/uvula surgery		T	0250	1.1743	$80.17	$25.10	$16.04
42300	Drainage of salivary gland		T	0253	17.4151	$1,188.88	$282.29	$237.78
42305	Drainage of salivary gland		T	0253	17.4151	$1,188.88	$282.29	$237.78
42310	Drainage of salivary gland		T	0251	3.4369	$234.63	.	$46.93
42320	Drainage of salivary gland		T	0251	3.4369	$234.63	.	$46.93
42330	Removal of salivary stone		T	0253	17.4151	$1,188.88	$282.29	$237.78
42335	Removal of salivary stone		T	0253	17.4151	$1,188.88	$282.29	$237.78
42340	Removal of salivary stone		T	0253	17.4151	$1,188.88	$282.29	$237.78
42400	Biopsy of salivary gland		T	0005	8.16	$557.06	.	$111.42
42405	Biopsy of salivary gland		T	0254	25.5397	$1,743.52	.	$348.71
42408	Excision of salivary cyst		T	0253	17.4151	$1,188.88	$282.29	$237.78
42409	Drainage of salivary cyst		T	0253	17.4151	$1,188.88	$282.29	$237.78
42410	Excise parotid gland/lesion		T	0256	44.8441	$3,061.37	.	$612.28
42415	Excise parotid gland/lesion		T	0256	44.8441	$3,061.37	.	$612.28
42420	Excise parotid gland/lesion		T	0256	44.8441	$3,061.37	.	$612.28
42425	Excise parotid gland/lesion		T	0256	44.8441	$3,061.37	.	$612.28
42426	Excise parotid gland/lesion		C					
42440	Excise submaxillary gland		T	0256	44.8441	$3,061.37	.	$612.28
42450	Excise sublingual gland		T	0254	25.5397	$1,743.52	.	$348.71
42500	Repair salivary duct		T	0254	25.5397	$1,743.52	.	$348.71
42505	Repair salivary duct		T	0256	44.8441	$3,061.37	.	$612.28
42507	Parotid duct diversion		T	0256	44.8441	$3,061.37	.	$612.28
42508	Parotid duct diversion		T	0256	44.8441	$3,061.37	.	$612.28
42509	Parotid duct diversion		T	0256	44.8441	$3,061.37	.	$612.28
42510	Parotid duct diversion		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42550	Injection for salivary x-ray		N					
42600	Closure of salivary fistula		T	0253	17.4151	$1,188.88	$282.29	$237.78
42650	Dilation of salivary duct		T	0252	7.8743	$537.55	$109.16	$107.51
42660	Dilation of salivary duct		T	0251	3.4369	$234.63	.	$46.93
42665	Ligation of salivary duct		T	0254	25.5397	$1,743.52	.	$348.71
42699	Salivary surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
42700	Drainage of tonsil abscess		T	0251	3.4369	$234.63	.	$46.93
42720	Drainage of throat abscess		T	0253	17.4151	$1,188.88	$282.29	$237.78
42725	Drainage of throat abscess		T	0256	44.8441	$3,061.37	.	$612.28
42800	Biopsy of throat	CH	T	0252	7.8743	$537.55	$109.16	$107.51
42802	Biopsy of throat		T	0253	17.4151	$1,188.88	$282.29	$237.78
42804	Biopsy of upper nose/throat		T	0253	17.4151	$1,188.88	$282.29	$237.78
42806	Biopsy of upper nose/throat		T	0254	25.5397	$1,743.52	.	$348.71
42808	Excise pharynx lesion		T	0254	25.5397	$1,743.52	.	$348.71
42809	Remove pharynx foreign body		X	0340	0.6899	$47.10	.	$9.42
42810	Excision of neck cyst		T	0254	25.5397	$1,743.52	.	$348.71
42815	Excision of neck cyst		T	0256	44.8441	$3,061.37	.	$612.28
42820	Remove tonsils and adenoids		T	0254	25.5397	$1,743.52	.	$348.71
42821	Remove tonsils and adenoids		T	0254	25.5397	$1,743.52	.	$348.71
42825	Removal of tonsils		T	0254	25.5397	$1,743.52	.	$348.71
42826	Removal of tonsils		T	0254	25.5397	$1,743.52	.	$348.71
42830	Removal of adenoids		T	0254	25.5397	$1,743.52	.	$348.71
42831	Removal of adenoids		T	0254	25.5397	$1,743.52	.	$348.71
42835	Removal of adenoids		T	0254	25.5397	$1,743.52	.	$348.71
42836	Removal of adenoids		T	0254	25.5397	$1,743.52	.	$348.71
42842	Extensive surgery of throat		T	0254	25.5397	$1,743.52	.	$348.71
42844	Extensive surgery of throat		T	0256	44.8441	$3,061.37	.	$612.28
42845	Extensive surgery of throat		C					
42860	Excision of tonsil tags		T	0254	25.5397	$1,743.52	.	$348.71

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42870	Excision of lingual tonsil		T	0254	25.5397	$1,743.52	.	$348.71
42890	Partial removal of pharynx		T	0256	44.8441	$3,061.37	.	$612.28
42892	Revision of pharyngeal walls		T	0256	44.8441	$3,061.37	.	$612.28
42894	Revision of pharyngeal walls		C					
42900	Repair throat wound		T	0252	7.8743	$537.55	$109.16	$107.51
42950	Reconstruction of throat		T	0254	25.5397	$1,743.52	.	$348.71
42953	Repair throat, esophagus		C					
42955	Surgical opening of throat		T	0254	25.5397	$1,743.52	.	$348.71
42960	Control throat bleeding		T	0250	1.1743	$80.17	$25.10	$16.04
42961	Control throat bleeding		C					
42962	Control throat bleeding		T	0256	44.8441	$3,061.37	.	$612.28
42970	Control nose/throat bleeding		T	0250	1.1743	$80.17	$25.10	$16.04
42971	Control nose/throat bleeding		C					
42972	Control nose/throat bleeding		T	0253	17.4151	$1,188.88	$282.29	$237.78
42999	Throat surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
43020	Incision of esophagus		T	0252	7.8743	$537.55	$109.16	$107.51
43030	Throat muscle surgery		T	0253	17.4151	$1,188.88	$282.29	$237.78
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43123	Partial removal of esophagus		C					
43124	Removal of esophagus		C					
43130	Removal of esophagus pouch		T	0256	44.8441	$3,061.37	.	$612.28
43135	Removal of esophagus pouch		C					
43200	Esophagus endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43201	Esoph scope w/submucous inj		T	0141	8.8811	$606.29	$143.38	$121.26
43202	Esophagus endoscopy, biopsy		T	0141	8.8811	$606.29	$143.38	$121.26
43204	Esoph scope w/sclerosis inj		T	0141	8.8811	$606.29	$143.38	$121.26
43205	Esophagus endoscopy/ligation		T	0141	8.8811	$606.29	$143.38	$121.26
43215	Esophagus endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43216	Esophagus endoscopy/lesion	CH	T	0422	16.3107	$1,113.48	$271.47	$222.70
43217	Esophagus endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43219	Esophagus endoscopy		T	0384	27.4802	$1,875.99	.	$375.20
43220	Esoph endoscopy, dilation		T	0141	8.8811	$606.29	$143.38	$121.26
43226	Esoph endoscopy, dilation		T	0141	8.8811	$606.29	$143.38	$121.26
43227	Esoph endoscopy, repair		T	0141	8.8811	$606.29	$143.38	$121.26
43228	Esoph endoscopy, ablation		T	0422	16.3107	$1,113.48	$271.47	$222.70
43231	Esoph endoscopy w/us exam		T	0141	8.8811	$606.29	$143.38	$121.26
43232	Esoph endoscopy w/us fn bx		T	0141	8.8811	$606.29	$143.38	$121.26
43234	Upper GI endoscopy, exam		T	0141	8.8811	$606.29	$143.38	$121.26
43235	Uppr gi endoscopy, diagnosis		T	0141	8.8811	$606.29	$143.38	$121.26
43236	Uppr gi scope w/submuc inj		T	0141	8.8811	$606.29	$143.38	$121.26
43237	Endoscopic us exam, esoph		T	0141	8.8811	$606.29	$143.38	$121.26
43238	Uppr gi endoscopy w/us fn bx		T	0141	8.8811	$606.29	$143.38	$121.26
43239	Upper GI endoscopy, biopsy		T	0141	8.8811	$606.29	$143.38	$121.26
43240	Esoph endoscope w/drain cyst		T	0141	8.8811	$606.29	$143.38	$121.26
43241	Upper GI endoscopy with tube		T	0141	8.8811	$606.29	$143.38	$121.26
43242	Uppr gi endoscopy w/us fn bx	CH	T	0422	16.3107	$1,113.48	$271.47	$222.70
43243	Upper gi endoscopy & inject		T	0141	8.8811	$606.29	$143.38	$121.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43244	Upper GI endoscopy/ligation		T	0141	8.8811	$606.29	$143.38	$121.26
43245	Uppr gi scope dilate strictr		T	0141	8.8811	$606.29	$143.38	$121.26
43246	Place gastrostomy tube		T	0141	8.8811	$606.29	$143.38	$121.26
43247	Operative upper GI endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43248	Uppr gi endoscopy/guide wire		T	0141	8.8811	$606.29	$143.38	$121.26
43249	Esoph endoscopy, dilation		T	0141	8.8811	$606.29	$143.38	$121.26
43250	Upper GI endoscopy/tumor		T	0141	8.8811	$606.29	$143.38	$121.26
43251	Operative upper GI endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43255	Operative upper GI endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43256	Uppr gi endoscopy w/stent		T	0384	27.4802	$1,875.99	.	$375.20
43257	Uppr gi scope w/thrml txmnt		T	0422	16.3107	$1,113.48	$271.47	$222.70
43258	Operative upper GI endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43259	Endoscopic ultrasound exam		T	0141	8.8811	$606.29	$143.38	$121.26
43260	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43261	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43262	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43263	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43264	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43265	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43267	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43268	Endo cholangiopancreatograph		T	0384	27.4802	$1,875.99	.	$375.20
43269	Endo cholangiopancreatograph		T	0384	27.4802	$1,875.99	.	$375.20
43271	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43272	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43273	Endoscopic pancreatoscopy		T	0151	23.0632	$1,574.46	.	$314.90
43279	Lap myotomy, heller		C					
43280	Laparoscopy, fundoplasty		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
43281	Lap paraesophag hern repair		C					
43282	Lap paraesoph her rpr w/mesh		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43289	Laparoscope proc, esoph		T	0130	38.7195	$2,643.26	$659.53	$528.66
43300	Repair of esophagus		C					
43305	Repair esophagus and fistula		C					
43310	Repair of esophagus		C					
43312	Repair esophagus and fistula		C					
43313	Esophagoplasty congenital		C					
43314	Tracheo-esophagoplasty cong		C					
43320	Fuse esophagus & stomach		C					
43324	Revise esophagus & stomach		C					
43325	Revise esophagus & stomach		C					
43326	Revise esophagus & stomach		C					
43330	Repair of esophagus		C					
43331	Repair of esophagus		C					
43340	Fuse esophagus & intestine		C					
43341	Fuse esophagus & intestine		C					
43350	Surgical opening, esophagus		C					
43351	Surgical opening, esophagus		C					
43352	Surgical opening, esophagus		C					
43360	Gastrointestinal repair		C					
43361	Gastrointestinal repair		C					
43400	Ligate esophagus veins		C					
43401	Esophagus surgery for veins		C					
43405	Ligate/staple esophagus		C					
43410	Repair esophagus wound		C					
43415	Repair esophagus wound		C					
43420	Repair esophagus opening		T	0254	25.5397	$1,743.52	.	$348.71
43425	Repair esophagus opening		C					
43450	Dilate esophagus		T	0140	6.4279	$438.81	.	$87.77
43453	Dilate esophagus		T	0140	6.4279	$438.81	.	$87.77

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43456	Dilate esophagus		T	0140	6.4279	$438.81	.	$87.77
43458	Dilate esophagus		T	0141	8.8811	$606.29	$143.38	$121.26
43460	Pressure treatment esophagus		C					
43496	Free jejunum flap, microvasc		C					
43499	Esophagus surgery procedure		T	0141	8.8811	$606.29	$143.38	$121.26
43500	Surgical opening of stomach		C					
43501	Surgical repair of stomach		C					
43502	Surgical repair of stomach		C					
43510	Surgical opening of stomach	CH	T	0422	16.3107	$1,113.48	$271.47	$222.70
43520	Incision of pyloric muscle		C					
43600	Biopsy of stomach		T	0141	8.8811	$606.29	$143.38	$121.26
43605	Biopsy of stomach		C					
43610	Excision of stomach lesion		C					
43611	Excision of stomach lesion		C					
43620	Removal of stomach		C					
43621	Removal of stomach		C					
43622	Removal of stomach		C					
43631	Removal of stomach, partial		C					
43632	Removal of stomach, partial		C					
43633	Removal of stomach, partial		C					
43634	Removal of stomach, partial		C					
43635	Removal of stomach, partial		C					
43640	Vagotomy & pylorus repair		C					
43641	Vagotomy & pylorus repair		C					
43644	Lap gastric bypass/roux-en-y		C					
43645	Lap gastr bypass incl smll i		C					
43647	Lap impl electrode, antrum		S	0061	88.8954	$6,068.62	.	$1,213.73
43648	Lap revise/remv eltrd antrum		T	0130	38.7195	$2,643.26	$659.53	$528.66
43651	Laparoscopy, vagus nerve		T	0132	71.1086	$4,854.37	$1,226.23	$970.88

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43652	Laparoscopy, vagus nerve		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
43653	Laparoscopy, gastrostomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
43659	Laparoscope proc, stom		T	0130	38.7195	$2,643.26	$659.53	$528.66
43752	Nasal/orogastric w/stent		X	0272	1.2472	$85.14	$31.07	$17.03
43760	Change gastrostomy tube		T	0676	2.3844	$162.78	.	$32.56
43761	Reposition gastrostomy tube		T	0141	8.8811	$606.29	$143.38	$121.26
43770	Lap place gastr adj device		C					
43771	Lap revise gastr adj device		C					
43772	Lap rmvl gastr adj device		C					
43773	Lap replace gastr adj device		C					
43774	Lap rmvl gastr adj all parts		C					
43775	Lap sleeve gastrectomy		C					
43800	Reconstruction of pylorus		C					
43810	Fusion of stomach and bowel		C					
43820	Fusion of stomach and bowel		C					
43825	Fusion of stomach and bowel		C					
43830	Place gastrostomy tube		T	0422	16.3107	$1,113.48	$271.47	$222.70
43831	Place gastrostomy tube		T	0141	8.8811	$606.29	$143.38	$121.26
43832	Place gastrostomy tube		C					
43840	Repair of stomach lesion		C					
43842	V-band gastroplasty		E					
43843	Gastroplasty w/o v-band		C					
43845	Gastroplasty duodenal switch		C					
43846	Gastric bypass for obesity		C					
43847	Gastric bypass incl small i		C					
43848	Revision gastroplasty		C					
43850	Revise stomach-bowel fusion		C					
43855	Revise stomach-bowel fusion		C					
43860	Revise stomach-bowel fusion		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43865	Revise stomach-bowel fusion		C					
43870	Repair stomach opening	CH	T	0422	16.3107	$1,113.48	$271.47	$222.70
43880	Repair stomach-bowel fistula		C					
43881	Impl/redo electrd, antrum		C					
43882	Revise/remove electrd antrum		C					
43886	Revise gastric port, open		T	0137	22.1186	$1,509.97	.	$302.00
43887	Remove gastric port, open		T	0135	4.6616	$318.23	.	$63.65
43888	Change gastric port, open		T	0137	22.1186	$1,509.97	.	$302.00
43999	Stomach surgery procedure		T	0141	8.8811	$606.29	$143.38	$121.26
44005	Freeing of bowel adhesion		C					
44010	Incision of small bowel		C					
44015	Insert needle cath bowel		C					
44020	Explore small intestine		C					
44021	Decompress small bowel		C					
44025	Incision of large bowel		C					
44050	Reduce bowel obstruction		C					
44055	Correct malrotation of bowel		C					
44100	Biopsy of bowel		T	0141	8.8811	$606.29	$143.38	$121.26
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44135	Intestine transplnt, cadaver		C					
44136	Intestine transplant, live		C					
44137	Remove intestinal allograft		C					
44139	Mobilization of colon		C					
44140	Partial removal of colon		C					
44141	Partial removal of colon		C					
44143	Partial removal of colon		C					
44144	Partial removal of colon		C					
44145	Partial removal of colon		C					
44146	Partial removal of colon		C					
44147	Partial removal of colon		C					
44150	Removal of colon		C					
44151	Removal of colon/ileostomy		C					
44155	Removal of colon/ileostomy		C					
44156	Removal of colon/ileostomy		C					
44157	Colectomy w/ileoanal anast		C					
44158	Colectomy w/neo-rectum pouch		C					
44160	Removal of colon		C					
44180	Lap, enterolysis		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
44186	Lap, jejunostomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
44187	Lap, ileo/jejuno-stomy		C					
44188	Lap, colostomy		C					
44202	Lap, enterectomy		C					
44203	Lap resect s/intestine, addl		C					
44204	Laparo partial colectomy		C					
44205	Lap colectomy part w/ileum		C					
44206	Lap part colectomy w/stoma		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
44207	L colectomy/coloproctostomy		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
44208	L colectomy/coloproctostomy		T	0132	71.1086	$4,854.37	$1,226.23	$970.88

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44210	Laparo total proctocolectomy		C					
44211	Lap colectomy w/proctectomy		C					
44212	Laparo total proctocolectomy		C					
44213	Lap, mobil splenic fl add-on		T	0130	38.7195	$2,643.26	$659.53	$528.66
44227	Lap, close enterostomy		C					
44238	Laparoscope proc, intestine		T	0130	38.7195	$2,643.26	$659.53	$528.66
44300	Open bowel to skin		C					
44310	Ileostomy/jejunostomy		C					
44312	Revision of ileostomy		T	0137	22.1186	$1,509.97	.	$302.00
44314	Revision of ileostomy		C					
44316	Devise bowel pouch		C					
44320	Colostomy		C					
44322	Colostomy with biopsies		C					
44340	Revision of colostomy		T	0137	22.1186	$1,509.97	.	$302.00
44345	Revision of colostomy		C					
44346	Revision of colostomy		C					
44360	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44361	Small bowel endoscopy/biopsy		T	0142	10.1443	$692.52	$152.78	$138.51
44363	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44364	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44365	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44366	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44369	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44370	Small bowel endoscopy/stent		T	0384	27.4802	$1,875.99	.	$375.20
44372	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44373	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44376	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44377	Small bowel endoscopy/biopsy		T	0142	10.1443	$692.52	$152.78	$138.51
44378	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44379	S bowel endoscope w/stent		T	0384	27.4802	$1,875.99	.	$375.20
44380	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44382	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44383	Ileoscopy w/stent		T	0384	27.4802	$1,875.99	.	$375.20
44385	Endoscopy of bowel pouch		T	0143	9.3206	$636.29	$186.06	$127.26
44386	Endoscopy, bowel pouch/biop		T	0143	9.3206	$636.29	$186.06	$127.26
44388	Colonoscopy		T	0143	9.3206	$636.29	$186.06	$127.26
44389	Colonoscopy with biopsy		T	0143	9.3206	$636.29	$186.06	$127.26
44390	Colonoscopy for foreign body		T	0143	9.3206	$636.29	$186.06	$127.26
44391	Colonoscopy for bleeding		T	0143	9.3206	$636.29	$186.06	$127.26
44392	Colonoscopy & polypectomy		T	0143	9.3206	$636.29	$186.06	$127.26
44393	Colonoscopy, lesion removal		T	0143	9.3206	$636.29	$186.06	$127.26
44394	Colonoscopy w/snare		T	0143	9.3206	$636.29	$186.06	$127.26
44397	Colonoscopy w/stent		T	0384	27.4802	$1,875.99	.	$375.20
44500	Intro, gastrointestinal tube		T	0121	6.3264	$431.88	.	$86.38
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44701	Intraop colon lavage add-on		N					
44715	Prepare donor intestine		C					
44720	Prep donor intestine/venous		C					
44721	Prep donor intestine/artery		C					
44799	Unlisted procedure intestine		T	0153	26.2068	$1,789.06	$368.04	$357.82
44800	Excision of bowel pouch		C					
44820	Excision of mesentery lesion		C					
44850	Repair of mesentery		C					
44899	Bowel surgery procedure		C					
44900	Drain app abscess, open		C					
44901	Drain app abscess, percut		T	0037	15.764	$1,076.16	$228.76	$215.24
44950	Appendectomy		T	0153	26.2068	$1,789.06	$368.04	$357.82
44955	Appendectomy add-on		T	0153	26.2068	$1,789.06	$368.04	$357.82
44960	Appendectomy		C					
44970	Laparoscopy, appendectomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
44979	Laparoscope proc, app		T	0130	38.7195	$2,643.26	$659.53	$528.66
45000	Drainage of pelvic abscess		T	0155	16.1014	$1,099.19	.	$219.84
45005	Drainage of rectal abscess		T	0155	16.1014	$1,099.19	.	$219.84
45020	Drainage of rectal abscess		T	0155	16.1014	$1,099.19	.	$219.84
45100	Biopsy of rectum		T	0149	24.5978	$1,679.22	.	$335.85
45108	Removal of anorectal lesion		T	0149	24.5978	$1,679.22	.	$335.85
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45121	Removal of rectum and colon		C					
45123	Partial proctectomy		C					
45126	Pelvic exenteration		C					
45130	Excision of rectal prolapse		C					
45135	Excision of rectal prolapse		C					
45136	Excise ileoanal reservior		C					
45150	Excision of rectal stricture		T	0149	24.5978	$1,679.22	.	$335.85
45160	Excision of rectal lesion		T	0149	24.5978	$1,679.22	.	$335.85
45171	Exc rect tum transanal part		T	0155	16.1014	$1,099.19	.	$219.84
45172	Exc rect tum transanal full		T	0149	24.5978	$1,679.22	.	$335.85
45190	Destruction, rectal tumor		T	0149	24.5978	$1,679.22	.	$335.85
45300	Proctosigmoidoscopy dx		T	0146	5.7839	$394.85	.	$78.97
45303	Proctosigmoidoscopy dilate		T	0147	9.5024	$648.70	.	$129.74
45305	Proctosigmoidoscopy w/bx		T	0147	9.5024	$648.70	.	$129.74
45307	Proctosigmoidoscopy fb		T	0428	24.5869	$1,678.47	.	$335.70
45308	Proctosigmoidoscopy removal		T	0147	9.5024	$648.70	.	$129.74
45309	Proctosigmoidoscopy removal		T	0147	9.5024	$648.70	.	$129.74
45315	Proctosigmoidoscopy removal		T	0147	9.5024	$648.70	.	$129.74
45317	Proctosigmoidoscopy bleed		T	0147	9.5024	$648.70	.	$129.74
45320	Proctosigmoidoscopy ablate		T	0428	24.5869	$1,678.47	.	$335.70
45321	Proctosigmoidoscopy volvul		T	0428	24.5869	$1,678.47	.	$335.70
45327	Proctosigmoidoscopy w/stent		T	0384	27.4802	$1,875.99	.	$375.20
45330	Diagnostic sigmoidoscopy		T	0146	5.7839	$394.85	.	$78.97
45331	Sigmoidoscopy and biopsy		T	0146	5.7839	$394.85	.	$78.97
45332	Sigmoidoscopy w/fb removal		T	0146	5.7839	$394.85	.	$78.97
45333	Sigmoidoscopy & polypectomy		T	0147	9.5024	$648.70	.	$129.74
45334	Sigmoidoscopy for bleeding		T	0147	9.5024	$648.70	.	$129.74
45335	Sigmoidoscopy w/submuc inj		T	0146	5.7839	$394.85	.	$78.97
45337	Sigmoidoscopy & decompress		T	0146	5.7839	$394.85	.	$78.97

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45338	Sigmoidoscopy w/tumr remove		T	0147	9.5024	$648.70	.	$129.74
45339	Sigmoidoscopy w/ablate tumr		T	0147	9.5024	$648.70	.	$129.74
45340	Sig w/balloon dilation		T	0147	9.5024	$648.70	.	$129.74
45341	Sigmoidoscopy w/ultrasound		T	0147	9.5024	$648.70	.	$129.74
45342	Sigmoidoscopy w/us guide bx		T	0147	9.5024	$648.70	.	$129.74
45345	Sigmoidoscopy w/stent		T	0384	27.4802	$1,875.99	.	$375.20
45355	Surgical colonoscopy		T	0143	9.3206	$636.29	$186.06	$127.26
45378	Diagnostic colonoscopy		T	0143	9.3206	$636.29	$186.06	$127.26
45379	Colonoscopy w/fb removal		T	0143	9.3206	$636.29	$186.06	$127.26
45380	Colonoscopy and biopsy		T	0143	9.3206	$636.29	$186.06	$127.26
45381	Colonoscopy, submucous inj		T	0143	9.3206	$636.29	$186.06	$127.26
45382	Colonoscopy/control bleeding		T	0143	9.3206	$636.29	$186.06	$127.26
45383	Lesion removal colonoscopy		T	0143	9.3206	$636.29	$186.06	$127.26
45384	Lesion remove colonoscopy		T	0143	9.3206	$636.29	$186.06	$127.26
45385	Lesion removal colonoscopy		T	0143	9.3206	$636.29	$186.06	$127.26
45386	Colonoscopy dilate stricture		T	0143	9.3206	$636.29	$186.06	$127.26
45387	Colonoscopy w/stent		T	0384	27.4802	$1,875.99	.	$375.20
45391	Colonoscopy w/endoscope us		T	0143	9.3206	$636.29	$186.06	$127.26
45392	Colonoscopy w/endoscopic fnb		T	0143	9.3206	$636.29	$186.06	$127.26
45395	Lap, removal of rectum		C					
45397	Lap, remove rectum w/pouch		C					
45400	Laparoscopic proc		C					
45402	Lap proctopexy w/sig resect		C					
45499	Laparoscope proc, rectum		T	0130	38.7195	$2,643.26	$659.53	$528.66
45500	Repair of rectum		T	0149	24.5978	$1,679.22	.	$335.85
45505	Repair of rectum		T	0150	32.6184	$2,226.76	.	$445.36
45520	Treatment of rectal prolapse		T	0013	0.8782	$59.95	.	$11.99
45540	Correct rectal prolapse		C					
45541	Correct rectal prolapse		T	0150	32.6184	$2,226.76	.	$445.36

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45550	Repair rectum/remove sigmoid		C					
45560	Repair of rectocele		T	0150	32.6184	$2,226.76	.	$445.36
45562	Exploration/repair of rectum		C					
45563	Exploration/repair of rectum		C					
45800	Repair rect/bladder fistula		C					
45805	Repair fistula w/colostomy		C					
45820	Repair rectourethral fistula		C					
45825	Repair fistula w/colostomy		C					
45900	Reduction of rectal prolapse		T	0148	6.2678	$427.88	.	$85.58
45905	Dilation of anal sphincter		T	0149	24.5978	$1,679.22	.	$335.85
45910	Dilation of rectal narrowing		T	0149	24.5978	$1,679.22	.	$335.85
45915	Remove rectal obstruction		T	0155	16.1014	$1,099.19	.	$219.84
45990	Surg dx exam, anorectal		T	0149	24.5978	$1,679.22	.	$335.85
45999	Rectum surgery procedure		T	0148	6.2678	$427.88	.	$85.58
46020	Placement of seton		T	0149	24.5978	$1,679.22	.	$335.85
46030	Removal of rectal marker		T	0148	6.2678	$427.88	.	$85.58
46040	Incision of rectal abscess		T	0149	24.5978	$1,679.22	.	$335.85
46045	Incision of rectal abscess		T	0149	24.5978	$1,679.22	.	$335.85
46050	Incision of anal abscess		T	0155	16.1014	$1,099.19	.	$219.84
46060	Incision of rectal abscess		T	0149	24.5978	$1,679.22	.	$335.85
46070	Incision of anal septum		T	0155	16.1014	$1,099.19	.	$219.84
46080	Incision of anal sphincter		T	0149	24.5978	$1,679.22	.	$335.85
46083	Incise external hemorrhoid		T	0164	2.0672	$141.12	.	$28.23
46200	Removal of anal fissure		T	0149	24.5978	$1,679.22	.	$335.85
46220	Excise anal ext tag/papilla		T	0155	16.1014	$1,099.19	.	$219.84
46221	Ligation of hemorrhoid(s)		T	0148	6.2678	$427.88	.	$85.58
46230	Removal of anal tags		T	0149	24.5978	$1,679.22	.	$335.85
46250	Remove ext hem groups = 2		T	0149	24.5978	$1,679.22	.	$335.85
46255	Remove int/ext hem 1 group		T	0149	24.5978	$1,679.22	.	$335.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46257	Remove in/ex hem grp & fiss		T	0149	24.5978	$1,679.22	.	$335.85
46258	Remove in/ex hem grp w/fistu		T	0149	24.5978	$1,679.22	.	$335.85
46260	Remove in/ex hem groups = 2		T	0149	24.5978	$1,679.22	.	$335.85
46261	Remove in/ex hem grps & fiss		T	0149	24.5978	$1,679.22	.	$335.85
46262	Remove in/ex hem grps w/fist		T	0149	24.5978	$1,679.22	.	$335.85
46270	Remove anal fist subq		T	0149	24.5978	$1,679.22	.	$335.85
46275	Remove anal fist inter		T	0149	24.5978	$1,679.22	.	$335.85
46280	Remove anal fist complex		T	0149	24.5978	$1,679.22	.	$335.85
46285	Remove anal fist 2 stage		T	0149	24.5978	$1,679.22	.	$335.85
46288	Repair anal fistula		T	0149	24.5978	$1,679.22	.	$335.85
46320	Removal of hemorrhoid clot		T	0149	24.5978	$1,679.22	.	$335.85
46500	Injection into hemorrhoid(s)		T	0155	16.1014	$1,099.19	.	$219.84
46505	Chemodenervation anal musc		T	0149	24.5978	$1,679.22	.	$335.85
46600	Diagnostic anoscopy		X	0340	0.6899	$47.10	.	$9.42
46604	Anoscopy and dilation		T	0147	9.5024	$648.70	.	$129.74
46606	Anoscopy and biopsy		T	0146	5.7839	$394.85	.	$78.97
46608	Anoscopy, remove for body		T	0147	9.5024	$648.70	.	$129.74
46610	Anoscopy, remove lesion		T	0428	24.5869	$1,678.47	.	$335.70
46611	Anoscopy		T	0147	9.5024	$648.70	.	$129.74
46612	Anoscopy, remove lesions		T	0428	24.5869	$1,678.47	.	$335.70
46614	Anoscopy, control bleeding		T	0146	5.7839	$394.85	.	$78.97
46615	Anoscopy		T	0428	24.5869	$1,678.47	.	$335.70
46700	Repair of anal stricture		T	0149	24.5978	$1,679.22	.	$335.85
46705	Repair of anal stricture		C					
46706	Repr of anal fistula w/glue		T	0150	32.6184	$2,226.76	.	$445.36
46707	Repair anorectal fist w/plug		T	0150	32.6184	$2,226.76	.	$445.36
46710	Repr per/vag pouch sngl proc		C					
46712	Repr per/vag pouch dbl proc		C					
46715	Rep perf anoper fistu		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46716	Rep perf anoper/vestib fistu		C					
46730	Construction of absent anus		C					
46735	Construction of absent anus		C					
46740	Construction of absent anus		C					
46742	Repair of imperforated anus		C					
46744	Repair of cloacal anomaly		C					
46746	Repair of cloacal anomaly		C					
46748	Repair of cloacal anomaly		C					
46750	Repair of anal sphincter		T	0150	32.6184	$2,226.76	.	$445.36
46751	Repair of anal sphincter		C					
46753	Reconstruction of anus		T	0149	24.5978	$1,679.22	.	$335.85
46754	Removal of suture from anus		T	0149	24.5978	$1,679.22	.	$335.85
46760	Repair of anal sphincter		T	0150	32.6184	$2,226.76	.	$445.36
46761	Repair of anal sphincter		T	0150	32.6184	$2,226.76	.	$445.36
46762	Implant artificial sphincter		T	0150	32.6184	$2,226.76	.	$445.36
46900	Destruction, anal lesion(s)		T	0016	2.8176	$192.35	.	$38.47
46910	Destruction, anal lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
46916	Cryosurgery, anal lesion(s)		T	0015	1.5303	$104.47	.	$20.90
46917	Laser surgery, anal lesions		T	0017	21.8217	$1,489.70	.	$297.94
46922	Excision of anal lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
46924	Destruction, anal lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
46930	Destroy internal hemorrhoids		T	0148	6.2678	$427.88	.	$85.58
46940	Treatment of anal fissure		T	0149	24.5978	$1,679.22	.	$335.85
46942	Treatment of anal fissure		T	0148	6.2678	$427.88	.	$85.58
46945	Remove by ligat int hem grp		T	0155	16.1014	$1,099.19	.	$219.84
46946	Remove by ligat int hem grps		T	0155	16.1014	$1,099.19	.	$219.84
46947	Hemorrhoidopexy by stapling		T	0150	32.6184	$2,226.76	.	$445.36
46999	Anus surgery procedure		T	0148	6.2678	$427.88	.	$85.58
47000	Needle biopsy of liver		T	0685	9.9046	$676.16	.	$135.24

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
47001	Needle biopsy, liver add-on		N					
47010	Open drainage, liver lesion		C					
47011	Percut drain, liver lesion		T	0037	15.764	$1,076.16	$228.76	$215.24
47015	Inject/aspirate liver cyst		C					
47100	Wedge biopsy of liver		C					
47120	Partial removal of liver		C					
47122	Extensive removal of liver		C					
47125	Partial removal of liver		C					
47130	Partial removal of liver		C					
47133	Removal of donor liver		C					
47135	Transplantation of liver		C					
47136	Transplantation of liver		C					
47140	Partial removal, donor liver		C					
47141	Partial removal, donor liver		C					
47142	Partial removal, donor liver		C					
47143	Prep donor liver, whole		C					
47144	Prep donor liver, 3-segment		C					
47145	Prep donor liver, lobe split		C					
47146	Prep donor liver/venous		C					
47147	Prep donor liver/arterial		C					
47300	Surgery for liver lesion		C					
47350	Repair liver wound		C					
47360	Repair liver wound		C					
47361	Repair liver wound		C					
47362	Repair liver wound		C					
47370	Laparo ablate liver tumor rf		T	0174	112.2008	$7,659.61	$2,064.24	$1,531.93
47371	Laparo ablate liver cryosurg		T	0174	112.2008	$7,659.61	$2,064.24	$1,531.93
47379	Laparoscope procedure, liver		T	0130	38.7195	$2,643.26	$659.53	$528.66
47380	Open ablate liver tumor rf		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
47381	Open ablate liver tumor cryo		C					
47382	Percut ablate liver rf		T	0423	57.2089	$3,905.48	.	$781.10
47399	Liver surgery procedure		T	0004	4.6624	$318.29	.	$63.66
47400	Incision of liver duct		C					
47420	Incision of bile duct		C					
47425	Incision of bile duct		C					
47460	Incise bile duct sphincter		C					
47480	Incision of gallbladder		C					
47490	Incision of gallbladder		T	0152	32.3789	$2,210.41	.	$442.09
47500	Injection for liver x-rays		N					
47505	Injection for liver x-rays		N					
47510	Insert catheter, bile duct		T	0152	32.3789	$2,210.41	.	$442.09
47511	Insert bile duct drain		T	0152	32.3789	$2,210.41	.	$442.09
47525	Change bile duct catheter		T	0427	16.3601	$1,116.85	.	$223.37
47530	Revise/reinsert bile tube		T	0427	16.3601	$1,116.85	.	$223.37
47550	Bile duct endoscopy add-on		C					
47552	Biliary endoscopy thru skin		T	0152	32.3789	$2,210.41	.	$442.09
47553	Biliary endoscopy thru skin		T	0152	32.3789	$2,210.41	.	$442.09
47554	Biliary endoscopy thru skin		T	0152	32.3789	$2,210.41	.	$442.09
47555	Biliary endoscopy thru skin		T	0152	32.3789	$2,210.41	.	$442.09
47556	Biliary endoscopy thru skin		T	0152	32.3789	$2,210.41	.	$442.09
47560	Laparoscopy w/cholangio		T	0130	38.7195	$2,643.26	$659.53	$528.66
47561	Laparo w/cholangio/biopsy		T	0130	38.7195	$2,643.26	$659.53	$528.66
47562	Laparoscopic cholecystectomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
47563	Laparo cholecystectomy/graph		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
47564	Laparo cholecystectomy/explr		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
47570	Laparo cholecystoenterostomy		C					
47579	Laparoscope proc, biliary		T	0130	38.7195	$2,643.26	$659.53	$528.66
47600	Removal of gallbladder		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
47605	Removal of gallbladder		C					
47610	Removal of gallbladder		C					
47612	Removal of gallbladder		C					
47620	Removal of gallbladder		C					
47630	Remove bile duct stone		T	0152	32.3789	$2,210.41	.	$442.09
47700	Exploration of bile ducts		C					
47701	Bile duct revision		C					
47711	Excision of bile duct tumor		C					
47712	Excision of bile duct tumor		C					
47715	Excision of bile duct cyst		C					
47720	Fuse gallbladder & bowel		C					
47721	Fuse upper gi structures		C					
47740	Fuse gallbladder & bowel		C					
47741	Fuse gallbladder & bowel		C					
47760	Fuse bile ducts and bowel		C					
47765	Fuse liver ducts & bowel		C					
47780	Fuse bile ducts and bowel		C					
47785	Fuse bile ducts and bowel		C					
47800	Reconstruction of bile ducts		C					
47801	Placement, bile duct support		C					
47802	Fuse liver duct & intestine		C					
47900	Suture bile duct injury		C					
47999	Bile tract surgery procedure		T	0152	32.3789	$2,210.41	.	$442.09
48000	Drainage of abdomen		C					
48001	Placement of drain, pancreas		C					
48020	Removal of pancreatic stone		C					
48100	Biopsy of pancreas, open		C					
48102	Needle biopsy, pancreas		T	0685	9.9046	$676.16	.	$135.24
48105	Resect/debride pancreas		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
48120	Removal of pancreas lesion		C					
48140	Partial removal of pancreas		C					
48145	Partial removal of pancreas		C					
48146	Pancreatectomy		C					
48148	Removal of pancreatic duct		C					
48150	Partial removal of pancreas		C					
48152	Pancreatectomy		C					
48153	Pancreatectomy		C					
48154	Pancreatectomy		C					
48155	Removal of pancreas		C					
48160	Pancreas removal/transplant		E					
48400	Injection, intraop add-on		C					
48500	Surgery of pancreatic cyst		C					
48510	Drain pancreatic pseudocyst		C					
48511	Drain pancreatic pseudocyst		T	0037	15.764	$1,076.16	$228.76	$215.24
48520	Fuse pancreas cyst and bowel		C					
48540	Fuse pancreas cyst and bowel		C					
48545	Pancreatorrhaphy		C					
48547	Duodenal exclusion		C					
48548	Fuse pancreas and bowel		C					
48550	Donor pancreatectomy		E					
48551	Prep donor pancreas		C					
48552	Prep donor pancreas/venous		C					
48554	Transpl allograft pancreas		C					
48556	Removal, allograft pancreas		C					
48999	Pancreas surgery procedure		T	0004	4.6624	$318.29	.	$63.66
49000	Exploration of abdomen		C					
49002	Reopening of abdomen		C					
49010	Exploration behind abdomen		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49020	Drain abdominal abscess		C					
49021	Drain abdominal abscess		T	0037	15.764	$1,076.16	$228.76	$215.24
49040	Drain, open, abdom abscess		C					
49041	Drain, percut, abdom abscess		T	0037	15.764	$1,076.16	$228.76	$215.24
49060	Drain, open, retrop abscess		C					
49061	Drain, percut, retroper absc		T	0037	15.764	$1,076.16	$228.76	$215.24
49062	Drain to peritoneal cavity		C					
49080	Puncture, peritoneal cavity		T	0070	5.6491	$385.65	.	$77.13
49081	Removal of abdominal fluid		T	0070	5.6491	$385.65	.	$77.13
49180	Biopsy, abdominal mass		T	0685	9.9046	$676.16	.	$135.24
49203	Exc abd tum 5 cm or less		C					
49204	Exc abd tum over 5 cm		C					
49205	Exc abd tum over 10 cm		C					
49215	Excise sacral spine tumor		C					
49220	Multiple surgery, abdomen		C					
49250	Excision of umbilicus		T	0153	26.2068	$1,789.06	$368.04	$357.82
49255	Removal of omentum		C					
49320	Diag laparo separate proc		T	0130	38.7195	$2,643.26	$659.53	$528.66
49321	Laparoscopy, biopsy		T	0130	38.7195	$2,643.26	$659.53	$528.66
49322	Laparoscopy, aspiration		T	0130	38.7195	$2,643.26	$659.53	$528.66
49323	Laparo drain lymphocele		T	0130	38.7195	$2,643.26	$659.53	$528.66
49324	Lap insertion perm ip cath		T	0130	38.7195	$2,643.26	$659.53	$528.66
49325	Lap revision perm ip cath		T	0130	38.7195	$2,643.26	$659.53	$528.66
49326	Lap w/omentopexy add-on		T	0130	38.7195	$2,643.26	$659.53	$528.66
49329	Laparo proc, abdm/per/oment		T	0130	38.7195	$2,643.26	$659.53	$528.66
49400	Air injection into abdomen		N					
49402	Remove foreign body, adbomen		T	0153	26.2068	$1,789.06	$368.04	$357.82
49411	Ins mark abd/pel for rt perq		X	0310	13.5651	$926.05	$325.27	$185.21
49419	Insrt abdom cath for chemotx		T	0115	33.3074	$2,273.80	.	$454.76

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49420	Insert abdom drain, temp		T	0652	31.1286	$2,125.06	.	$425.02
49421	Insert abdom drain, perm		T	0652	31.1286	$2,125.06	.	$425.02
49422	Remove perm cannula/catheter		T	0105	23.2281	$1,585.71	.	$317.15
49423	Exchange drainage catheter		T	0427	16.3601	$1,116.85	.	$223.37
49424	Assess cyst, contrast inject		N					
49425	Insert abdomen-venous drain		C					
49426	Revise abdomen-venous shunt		T	0153	26.2068	$1,789.06	$368.04	$357.82
49427	Injection, abdominal shunt		N					
49428	Ligation of shunt		C					
49429	Removal of shunt		T	0105	23.2281	$1,585.71	.	$317.15
49435	Insert subq exten to ip cath		T	0427	16.3601	$1,116.85	.	$223.37
49436	Embedded ip cath exit-site		T	0427	16.3601	$1,116.85	.	$223.37
49440	Place gastrostomy tube perc		T	0141	8.8811	$606.29	$143.38	$121.26
49441	Place duod/jej tube perc		T	0141	8.8811	$606.29	$143.38	$121.26
49442	Place cecostomy tube perc		T	0155	16.1014	$1,099.19	.	$219.84
49446	Change g-tube to g-j perc		T	0141	8.8811	$606.29	$143.38	$121.26
49450	Replace g/c tube perc		T	0121	6.3264	$431.88	.	$86.38
49451	Replace duod/jej tube perc		T	0121	6.3264	$431.88	.	$86.38
49452	Replace g-j tube perc		T	0121	6.3264	$431.88	.	$86.38
49460	Fix g/colon tube w/device		T	0121	6.3264	$431.88	.	$86.38
49465	Fluoro exam of g/colon tube	CH	Q1	0277	2.0916	$142.79	$53.90	$28.56
49491	Rpr hern preemie reduc		T	0154	33.368	$2,277.93	$464.85	$455.59
49492	Rpr ing hern premie, blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49495	Rpr ing hernia baby, reduc		T	0154	33.368	$2,277.93	$464.85	$455.59
49496	Rpr ing hernia baby, blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49500	Rpr ing hernia, init, reduce		T	0154	33.368	$2,277.93	$464.85	$455.59
49501	Rpr ing hernia, init blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49505	Prp i/hern init reduc >5 yr		T	0154	33.368	$2,277.93	$464.85	$455.59
49507	Prp i/hern init block >5 yr		T	0154	33.368	$2,277.93	$464.85	$455.59

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49520	Rerepair ing hernia, reduce		T	0154	33.368	$2,277.93	$464.85	$455.59
49521	Rerepair ing hernia, blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49525	Repair ing hernia, sliding		T	0154	33.368	$2,277.93	$464.85	$455.59
49540	Repair lumbar hernia		T	0154	33.368	$2,277.93	$464.85	$455.59
49550	Rpr rem hernia, init, reduce		T	0154	33.368	$2,277.93	$464.85	$455.59
49553	Rpr fem hernia, init blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49555	Rerepair fem hernia, reduce		T	0154	33.368	$2,277.93	$464.85	$455.59
49557	Rerepair fem hernia, blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49560	Rpr ventral hern init, reduc		T	0154	33.368	$2,277.93	$464.85	$455.59
49561	Rpr ventral hern init, block		T	0154	33.368	$2,277.93	$464.85	$455.59
49565	Rerepair ventrl hern, reduce		T	0154	33.368	$2,277.93	$464.85	$455.59
49566	Rerepair ventrl hern, block		T	0154	33.368	$2,277.93	$464.85	$455.59
49568	Hernia repair w/mesh		T	0154	33.368	$2,277.93	$464.85	$455.59
49570	Rpr epigastric hern, reduce		T	0154	33.368	$2,277.93	$464.85	$455.59
49572	Rpr epigastric hern, blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49580	Rpr umbil hern, reduc < 5 yr		T	0154	33.368	$2,277.93	$464.85	$455.59
49582	Rpr umbil hern, block < 5 yr		T	0154	33.368	$2,277.93	$464.85	$455.59
49585	Rpr umbil hern, reduc > 5 yr		T	0154	33.368	$2,277.93	$464.85	$455.59
49587	Rpr umbil hern, block > 5 yr		T	0154	33.368	$2,277.93	$464.85	$455.59
49590	Repair spigelian hernia		T	0154	33.368	$2,277.93	$464.85	$455.59
49600	Repair umbilical lesion		T	0154	33.368	$2,277.93	$464.85	$455.59
49605	Repair umbilical lesion		C					
49606	Repair umbilical lesion		C					
49610	Repair umbilical lesion		C					
49611	Repair umbilical lesion		C					
49650	Lap ing hernia repair init		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
49651	Lap ing hernia repair recur		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
49652	Lap vent/abd hernia repair		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
49653	Lap vent/abd hern proc comp		T	0132	71.1086	$4,854.37	$1,226.23	$970.88

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49654	Lap inc hernia repair		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
49655	Lap inc hern repair comp		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
49656	Lap inc hernia repair recur		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
49657	Lap inc hern recur comp		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
49659	Laparo proc, hernia repair		T	0130	38.7195	$2,643.26	$659.53	$528.66
49900	Repair of abdominal wall		C					
49904	Omental flap, extra-abdom		C					
49905	Omental flap, intra-abdom		C					
49906	Free omental flap, microvasc		C					
49999	Abdomen surgery procedure		T	0153	26.2068	$1,789.06	$368.04	$357.82
50010	Exploration of kidney		C					
50020	Renal abscess, open drain		T	0162	26.4198	$1,803.60	.	$360.72
50021	Renal abscess, percut drain		T	0037	15.764	$1,076.16	$228.76	$215.24
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					
50080	Removal of kidney stone		T	0429	46.5713	$3,179.28	.	$635.86
50081	Removal of kidney stone		T	0429	46.5713	$3,179.28	.	$635.86
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					
50200	Renal biopsy perq		T	0685	9.9046	$676.16	.	$135.24
50205	Renal biopsy open		C					
50220	Remove kidney, open		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50225	Removal kidney open, complex		C					
50230	Removal kidney open, radical		C					
50234	Removal of kidney & ureter		C					
50236	Removal of kidney & ureter		C					
50240	Partial removal of kidney		C					
50250	Cryoablate renal mass open		C					
50280	Removal of kidney lesion		C					
50290	Removal of kidney lesion		C					
50300	Remove cadaver donor kidney		C					
50320	Remove kidney, living donor		C					
50323	Prep cadaver renal allograft		C					
50325	Prep donor renal graft		C					
50327	Prep renal graft/venous		C					
50328	Prep renal graft/arterial		C					
50329	Prep renal graft/ureteral		C					
50340	Removal of kidney		C					
50360	Transplantation of kidney		C					
50365	Transplantation of kidney		C					
50370	Remove transplanted kidney		C					
50380	Reimplantation of kidney		C					
50382	Change ureter stent, percut		T	0162	26.4198	$1,803.60	.	$360.72
50384	Remove ureter stent, percut		T	0161	17.7215	$1,209.79	.	$241.96
50385	Change stent via transureth		T	0162	26.4198	$1,803.60	.	$360.72
50386	Remove stent via transureth		T	0160	7.2012	$491.60	.	$98.32
50387	Change ext/int ureter stent		T	0427	16.3601	$1,116.85	.	$223.37
50389	Remove renal tube w/fluoro		T	0160	7.2012	$491.60	.	$98.32
50390	Drainage of kidney lesion		T	0685	9.9046	$676.16	.	$135.24
50391	Instll rx agnt into rnal tub		T	0126	1.0983	$74.98	$16.21	$15.00
50392	Insert kidney drain		T	0161	17.7215	$1,209.79	.	$241.96

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50393	Insert ureteral tube		T	0162	26.4198	$1,803.60	.	$360.72
50394	Injection for kidney x-ray		N					
50395	Create passage to kidney		T	0162	26.4198	$1,803.60	.	$360.72
50396	Measure kidney pressure		T	0164	2.0672	$141.12	.	$28.23
50398	Change kidney tube		T	0427	16.3601	$1,116.85	.	$223.37
50400	Revision of kidney/ureter		C					
50405	Revision of kidney/ureter		C					
50500	Repair of kidney wound		C					
50520	Close kidney-skin fistula		C					
50525	Repair renal-abdomen fistula		C					
50526	Repair renal-abdomen fistula		C					
50540	Revision of horseshoe kidney		C					
50541	Laparo ablate renal cyst		T	0130	38.7195	$2,643.26	$659.53	$528.66
50542	Laparo ablate renal mass		T	0174	112.2008	$7,659.61	$2,064.24	$1,531.93
50543	Laparo partial nephrectomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
50544	Laparoscopy, pyeloplasty		T	0130	38.7195	$2,643.26	$659.53	$528.66
50545	Laparo radical nephrectomy		C					
50546	Laparoscopic nephrectomy		C					
50547	Laparo removal donor kidney		C					
50548	Laparo remove w/ureter		C					
50549	Laparoscope proc, renal		T	0130	38.7195	$2,643.26	$659.53	$528.66
50551	Kidney endoscopy		T	0160	7.2012	$491.60	.	$98.32
50553	Kidney endoscopy		T	0162	26.4198	$1,803.60	.	$360.72
50555	Kidney endoscopy & biopsy		T	0160	7.2012	$491.60	.	$98.32
50557	Kidney endoscopy & treatment		T	0162	26.4198	$1,803.60	.	$360.72
50561	Kidney endoscopy & treatment		T	0162	26.4198	$1,803.60	.	$360.72
50562	Renal scope w/tumor resect		T	0160	7.2012	$491.60	.	$98.32
50570	Kidney endoscopy		T	0160	7.2012	$491.60	.	$98.32
50572	Kidney endoscopy		T	0160	7.2012	$491.60	.	$98.32

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50574	Kidney endoscopy & biopsy		T	0160	7.2012	$491.60	.	$98.32
50575	Kidney endoscopy		T	0163	37.4369	$2,555.70	.	$511.14
50576	Kidney endoscopy & treatment		T	0161	17.7215	$1,209.79	.	$241.96
50580	Kidney endoscopy & treatment		T	0161	17.7215	$1,209.79	.	$241.96
50590	Fragmenting of kidney stone		T	0169	41.7267	$2,848.56	$997.74	$569.72
50592	Perc rf ablate renal tumor		T	0423	57.2089	$3,905.48	.	$781.10
50593	Perc cryo ablate renal tum		T	0423	57.2089	$3,905.48	.	$781.10
50600	Exploration of ureter		C					
50605	Insert ureteral support		C					
50610	Removal of ureter stone		C					
50620	Removal of ureter stone		C					
50630	Removal of ureter stone		C					
50650	Removal of ureter		C					
50660	Removal of ureter		C					
50684	Injection for ureter x-ray		N					
50686	Measure ureter pressure		T	0126	1.0983	$74.98	$16.21	$15.00
50688	Change of ureter tube/stent		T	0427	16.3601	$1,116.85	.	$223.37
50690	Injection for ureter x-ray		N					
50700	Revision of ureter		C					
50715	Release of ureter		C					
50722	Release of ureter		C					
50725	Release/revise ureter		C					
50727	Revise ureter		T	0165	20.5471	$1,402.69	.	$280.54
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50782	Reimplant ureter in bladder		C					
50783	Reimplant ureter in bladder		C					
50785	Reimplant ureter in bladder		C					
50800	Implant ureter in bowel		C					
50810	Fusion of ureter & bowel		C					
50815	Urine shunt to intestine		C					
50820	Construct bowel bladder		C					
50825	Construct bowel bladder		C					
50830	Revise urine flow		C					
50840	Replace ureter by bowel		C					
50845	Appendico-vesicostomy		C					
50860	Transplant ureter to skin		C					
50900	Repair of ureter		C					
50920	Closure ureter/skin fistula		C					
50930	Closure ureter/bowel fistula		C					
50940	Release of ureter		C					
50945	Laparoscopy ureterolithotomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
50947	Laparo new ureter/bladder		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
50948	Laparo new ureter/bladder		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
50949	Laparoscope proc, ureter		T	0130	38.7195	$2,643.26	$659.53	$528.66
50951	Endoscopy of ureter		T	0160	7.2012	$491.60	.	$98.32
50953	Endoscopy of ureter		T	0160	7.2012	$491.60	.	$98.32
50955	Ureter endoscopy & biopsy		T	0162	26.4198	$1,803.60	.	$360.72
50957	Ureter endoscopy & treatment		T	0162	26.4198	$1,803.60	.	$360.72
50961	Ureter endoscopy & treatment		T	0162	26.4198	$1,803.60	.	$360.72
50970	Ureter endoscopy		T	0160	7.2012	$491.60	.	$98.32
50972	Ureter endoscopy & catheter		T	0160	7.2012	$491.60	.	$98.32
50974	Ureter endoscopy & biopsy		T	0161	17.7215	$1,209.79	.	$241.96
50976	Ureter endoscopy & treatment		T	0161	17.7215	$1,209.79	.	$241.96

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50980	Ureter endoscopy & treatment		T	0162	26.4198	$1,803.60	.	$360.72
51020	Incise & treat bladder		T	0162	26.4198	$1,803.60	.	$360.72
51030	Incise & treat bladder		T	0162	26.4198	$1,803.60	.	$360.72
51040	Incise & drain bladder		T	0162	26.4198	$1,803.60	.	$360.72
51045	Incise bladder/drain ureter		T	0160	7.2012	$491.60	.	$98.32
51050	Removal of bladder stone		T	0162	26.4198	$1,803.60	.	$360.72
51060	Removal of ureter stone		T	0163	37.4369	$2,555.70	.	$511.14
51065	Remove ureter calculus		T	0162	26.4198	$1,803.60	.	$360.72
51080	Drainage of bladder abscess		T	0008	20.2481	$1,382.28	.	$276.46
51100	Drain bladder by needle		T	0164	2.0672	$141.12	.	$28.23
51101	Drain bladder by trocar/cath		T	0126	1.0983	$74.98	$16.21	$15.00
51102	Drain bl w/cath insertion		T	0165	20.5471	$1,402.69	.	$280.54
51500	Removal of bladder cyst		T	0154	33.368	$2,277.93	$464.85	$455.59
51520	Removal of bladder lesion		T	0162	26.4198	$1,803.60	.	$360.72
51525	Removal of bladder lesion		C					
51530	Removal of bladder lesion		C					
51535	Repair of ureter lesion		T	0162	26.4198	$1,803.60	.	$360.72
51550	Partial removal of bladder		C					
51555	Partial removal of bladder		C					
51565	Revise bladder & ureter(s)		C					
51570	Removal of bladder		C					
51575	Removal of bladder & nodes		C					
51580	Remove bladder/revise tract		C					
51585	Removal of bladder & nodes		C					
51590	Remove bladder/revise tract		C					
51595	Remove bladder/revise tract		C					
51596	Remove bladder/create pouch		C					
51597	Removal of pelvic structures		C					
51600	Injection for bladder x-ray		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
51605	Preparation for bladder xray		N					
51610	Injection for bladder x-ray		N					
51700	Irrigation of bladder		T	0164	2.0672	$141.12	.	$28.23
51701	Insert bladder catheter		X	0340	0.6899	$47.10	.	$9.42
51702	Insert temp bladder cath		X	0340	0.6899	$47.10	.	$9.42
51703	Insert bladder cath, complex		T	0126	1.0983	$74.98	$16.21	$15.00
51705	Change of bladder tube		T	0164	2.0672	$141.12	.	$28.23
51710	Change of bladder tube		T	0121	6.3264	$431.88	.	$86.38
51715	Endoscopic injection/implant		T	0168	32.3809	$2,210.55	.	$442.11
51720	Treatment of bladder lesion		T	0156	3.0859	$210.67	.	$42.14
51725	Simple cystometrogram		T	0156	3.0859	$210.67	.	$42.14
51726	Complex cystometrogram		T	0156	3.0859	$210.67	.	$42.14
51727	Cystometrogram w/up		T	0156	3.0859	$210.67	.	$42.14
51728	Cystometrogram w/vp		T	0156	3.0859	$210.67	.	$42.14
51729	Cystometrogram w/vp&up		T	0156	3.0859	$210.67	.	$42.14
51736	Urine flow measurement	CH	X	0340	0.6899	$47.10	.	$9.42
51741	Electro-uroflowmetry, first		T	0126	1.0983	$74.98	$16.21	$15.00
51784	Anal/urinary muscle study		T	0126	1.0983	$74.98	$16.21	$15.00
51785	Anal/urinary muscle study		T	0164	2.0672	$141.12	.	$28.23
51792	Urinary reflex study		T	0126	1.0983	$74.98	$16.21	$15.00
51797	Intraabdominal pressure test		T	0164	2.0672	$141.12	.	$28.23
51798	Us urine capacity measure		X	0340	0.6899	$47.10	.	$9.42
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		T	0202	45.2093	$3,086.30	$981.50	$617.26
51860	Repair of bladder wound		T	0162	26.4198	$1,803.60	.	$360.72
51865	Repair of bladder wound		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
51880	Repair of bladder opening		T	0162	26.4198	$1,803.60	.	$360.72
51900	Repair bladder/vagina lesion		C					
51920	Close bladder-uterus fistula		C					
51925	Hysterectomy/bladder repair		C					
51940	Correction of bladder defect		C					
51960	Revision of bladder & bowel		C					
51980	Construct bladder opening		C					
51990	Laparo urethral suspension		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
51992	Laparo sling operation		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
51999	Laparoscope proc, bla		T	0130	38.7195	$2,643.26	$659.53	$528.66
52000	Cystoscopy		T	0160	7.2012	$491.60	.	$98.32
52001	Cystoscopy, removal of clots		T	0161	17.7215	$1,209.79	.	$241.96
52005	Cystoscopy & ureter catheter		T	0162	26.4198	$1,803.60	.	$360.72
52007	Cystoscopy and biopsy		T	0162	26.4198	$1,803.60	.	$360.72
52010	Cystoscopy & duct catheter		T	0160	7.2012	$491.60	.	$98.32
52204	Cystoscopy w/biopsy(s)		T	0162	26.4198	$1,803.60	.	$360.72
52214	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52224	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52234	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52235	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52240	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52250	Cystoscopy and radiotracer		T	0162	26.4198	$1,803.60	.	$360.72
52260	Cystoscopy and treatment		T	0161	17.7215	$1,209.79	.	$241.96
52265	Cystoscopy and treatment		T	0160	7.2012	$491.60	.	$98.32
52270	Cystoscopy & revise urethra		T	0161	17.7215	$1,209.79	.	$241.96
52275	Cystoscopy & revise urethra		T	0162	26.4198	$1,803.60	.	$360.72
52276	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52277	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52281	Cystoscopy and treatment		T	0161	17.7215	$1,209.79	.	$241.96

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
52282	Cystoscopy, implant stent		T	0163	37.4369	$2,555.70	.	$511.14
52283	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52285	Cystoscopy and treatment		T	0161	17.7215	$1,209.79	.	$241.96
52290	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52300	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52301	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52305	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52310	Cystoscopy and treatment		T	0161	17.7215	$1,209.79	.	$241.96
52315	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52317	Remove bladder stone		T	0162	26.4198	$1,803.60	.	$360.72
52318	Remove bladder stone		T	0162	26.4198	$1,803.60	.	$360.72
52320	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52325	Cystoscopy, stone removal		T	0162	26.4198	$1,803.60	.	$360.72
52327	Cystoscopy, inject material		T	0163	37.4369	$2,555.70	.	$511.14
52330	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52332	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52334	Create passage to kidney		T	0162	26.4198	$1,803.60	.	$360.72
52341	Cysto w/ureter stricture tx		T	0162	26.4198	$1,803.60	.	$360.72
52342	Cysto w/up stricture tx		T	0162	26.4198	$1,803.60	.	$360.72
52343	Cysto w/renal stricture tx		T	0162	26.4198	$1,803.60	.	$360.72
52344	Cysto/uretero, stricture tx		T	0162	26.4198	$1,803.60	.	$360.72
52345	Cysto/uretero w/up stricture		T	0162	26.4198	$1,803.60	.	$360.72
52346	Cystouretero w/renal strict		T	0162	26.4198	$1,803.60	.	$360.72
52351	Cystouretero & or pyeloscope		T	0162	26.4198	$1,803.60	.	$360.72
52352	Cystouretero w/stone remove		T	0162	26.4198	$1,803.60	.	$360.72
52353	Cystouretero w/lithotripsy		T	0163	37.4369	$2,555.70	.	$511.14
52354	Cystouretero w/biopsy		T	0162	26.4198	$1,803.60	.	$360.72
52355	Cystouretero w/excise tumor		T	0162	26.4198	$1,803.60	.	$360.72
52400	Cystouretero w/congen repr		T	0162	26.4198	$1,803.60	.	$360.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
52402	Cystourethro cut ejacul duct		T	0162	26.4198	$1,803.60	.	$360.72
52450	Incision of prostate		T	0162	26.4198	$1,803.60	.	$360.72
52500	Revision of bladder neck		T	0162	26.4198	$1,803.60	.	$360.72
52601	Prostatectomy (TURP)		T	0163	37.4369	$2,555.70	.	$511.14
52630	Remove prostate regrowth		T	0163	37.4369	$2,555.70	.	$511.14
52640	Relieve bladder contracture		T	0162	26.4198	$1,803.60	.	$360.72
52647	Laser surgery of prostate		T	0429	46.5713	$3,179.28	.	$635.86
52648	Laser surgery of prostate		T	0429	46.5713	$3,179.28	.	$635.86
52649	Prostate laser enucleation		T	0429	46.5713	$3,179.28	.	$635.86
52700	Drainage of prostate abscess		T	0162	26.4198	$1,803.60	.	$360.72
53000	Incision of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53010	Incision of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53020	Incision of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53025	Incision of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53040	Drainage of urethra abscess		T	0166	21.3781	$1,459.42	.	$291.89
53060	Drainage of urethra abscess		T	0166	21.3781	$1,459.42	.	$291.89
53080	Drainage of urinary leakage		T	0166	21.3781	$1,459.42	.	$291.89
53085	Drainage of urinary leakage		T	0166	21.3781	$1,459.42	.	$291.89
53200	Biopsy of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53210	Removal of urethra		T	0168	32.3809	$2,210.55	.	$442.11
53215	Removal of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53220	Treatment of urethra lesion		T	0168	32.3809	$2,210.55	.	$442.11
53230	Removal of urethra lesion		T	0168	32.3809	$2,210.55	.	$442.11
53235	Removal of urethra lesion		T	0166	21.3781	$1,459.42	.	$291.89
53240	Surgery for urethra pouch		T	0168	32.3809	$2,210.55	.	$442.11
53250	Removal of urethra gland		T	0166	21.3781	$1,459.42	.	$291.89
53260	Treatment of urethra lesion		T	0166	21.3781	$1,459.42	.	$291.89
53265	Treatment of urethra lesion		T	0166	21.3781	$1,459.42	.	$291.89
53270	Removal of urethra gland		T	0166	21.3781	$1,459.42	.	$291.89

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
53275	Repair of urethra defect		T	0166	21.3781	$1,459.42	.	$291.89
53400	Revise urethra, stage 1		T	0168	32.3809	$2,210.55	.	$442.11
53405	Revise urethra, stage 2		T	0168	32.3809	$2,210.55	.	$442.11
53410	Reconstruction of urethra		T	0168	32.3809	$2,210.55	.	$442.11
53415	Reconstruction of urethra		C					
53420	Reconstruct urethra, stage 1		T	0168	32.3809	$2,210.55	.	$442.11
53425	Reconstruct urethra, stage 2		T	0168	32.3809	$2,210.55	.	$442.11
53430	Reconstruction of urethra		T	0168	32.3809	$2,210.55	.	$442.11
53431	Reconstruct urethra/bladder		T	0168	32.3809	$2,210.55	.	$442.11
53440	Male sling procedure		S	0385	102.2894	$6,982.99	.	$1,396.60
53442	Remove/revise male sling		T	0168	32.3809	$2,210.55	.	$442.11
53444	Insert tandem cuff		S	0385	102.2894	$6,982.99	.	$1,396.60
53445	Insert uro/ves nck sphincter		S	0386	168.1193	$11,477.00	.	$2,295.40
53446	Remove uro sphincter		T	0168	32.3809	$2,210.55	.	$442.11
53447	Remove/replace ur sphincter		S	0386	168.1193	$11,477.00	.	$2,295.40
53448	Remov/replc ur sphinctr comp		C					
53449	Repair uro sphincter		T	0168	32.3809	$2,210.55	.	$442.11
53450	Revision of urethra		T	0168	32.3809	$2,210.55	.	$442.11
53460	Revision of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53500	Urethrlys, transvag w/ scope		T	0168	32.3809	$2,210.55	.	$442.11
53502	Repair of urethra injury		T	0166	21.3781	$1,459.42	.	$291.89
53505	Repair of urethra injury		T	0168	32.3809	$2,210.55	.	$442.11
53510	Repair of urethra injury		T	0166	21.3781	$1,459.42	.	$291.89
53515	Repair of urethra injury		T	0168	32.3809	$2,210.55	.	$442.11
53520	Repair of urethra defect		T	0168	32.3809	$2,210.55	.	$442.11
53600	Dilate urethra stricture		T	0156	3.0859	$210.67	.	$42.14
53601	Dilate urethra stricture		T	0126	1.0983	$74.98	$16.21	$15.00
53605	Dilate urethra stricture		T	0161	17.7215	$1,209.79	.	$241.96
53620	Dilate urethra stricture		T	0165	20.5471	$1,402.69	.	$280.54

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
53621	Dilate urethra stricture		T	0164	2.0672	$141.12	.	$28.23
53660	Dilation of urethra		T	0126	1.0983	$74.98	$16.21	$15.00
53661	Dilation of urethra		T	0126	1.0983	$74.98	$16.21	$15.00
53665	Dilation of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53850	Prostatic microwave thermotx		T	0429	46.5713	$3,179.28	.	$635.86
53852	Prostatic rf thermotx		T	0429	46.5713	$3,179.28	.	$635.86
53855	Insert prost urethral stent		T	0164	2.0672	$141.12	.	$28.23
53899	Urology surgery procedure		T	0126	1.0983	$74.98	$16.21	$15.00
54000	Slitting of prepuce		T	0166	21.3781	$1,459.42	.	$291.89
54001	Slitting of prepuce		T	0166	21.3781	$1,459.42	.	$291.89
54015	Drain penis lesion		T	0008	20.2481	$1,382.28	.	$276.46
54050	Destruction, penis lesion(s)		T	0013	0.8782	$59.95	.	$11.99
54055	Destruction, penis lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
54056	Cryosurgery, penis lesion(s)		T	0013	0.8782	$59.95	.	$11.99
54057	Laser surg, penis lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
54060	Excision of penis lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
54065	Destruction, penis lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
54100	Biopsy of penis		T	0021	18.2223	$1,243.98	.	$248.80
54105	Biopsy of penis		T	0022	24.1269	$1,647.07	$354.45	$329.42
54110	Treatment of penis lesion		T	0181	36.4186	$2,486.19	$620.84	$497.24
54111	Treat penis lesion, graft		T	0181	36.4186	$2,486.19	$620.84	$497.24
54112	Treat penis lesion, graft		T	0181	36.4186	$2,486.19	$620.84	$497.24
54115	Treatment of penis lesion		T	0008	20.2481	$1,382.28	.	$276.46
54120	Partial removal of penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54125	Removal of penis		C					
54130	Remove penis & nodes		C					
54135	Remove penis & nodes		C					
54150	Circumcision w/regionl block		T	0183	23.7895	$1,624.04	.	$324.81
54160	Circumcision, neonate		T	0183	23.7895	$1,624.04	.	$324.81

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54161	Circum 28 days or older		T	0183	23.7895	$1,624.04	.	$324.81
54162	Lysis penil circumic lesion		T	0183	23.7895	$1,624.04	.	$324.81
54163	Repair of circumcision		T	0183	23.7895	$1,624.04	.	$324.81
54164	Frenulotomy of penis		T	0183	23.7895	$1,624.04	.	$324.81
54200	Treatment of penis lesion		T	0164	2.0672	$141.12	.	$28.23
54205	Treatment of penis lesion		T	0181	36.4186	$2,486.19	$620.84	$497.24
54220	Treatment of penis lesion		T	0164	2.0672	$141.12	.	$28.23
54230	Prepare penis study		N					
54231	Dynamic cavernosometry		T	0165	20.5471	$1,402.69	.	$280.54
54235	Penile injection	CH	T	0156	3.0859	$210.67	.	$42.14
54240	Penis study		T	0126	1.0983	$74.98	$16.21	$15.00
54250	Penis study		T	0164	2.0672	$141.12	.	$28.23
54300	Revision of penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54304	Revision of penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54308	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54312	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54316	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54318	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54322	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54324	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54326	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54328	Revise penis/urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54332	Revise penis/urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54336	Revise penis/urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54340	Secondary urethral surgery		T	0181	36.4186	$2,486.19	$620.84	$497.24
54344	Secondary urethral surgery		T	0181	36.4186	$2,486.19	$620.84	$497.24
54348	Secondary urethral surgery		T	0181	36.4186	$2,486.19	$620.84	$497.24
54352	Reconstruct urethra/penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54360	Penis plastic surgery		T	0181	36.4186	$2,486.19	$620.84	$497.24

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54380	Repair penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54385	Repair penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54390	Repair penis and bladder		C					
54400	Insert semi-rigid prosthesis		S	0385	102.2894	$6,982.99	.	$1,396.60
54401	Insert self-contd prosthesis		S	0386	168.1193	$11,477.00	.	$2,295.40
54405	Insert multi-comp penis pros		S	0386	168.1193	$11,477.00	.	$2,295.40
54406	Remove muti-comp penis pros		T	0181	36.4186	$2,486.19	$620.84	$497.24
54408	Repair multi-comp penis pros		T	0181	36.4186	$2,486.19	$620.84	$497.24
54410	Remove/replace penis prosth		S	0386	168.1193	$11,477.00	.	$2,295.40
54411	Remov/replc penis pros, comp		C					
54415	Remove self-contd penis pros		T	0181	36.4186	$2,486.19	$620.84	$497.24
54416	Remv/repl penis contain pros		S	0386	168.1193	$11,477.00	.	$2,295.40
54417	Remv/replc penis pros, compl		C					
54420	Revision of penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54430	Revision of penis		C					
54435	Revision of penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54440	Repair of penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54450	Preputial stretching		T	0156	3.0859	$210.67	.	$42.14
54500	Biopsy of testis		T	0037	15.764	$1,076.16	$228.76	$215.24
54505	Biopsy of testis		T	0183	23.7895	$1,624.04	.	$324.81
54512	Excise lesion testis		T	0183	23.7895	$1,624.04	.	$324.81
54520	Removal of testis		T	0183	23.7895	$1,624.04	.	$324.81
54522	Orchiectomy, partial		T	0183	23.7895	$1,624.04	.	$324.81
54530	Removal of testis		T	0154	33.368	$2,277.93	$464.85	$455.59
54535	Extensive testis surgery		T	0181	36.4186	$2,486.19	$620.84	$497.24
54550	Exploration for testis		T	0154	33.368	$2,277.93	$464.85	$455.59
54560	Exploration for testis		T	0183	23.7895	$1,624.04	.	$324.81
54600	Reduce testis torsion		T	0183	23.7895	$1,624.04	.	$324.81
54620	Suspension of testis		T	0183	23.7895	$1,624.04	.	$324.81

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54640	Suspension of testis		T	0154	33.368	$2,277.93	$464.85	$455.59
54650	Orchiopexy (Fowler-Stephens)		C					
54660	Revision of testis		T	0183	23.7895	$1,624.04	.	$324.81
54670	Repair testis injury		T	0183	23.7895	$1,624.04	.	$324.81
54680	Relocation of testis(es)		T	0183	23.7895	$1,624.04	.	$324.81
54690	Laparoscopy, orchiectomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
54692	Laparoscopy, orchiopexy		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
54699	Laparoscope proc, testis		T	0130	38.7195	$2,643.26	$659.53	$528.66
54700	Drainage of scrotum		T	0183	23.7895	$1,624.04	.	$324.81
54800	Biopsy of epididymis		T	0004	4.6624	$318.29	.	$63.66
54830	Remove epididymis lesion		T	0183	23.7895	$1,624.04	.	$324.81
54840	Remove epididymis lesion		T	0183	23.7895	$1,624.04	.	$324.81
54860	Removal of epididymis		T	0183	23.7895	$1,624.04	.	$324.81
54861	Removal of epididymis		T	0183	23.7895	$1,624.04	.	$324.81
54865	Explore epididymis		T	0183	23.7895	$1,624.04	.	$324.81
54900	Fusion of spermatic ducts		T	0183	23.7895	$1,624.04	.	$324.81
54901	Fusion of spermatic ducts		T	0183	23.7895	$1,624.04	.	$324.81
55000	Drainage of hydrocele		T	0004	4.6624	$318.29	.	$63.66
55040	Removal of hydrocele		T	0154	33.368	$2,277.93	$464.85	$455.59
55041	Removal of hydroceles		T	0154	33.368	$2,277.93	$464.85	$455.59
55060	Repair of hydrocele		T	0183	23.7895	$1,624.04	.	$324.81
55100	Drainage of scrotum abscess		T	0007	13.3268	$909.78	.	$181.96
55110	Explore scrotum		T	0183	23.7895	$1,624.04	.	$324.81
55120	Removal of scrotum lesion		T	0183	23.7895	$1,624.04	.	$324.81
55150	Removal of scrotum		T	0183	23.7895	$1,624.04	.	$324.81
55175	Revision of scrotum		T	0183	23.7895	$1,624.04	.	$324.81
55180	Revision of scrotum		T	0183	23.7895	$1,624.04	.	$324.81
55200	Incision of sperm duct		T	0183	23.7895	$1,624.04	.	$324.81
55250	Removal of sperm duct(s)		T	0183	23.7895	$1,624.04	.	$324.81

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
55300	Prepare, sperm duct x-ray		N					
55400	Repair of sperm duct		T	0183	23.7895	$1,624.04	.	$324.81
55450	Ligation of sperm duct		T	0183	23.7895	$1,624.04	.	$324.81
55500	Removal of hydrocele		T	0183	23.7895	$1,624.04	.	$324.81
55520	Removal of sperm cord lesion		T	0183	23.7895	$1,624.04	.	$324.81
55530	Revise spermatic cord veins		T	0183	23.7895	$1,624.04	.	$324.81
55535	Revise spermatic cord veins		T	0154	33.368	$2,277.93	$464.85	$455.59
55540	Revise hernia & sperm veins		T	0154	33.368	$2,277.93	$464.85	$455.59
55550	Laparo ligate spermatic vein		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
55559	Laparo proc, spermatic cord		T	0130	38.7195	$2,643.26	$659.53	$528.66
55600	Incise sperm duct pouch		T	0183	23.7895	$1,624.04	.	$324.81
55605	Incise sperm duct pouch		C					
55650	Remove sperm duct pouch		C					
55680	Remove sperm pouch lesion		T	0183	23.7895	$1,624.04	.	$324.81
55700	Biopsy of prostate		T	0184	13.338	$910.55	.	$182.11
55705	Biopsy of prostate		T	0184	13.338	$910.55	.	$182.11
55706	Prostate saturation sampling		T	0184	13.338	$910.55	.	$182.11
55720	Drainage of prostate abscess		T	0162	26.4198	$1,803.60	.	$360.72
55725	Drainage of prostate abscess		T	0162	26.4198	$1,803.60	.	$360.72
55801	Removal of prostate		C					
55810	Extensive prostate surgery		C					
55812	Extensive prostate surgery		C					
55815	Extensive prostate surgery		C					
55821	Removal of prostate		C					
55831	Removal of prostate		C					
55840	Extensive prostate surgery		C					
55842	Extensive prostate surgery		C					
55845	Extensive prostate surgery		C					
55860	Surgical exposure, prostate		T	0165	20.5471	$1,402.69	.	$280.54

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
55862	Extensive prostate surgery		C					
55865	Extensive prostate surgery		C					
55866	Laparo radical prostatectomy		C					
55870	Electroejaculation		T	0189	3.5572	$242.84	.	$48.57
55873	Cryoablate prostate		T	0674	116.8825	$7,979.22	.	$1,595.85
55875	Transperi needle place, pros		Q3	0163	37.4369	$2,555.70	.	$511.14
55876	Place rt device/marker, pros		X	0310	13.5651	$926.05	$325.27	$185.21
55899	Genital surgery procedure		T	0126	1.0983	$74.98	$16.21	$15.00
55920	Place needles pelvic for rt		T	0153	26.2068	$1,789.06	$368.04	$357.82
55970	Sex transformation, M to F		E					
55980	Sex transformation, F to M		E					
56405	I & D of vulva/perineum		T	0188	1.5975	$109.06	.	$21.82
56420	Drainage of gland abscess		T	0188	1.5975	$109.06	.	$21.82
56440	Surgery for vulva lesion		T	0193	20.7158	$1,414.21	.	$282.85
56441	Lysis of labial lesion(s)		T	0193	20.7158	$1,414.21	.	$282.85
56442	Hymenotomy		T	0193	20.7158	$1,414.21	.	$282.85
56501	Destroy, vulva lesions, sim		T	0017	21.8217	$1,489.70	.	$297.94
56515	Destroy vulva lesion/s compl		T	0017	21.8217	$1,489.70	.	$297.94
56605	Biopsy of vulva/perineum		T	0189	3.5572	$242.84	.	$48.57
56606	Biopsy of vulva/perineum		T	0188	1.5975	$109.06	.	$21.82
56620	Partial removal of vulva		T	0193	20.7158	$1,414.21	.	$282.85
56625	Complete removal of vulva		T	0193	20.7158	$1,414.21	.	$282.85
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
56700	Partial removal of hymen		T	0193	20.7158	$1,414.21	.	$282.85
56740	Remove vagina gland lesion		T	0193	20.7158	$1,414.21	.	$282.85
56800	Repair of vagina		T	0193	20.7158	$1,414.21	.	$282.85
56805	Repair clitoris		T	0193	20.7158	$1,414.21	.	$282.85
56810	Repair of perineum		T	0193	20.7158	$1,414.21	.	$282.85
56820	Exam of vulva w/scope		T	0188	1.5975	$109.06	.	$21.82
56821	Exam/biopsy of vulva w/scope		T	0188	1.5975	$109.06	.	$21.82
57000	Exploration of vagina		T	0193	20.7158	$1,414.21	.	$282.85
57010	Drainage of pelvic abscess		T	0193	20.7158	$1,414.21	.	$282.85
57020	Drainage of pelvic fluid		T	0192	6.7542	$461.09	.	$92.22
57022	I & d vaginal hematoma, pp		T	0007	13.3268	$909.78	.	$181.96
57023	I & d vag hematoma, non-ob		T	0008	20.2481	$1,382.28	.	$276.46
57061	Destroy vag lesions, simple		T	0193	20.7158	$1,414.21	.	$282.85
57065	Destroy vag lesions, complex		T	0193	20.7158	$1,414.21	.	$282.85
57100	Biopsy of vagina		T	0192	6.7542	$461.09	.	$92.22
57105	Biopsy of vagina		T	0193	20.7158	$1,414.21	.	$282.85
57106	Remove vagina wall, partial		T	0193	20.7158	$1,414.21	.	$282.85
57107	Remove vagina tissue, part		T	0195	35.735	$2,439.52	.	$487.91
57109	Vaginectomy partial w/nodes		T	0195	35.735	$2,439.52	.	$487.91
57110	Remove vagina wall, complete		C					
57111	Remove vagina tissue, compl		C					
57112	Vaginectomy w/nodes, compl		C					
57120	Closure of vagina		T	0195	35.735	$2,439.52	.	$487.91
57130	Remove vagina lesion		T	0193	20.7158	$1,414.21	.	$282.85
57135	Remove vagina lesion		T	0193	20.7158	$1,414.21	.	$282.85
57150	Treat vagina infection		T	0188	1.5975	$109.06	.	$21.82
57155	Insert uteri tandems/ovoids		T	0192	6.7542	$461.09	.	$92.22
57160	Insert pessary/other device		T	0188	1.5975	$109.06	.	$21.82
57170	Fitting of diaphragm/cap		T	0191	0.1514	$10.34	$2.08	$2.07

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57180	Treat vaginal bleeding		T	0188	1.5975	$109.06	.	$21.82
57200	Repair of vagina		T	0193	20.7158	$1,414.21	.	$282.85
57210	Repair vagina/perineum		T	0193	20.7158	$1,414.21	.	$282.85
57220	Revision of urethra		T	0202	45.2093	$3,086.30	$981.50	$617.26
57230	Repair of urethral lesion		T	0195	35.735	$2,439.52	.	$487.91
57240	Repair bladder & vagina		T	0195	35.735	$2,439.52	.	$487.91
57250	Repair rectum & vagina		T	0195	35.735	$2,439.52	.	$487.91
57260	Repair of vagina		T	0195	35.735	$2,439.52	.	$487.91
57265	Extensive repair of vagina		T	0202	45.2093	$3,086.30	$981.50	$617.26
57267	Insert mesh/pelvic flr addon		T	0195	35.735	$2,439.52	.	$487.91
57268	Repair of bowel bulge		T	0195	35.735	$2,439.52	.	$487.91
57270	Repair of bowel pouch		C					
57280	Suspension of vagina		C					
57282	Colpopexy, extraperitoneal		T	0202	45.2093	$3,086.30	$981.50	$617.26
57283	Colpopexy, intraperitoneal		T	0202	45.2093	$3,086.30	$981.50	$617.26
57284	Repair paravag defect, open		T	0202	45.2093	$3,086.30	$981.50	$617.26
57285	Repair paravag defect, vag		T	0202	45.2093	$3,086.30	$981.50	$617.26
57287	Revise/remove sling repair		T	0195	35.735	$2,439.52	.	$487.91
57288	Repair bladder defect		T	0202	45.2093	$3,086.30	$981.50	$617.26
57289	Repair bladder & vagina		T	0195	35.735	$2,439.52	.	$487.91
57291	Construction of vagina		T	0195	35.735	$2,439.52	.	$487.91
57292	Construct vagina with graft		T	0195	35.735	$2,439.52	.	$487.91
57295	Revise vag graft via vagina		T	0193	20.7158	$1,414.21	.	$282.85
57296	Revise vag graft, open abd		C					
57300	Repair rectum-vagina fistula		T	0195	35.735	$2,439.52	.	$487.91
57305	Repair rectum-vagina fistula		C					
57307	Fistula repair & colostomy		C					
57308	Fistula repair, transperine		C					
57310	Repair urethrovaginal lesion		T	0202	45.2093	$3,086.30	$981.50	$617.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57311	Repair urethrovaginal lesion		C					
57320	Repair bladder-vagina lesion		T	0195	35.735	$2,439.52	.	$487.91
57330	Repair bladder-vagina lesion		T	0195	35.735	$2,439.52	.	$487.91
57335	Repair vagina		T	0195	35.735	$2,439.52	.	$487.91
57400	Dilation of vagina		T	0193	20.7158	$1,414.21	.	$282.85
57410	Pelvic examination		T	0193	20.7158	$1,414.21	.	$282.85
57415	Remove vaginal foreign body		T	0193	20.7158	$1,414.21	.	$282.85
57420	Exam of vagina w/scope		T	0189	3.5572	$242.84	.	$48.57
57421	Exam/biopsy of vag w/scope		T	0189	3.5572	$242.84	.	$48.57
57423	Repair paravag defect, lap		T	0202	45.2093	$3,086.30	$981.50	$617.26
57425	Laparoscopy, surg, colpopexy		T	0130	38.7195	$2,643.26	$659.53	$528.66
57426	Revise prosth vag graft lap		T	0193	20.7158	$1,414.21	.	$282.85
57452	Exam of cervix w/scope		T	0188	1.5975	$109.06	.	$21.82
57454	Bx/curett of cervix w/scope		T	0189	3.5572	$242.84	.	$48.57
57455	Biopsy of cervix w/scope		T	0189	3.5572	$242.84	.	$48.57
57456	Endocerv curettage w/scope		T	0189	3.5572	$242.84	.	$48.57
57460	Bx of cervix w/scope, leep		T	0193	20.7158	$1,414.21	.	$282.85
57461	Conz of cervix w/scope, leep		T	0193	20.7158	$1,414.21	.	$282.85
57500	Biopsy of cervix		T	0192	6.7542	$461.09	.	$92.22
57505	Endocervical curettage		T	0192	6.7542	$461.09	.	$92.22
57510	Cauterization of cervix		T	0193	20.7158	$1,414.21	.	$282.85
57511	Cryocautery of cervix		T	0188	1.5975	$109.06	.	$21.82
57513	Laser surgery of cervix		T	0193	20.7158	$1,414.21	.	$282.85
57520	Conization of cervix		T	0193	20.7158	$1,414.21	.	$282.85
57522	Conization of cervix		T	0193	20.7158	$1,414.21	.	$282.85
57530	Removal of cervix		T	0195	35.735	$2,439.52	.	$487.91
57531	Removal of cervix, radical		C					
57540	Removal of residual cervix		C					
57545	Remove cervix/repair pelvis		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57550	Removal of residual cervix		T	0195	35.735	$2,439.52	.	$487.91
57555	Remove cervix/repair vagina		T	0195	35.735	$2,439.52	.	$487.91
57556	Remove cervix, repair bowel		T	0202	45.2093	$3,086.30	$981.50	$617.26
57558	D&c of cervical stump		T	0193	20.7158	$1,414.21	.	$282.85
57700	Revision of cervix		T	0193	20.7158	$1,414.21	.	$282.85
57720	Revision of cervix		T	0193	20.7158	$1,414.21	.	$282.85
57800	Dilation of cervical canal		T	0193	20.7158	$1,414.21	.	$282.85
58100	Biopsy of uterus lining		T	0188	1.5975	$109.06	.	$21.82
58110	Bx done w/colposcopy add-on		N					
58120	Dilation and curettage		T	0193	20.7158	$1,414.21	.	$282.85
58140	Myomectomy abdom method		C					
58145	Myomectomy vag method		T	0195	35.735	$2,439.52	.	$487.91
58146	Myomectomy abdom complex		C					
58150	Total hysterectomy		C					
58152	Total hysterectomy		C					
58180	Partial hysterectomy		C					
58200	Extensive hysterectomy		C					
58210	Extensive hysterectomy		C					
58240	Removal of pelvis contents		C					
58260	Vaginal hysterectomy		T	0195	35.735	$2,439.52	.	$487.91
58262	Vag hyst including t/o		T	0195	35.735	$2,439.52	.	$487.91
58263	Vag hyst w/t/o & vag repair		T	0195	35.735	$2,439.52	.	$487.91
58267	Vag hyst w/urinary repair		C					
58270	Vag hyst w/enterocele repair		T	0195	35.735	$2,439.52	.	$487.91
58275	Hysterectomy/revise vagina		C					
58280	Hysterectomy/revise vagina		C					
58285	Extensive hysterectomy		C					
58290	Vag hyst complex		T	0202	45.2093	$3,086.30	$981.50	$617.26
58291	Vag hyst incl t/o, complex		T	0202	45.2093	$3,086.30	$981.50	$617.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58292	Vag hyst t/o & repair, compl		T	0202	45.2093	$3,086.30	$981.50	$617.26
58293	Vag hyst w/uro repair, compl		C					
58294	Vag hyst w/enterocele, compl		T	0202	45.2093	$3,086.30	$981.50	$617.26
58300	Insert intrauterine device		E					
58301	Remove intrauterine device		T	0188	1.5975	$109.06	.	$21.82
58321	Artificial insemination		T	0189	3.5572	$242.84	.	$48.57
58322	Artificial insemination		T	0189	3.5572	$242.84	.	$48.57
58323	Sperm washing		T	0189	3.5572	$242.84	.	$48.57
58340	Catheter for hysterography		N					
58345	Reopen fallopian tube		T	0193	20.7158	$1,414.21	.	$282.85
58346	Insert heyman uteri capsule		T	0193	20.7158	$1,414.21	.	$282.85
58350	Reopen fallopian tube		T	0195	35.735	$2,439.52	.	$487.91
58353	Endometr ablate, thermal		T	0195	35.735	$2,439.52	.	$487.91
58356	Endometrial cryoablation		T	0202	45.2093	$3,086.30	$981.50	$617.26
58400	Suspension of uterus		C					
58410	Suspension of uterus		C					
58520	Repair of ruptured uterus		C					
58540	Revision of uterus		C					
58541	Lsh, uterus 250 g or less		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
58542	Lsh w/t/o ut 250 g or less		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
58543	Lsh uterus above 250 g		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
58544	Lsh w/t/o uterus above 250 g		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
58545	Laparoscopic myomectomy		T	0130	38.7195	$2,643.26	$659.53	$528.66
58546	Laparo-myomectomy, complex		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58548	Lap radical hyst		C					
58550	Laparo-asst vag hysterectomy		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
58552	Laparo-vag hyst incl t/o		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58553	Laparo-vag hyst, complex		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58554	Laparo-vag hyst w/t/o, compl		T	0131	48.0382	$3,279.42	$1,001.89	$655.89

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58555	Hysteroscopy, dx, sep proc		T	0190	23.199	$1,583.73	$424.28	$316.75
58558	Hysteroscopy, biopsy		T	0190	23.199	$1,583.73	$424.28	$316.75
58559	Hysteroscopy, lysis		T	0190	23.199	$1,583.73	$424.28	$316.75
58560	Hysteroscopy, resect septum		T	0387	38.2775	$2,613.09	$655.55	$522.62
58561	Hysteroscopy, remove myoma		T	0387	38.2775	$2,613.09	$655.55	$522.62
58562	Hysteroscopy, remove fb		T	0190	23.199	$1,583.73	$424.28	$316.75
58563	Hysteroscopy, ablation		T	0387	38.2775	$2,613.09	$655.55	$522.62
58565	Hysteroscopy, sterilization		T	0202	45.2093	$3,086.30	$981.50	$617.26
58570	Tlh, uterus 250 g or less		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58571	Tlh w/t/o 250 g or less		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58572	Tlh, uterus over 250 g		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58573	Tlh w/t/o uterus over 250 g		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58578	Laparo proc, uterus		T	0130	38.7195	$2,643.26	$659.53	$528.66
58579	Hysteroscope procedure		T	0190	23.199	$1,583.73	$424.28	$316.75
58600	Division of fallopian tube		T	0195	35.735	$2,439.52	.	$487.91
58605	Division of fallopian tube		C					
58611	Ligate oviduct(s) add-on		C					
58615	Occlude fallopian tube(s)		T	0193	20.7158	$1,414.21	.	$282.85
58660	Laparoscopy, lysis		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58661	Laparoscopy, remove adnexa		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58662	Laparoscopy, excise lesions		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58670	Laparoscopy, tubal cautery		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58671	Laparoscopy, tubal block		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58672	Laparoscopy, fimbrioplasty		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58673	Laparoscopy, salpingostomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58679	Laparo proc, oviduct-ovary		T	0130	38.7195	$2,643.26	$659.53	$528.66
58700	Removal of fallopian tube		C					
58720	Removal of ovary/tube(s)		C					
58740	Adhesiolysis tube, ovary		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58750	Repair oviduct		C					
58752	Revise ovarian tube(s)		C					
58760	Fimbrioplasty		C					
58770	Create new tubal opening		T	0195	35.735	$2,439.52	.	$487.91
58800	Drainage of ovarian cyst(s)		T	0193	20.7158	$1,414.21	.	$282.85
58805	Drainage of ovarian cyst(s)		T	0195	35.735	$2,439.52	.	$487.91
58820	Drain ovary abscess, open		T	0195	35.735	$2,439.52	.	$487.91
58822	Drain ovary abscess, percut		C					
58823	Drain pelvic abscess, percut		T	0193	20.7158	$1,414.21	.	$282.85
58825	Transposition, ovary(s)		C					
58900	Biopsy of ovary(s)		T	0193	20.7158	$1,414.21	.	$282.85
58920	Partial removal of ovary(s)		T	0195	35.735	$2,439.52	.	$487.91
58925	Removal of ovarian cyst(s)		T	0195	35.735	$2,439.52	.	$487.91
58940	Removal of ovary(s)		C					
58943	Removal of ovary(s)		C					
58950	Resect ovarian malignancy		C					
58951	Resect ovarian malignancy		C					
58952	Resect ovarian malignancy		C					
58953	Tah, rad dissect for debulk		C					
58954	Tah rad debulk/lymph remove		C					
58956	Bso, omentectomy w/tah		C					
58957	Resect recurrent gyn mal		C					
58958	Resect recur gyn mal w/lym		C					
58960	Exploration of abdomen		C					
58970	Retrieval of oocyte		T	0189	3.5572	$242.84	.	$48.57
58974	Transfer of embryo		T	0189	3.5572	$242.84	.	$48.57
58976	Transfer of embryo		T	0189	3.5572	$242.84	.	$48.57
58999	Genital surgery procedure		T	0191	0.1514	$10.34	$2.08	$2.07
59000	Amniocentesis, diagnostic		T	0189	3.5572	$242.84	.	$48.57

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59001	Amniocentesis, therapeutic		T	0192	6.7542	$461.09	.	$92.22
59012	Fetal cord puncture,prenatal		T	0189	3.5572	$242.84	.	$48.57
59015	Chorion biopsy		T	0189	3.5572	$242.84	.	$48.57
59020	Fetal contract stress test		T	0188	1.5975	$109.06	.	$21.82
59025	Fetal non-stress test		T	0188	1.5975	$109.06	.	$21.82
59030	Fetal scalp blood sample		T	0189	3.5572	$242.84	.	$48.57
59050	Fetal monitor w/report		M					
59051	Fetal monitor/interpret only		B					
59070	Transabdom amnioinfus w/us		T	0188	1.5975	$109.06	.	$21.82
59072	Umbilical cord occlud w/us		T	0189	3.5572	$242.84	.	$48.57
59074	Fetal fluid drainage w/us		T	0189	3.5572	$242.84	.	$48.57
59076	Fetal shunt placement, w/us		T	0189	3.5572	$242.84	.	$48.57
59100	Remove uterus lesion		T	0195	35.735	$2,439.52	.	$487.91
59120	Treat ectopic pregnancy		C					
59121	Treat ectopic pregnancy		C					
59130	Treat ectopic pregnancy		C					
59135	Treat ectopic pregnancy		C					
59136	Treat ectopic pregnancy		C					
59140	Treat ectopic pregnancy		C					
59150	Treat ectopic pregnancy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
59151	Treat ectopic pregnancy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
59160	D & c after delivery		T	0193	20.7158	$1,414.21	.	$282.85
59200	Insert cervical dilator		T	0188	1.5975	$109.06	.	$21.82
59300	Episiotomy or vaginal repair		T	0193	20.7158	$1,414.21	.	$282.85
59320	Revision of cervix		T	0193	20.7158	$1,414.21	.	$282.85
59325	Revision of cervix		C					
59350	Repair of uterus		C					
59400	Obstetrical care		B					
59409	Obstetrical care		T	0193	20.7158	$1,414.21	.	$282.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59410	Obstetrical care		B					
59412	Antepartum manipulation		T	0193	20.7158	$1,414.21	.	$282.85
59414	Deliver placenta		T	0193	20.7158	$1,414.21	.	$282.85
59425	Antepartum care only		B					
59426	Antepartum care only		B					
59430	Care after delivery		B					
59510	Cesarean delivery		B					
59514	Cesarean delivery only		C					
59515	Cesarean delivery		B					
59525	Remove uterus after cesarean		C					
59610	Vbac delivery		B					
59612	Vbac delivery only		T	0193	20.7158	$1,414.21	.	$282.85
59614	Vbac care after delivery		B					
59618	Attempted vbac delivery		B					
59620	Attempted vbac delivery only		C					
59622	Attempted vbac after care		B					
59812	Treatment of miscarriage		T	0193	20.7158	$1,414.21	.	$282.85
59820	Care of miscarriage		T	0193	20.7158	$1,414.21	.	$282.85
59821	Treatment of miscarriage		T	0193	20.7158	$1,414.21	.	$282.85
59830	Treat uterus infection		C					
59840	Abortion		T	0193	20.7158	$1,414.21	.	$282.85
59841	Abortion		T	0193	20.7158	$1,414.21	.	$282.85
59850	Abortion		C					
59851	Abortion		C					
59852	Abortion		C					
59855	Abortion		C					
59856	Abortion		C					
59857	Abortion		C					
59866	Abortion (mpr)		T	0189	3.5572	$242.84	.	$48.57

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59870	Evacuate mole of uterus		T	0193	20.7158	$1,414.21	.	$282.85
59871	Remove cerclage suture		T	0193	20.7158	$1,414.21	.	$282.85
59897	Fetal invas px w/us		T	0191	0.1514	$10.34	$2.08	$2.07
59898	Laparo proc, ob care/deliver		T	0130	38.7195	$2,643.26	$659.53	$528.66
59899	Maternity care procedure		T	0191	0.1514	$10.34	$2.08	$2.07
60000	Drain thyroid/tongue cyst		T	0252	7.8743	$537.55	$109.16	$107.51
60100	Biopsy of thyroid		T	0004	4.6624	$318.29	.	$63.66
60200	Remove thyroid lesion		T	0114	50.9844	$3,480.55	.	$696.11
60210	Partial thyroid excision		T	0114	50.9844	$3,480.55	.	$696.11
60212	Partial thyroid excision		T	0114	50.9844	$3,480.55	.	$696.11
60220	Partial removal of thyroid		T	0114	50.9844	$3,480.55	.	$696.11
60225	Partial removal of thyroid		T	0114	50.9844	$3,480.55	.	$696.11
60240	Removal of thyroid		T	0114	50.9844	$3,480.55	.	$696.11
60252	Removal of thyroid		T	0256	44.8441	$3,061.37	.	$612.28
60254	Extensive thyroid surgery		C					
60260	Repeat thyroid surgery		T	0256	44.8441	$3,061.37	.	$612.28
60270	Removal of thyroid		C					
60271	Removal of thyroid		T	0256	44.8441	$3,061.37	.	$612.28
60280	Remove thyroid duct lesion		T	0114	50.9844	$3,480.55	.	$696.11
60281	Remove thyroid duct lesion		T	0114	50.9844	$3,480.55	.	$696.11
60300	Aspir/inj thyroid cyst		T	0004	4.6624	$318.29	.	$63.66
60500	Explore parathyroid glands		T	0256	44.8441	$3,061.37	.	$612.28
60502	Re-explore parathyroids		T	0256	44.8441	$3,061.37	.	$612.28
60505	Explore parathyroid glands		C					
60512	Autotransplant parathyroid		T	0022	24.1269	$1,647.07	$354.45	$329.42
60520	Removal of thymus gland		T	0256	44.8441	$3,061.37	.	$612.28
60521	Removal of thymus gland		C					
60522	Removal of thymus gland		C					
60540	Explore adrenal gland		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
60545	Explore adrenal gland		C					
60600	Remove carotid body lesion		C					
60605	Remove carotid body lesion		C					
60650	Laparoscopy adrenalectomy		C					
60659	Laparo proc, endocrine		T	0130	38.7195	$2,643.26	$659.53	$528.66
60699	Endocrine surgery procedure		T	0114	50.9844	$3,480.55	.	$696.11
61000	Remove cranial cavity fluid		T	0207	7.7204	$527.05	.	$105.41
61001	Remove cranial cavity fluid		T	0207	7.7204	$527.05	.	$105.41
61020	Remove brain cavity fluid		T	0207	7.7204	$527.05	.	$105.41
61026	Injection into brain canal		T	0207	7.7204	$527.05	.	$105.41
61050	Remove brain canal fluid		T	0207	7.7204	$527.05	.	$105.41
61055	Injection into brain canal		T	0207	7.7204	$527.05	.	$105.41
61070	Brain canal shunt procedure		T	0121	6.3264	$431.88	.	$86.38
61105	Twist drill hole		C					
61107	Drill skull for implantation		C					
61108	Drill skull for drainage		C					
61120	Burr hole for puncture		C					
61140	Pierce skull for biopsy		C					
61150	Pierce skull for drainage		C					
61151	Pierce skull for drainage		C					
61154	Pierce skull & remove clot		C					
61156	Pierce skull for drainage		C					
61210	Pierce skull, implant device		C					
61215	Insert brain-fluid device		T	0224	41.9698	$2,865.15	.	$573.03
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61313	Open skull for drainage		C					
61314	Open skull for drainage		C					
61315	Open skull for drainage		C					
61316	Implt cran bone flap to abdo		C					
61320	Open skull for drainage		C					
61321	Open skull for drainage		C					
61322	Decompressive craniotomy		C					
61323	Decompressive lobectomy		C					
61330	Decompress eye socket		T	0256	44.8441	$3,061.37	.	$612.28
61332	Explore/biopsy eye socket		C					
61333	Explore orbit/remove lesion		C					
61334	Explore orbit/remove object		T	0256	44.8441	$3,061.37	.	$612.28
61340	Subtemporal decompression		C					
61343	Incise skull (press relief)		C					
61345	Relieve cranial pressure		C					
61440	Incise skull for surgery		C					
61450	Incise skull for surgery		C					
61458	Incise skull for brain wound		C					
61460	Incise skull for surgery		C					
61470	Incise skull for surgery		C					
61480	Incise skull for surgery		C					
61490	Incise skull for surgery		C					
61500	Removal of skull lesion		C					
61501	Remove infected skull bone		C					
61510	Removal of brain lesion		C					
61512	Remove brain lining lesion		C					
61514	Removal of brain abscess		C					
61516	Removal of brain lesion		C					
61517	Implt brain chemotx add-on		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61559	Excision of skull/sutures		C					
61563	Excision of skull tumor		C					
61564	Excision of skull tumor		C					
61566	Removal of brain tissue		C					
61567	Incision of brain tissue		C					
61570	Remove foreign body, brain		C					
61571	Incise skull for brain wound		C					
61575	Skull base/brainstem surgery		C					
61576	Skull base/brainstem surgery		C					
61580	Craniofacial approach, skull		C					
61581	Craniofacial approach, skull		C					
61582	Craniofacial approach, skull		C					
61583	Craniofacial approach, skull		C					
61584	Orbitocranial approach/skull		C					
61585	Orbitocranial approach/skull		C					
61586	Resect nasopharynx, skull		C					
61590	Infratemporal approach/skull		C					
61591	Infratemporal approach/skull		C					
61592	Orbitocranial approach/skull		C					
61595	Transtemporal approach/skull		C					
61596	Transcochlear approach/skull		C					
61597	Transcondylar approach/skull		C					
61598	Transpetrosal approach/skull		C					
61600	Resect/excise cranial lesion		C					
61601	Resect/excise cranial lesion		C					
61605	Resect/excise cranial lesion		C					
61606	Resect/excise cranial lesion		C					
61607	Resect/excise cranial lesion		C					
61608	Resect/excise cranial lesion		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61609	Transect artery, sinus		C					
61610	Transect artery, sinus		C					
61611	Transect artery, sinus		C					
61612	Transect artery, sinus		C					
61613	Remove aneurysm, sinus		C					
61615	Resect/excise lesion, skull		C					
61616	Resect/excise lesion, skull		C					
61618	Repair dura		C					
61619	Repair dura		C					
61623	Endovasc tempory vessel occl		T	0082	97.8929	$6,682.85	.	$1,336.57
61624	Transcath occlusion, cns		C					
61626	Transcath occlusion, non-cns		T	0082	97.8929	$6,682.85	.	$1,336.57
61630	Intracranial angioplasty		C					
61635	Intracran angioplsty w/stent		C					
61640	Dilate ic vasospasm, init		E					
61641	Dilate ic vasospasm add-on		E					
61642	Dilate ic vasospasm add-on		E					
61680	Intracranial vessel surgery		C					
61682	Intracranial vessel surgery		C					
61684	Intracranial vessel surgery		C					
61686	Intracranial vessel surgery		C					
61690	Intracranial vessel surgery		C					
61692	Intracranial vessel surgery		C					
61697	Brain aneurysm repr, complx		C					
61698	Brain aneurysm repr, complx		C					
61700	Brain aneurysm repr, simple		C					
61702	Inner skull vessel surgery		C					
61703	Clamp neck artery		C					
61705	Revise circulation to head		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61708	Revise circulation to head		C					
61710	Revise circulation to head		C					
61711	Fusion of skull arteries		C					
61720	Incise skull/brain surgery		T	0221	37.5345	$2,562.37	.	$512.48
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		T	0221	37.5345	$2,562.37	.	$512.48
61790	Treat trigeminal nerve		T	0220	19.3535	$1,321.21	.	$264.25
61791	Treat trigeminal tract		T	0203	13.3062	$908.37	$225.43	$181.68
61795	Brain surgery using computer		N					
61796	Srs, cranial lesion simple		B					
61797	Srs, cran les simple, addl		B					
61798	Srs, cranial lesion complex		B					
61799	Srs, cran les complex, addl		B					
61800	Apply srs headframe add-on		B					
61850	Implant neuroelectrodes		C					
61860	Implant neuroelectrodes		C					
61863	Implant neuroelectrode		C					
61864	Implant neuroelectrde, addl		C					
61867	Implant neuroelectrode		C					
61868	Implant neuroelectrde, addl		C					
61870	Implant neuroelectrodes		C					
61875	Implant neuroelectrodes		C					
61880	Revise/remove neuroelectrode		T	0687	21.9323	$1,497.25	$397.37	$299.45
61885	Insrt/redo neurostim 1 array		S	0039	210.3341	$14,358.88	.	$2,871.78
61886	Implant neurostim arrays		S	0315	270.0348	$18,434.47	.	$3,686.90
61888	Revise/remove neuroreceiver		T	0688	29.5816	$2,019.45	$768.94	$403.89

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62000	Treat skull fracture		T	0254	25.5397	$1,743.52	.	$348.71
62005	Treat skull fracture		C					
62010	Treatment of head injury		C					
62100	Repair brain fluid leakage		C					
62115	Reduction of skull defect		C					
62116	Reduction of skull defect		C					
62117	Reduction of skull defect		C					
62120	Repair skull cavity lesion		C					
62121	Incise skull repair		C					
62140	Repair of skull defect		C					
62141	Repair of skull defect		C					
62142	Remove skull plate/flap		C					
62143	Replace skull plate/flap		C					
62145	Repair of skull & brain		C					
62146	Repair of skull with graft		C					
62147	Repair of skull with graft		C					
62148	Retr bone flap to fix skull		C					
62160	Neuroendoscopy add-on		N					
62161	Dissect brain w/scope		C					
62162	Remove colloid cyst w/scope		C					
62163	Neuroendoscopy w/fb removal		C					
62164	Remove brain tumor w/scope		C					
62165	Remove pituit tumor w/scope		C					
62180	Establish brain cavity shunt		C					
62190	Establish brain cavity shunt		C					
62192	Establish brain cavity shunt		C					
62194	Replace/irrigate catheter		T	0207	7.7204	$527.05	.	$105.41
62200	Establish brain cavity shunt		C					
62201	Brain cavity shunt w/scope		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62220	Establish brain cavity shunt		C					
62223	Establish brain cavity shunt		C					
62225	Replace/irrigate catheter		T	0427	16.3601	$1,116.85	.	$223.37
62230	Replace/revise brain shunt		T	0224	41.9698	$2,865.15	.	$573.03
62252	Csf shunt reprogram		S	0691	2.4765	$169.06	.	$33.82
62256	Remove brain cavity shunt		C					
62258	Replace brain cavity shunt		C					
62263	Epidural lysis mult sessions		T	0207	7.7204	$527.05	.	$105.41
62264	Epidural lysis on single day		T	0203	13.3062	$908.37	$225.43	$181.68
62267	Interdiscal perq aspir, dx		T	0004	4.6624	$318.29	.	$63.66
62268	Drain spinal cord cyst		T	0207	7.7204	$527.05	.	$105.41
62269	Needle biopsy, spinal cord		T	0685	9.9046	$676.16	.	$135.24
62270	Spinal fluid tap, diagnostic		T	0206	3.8796	$264.85	.	$52.97
62272	Drain cerebro spinal fluid		T	0206	3.8796	$264.85	.	$52.97
62273	Inject epidural patch	CH	T	0207	7.7204	$527.05	.	$105.41
62280	Treat spinal cord lesion		T	0207	7.7204	$527.05	.	$105.41
62281	Treat spinal cord lesion		T	0207	7.7204	$527.05	.	$105.41
62282	Treat spinal canal lesion		T	0207	7.7204	$527.05	.	$105.41
62284	Injection for myelogram		N					
62287	Percutaneous diskectomy		T	0221	37.5345	$2,562.37	.	$512.48
62290	Inject for spine disk x-ray		N					
62291	Inject for spine disk x-ray		N					
62292	Injection into disk lesion		T	0207	7.7204	$527.05	.	$105.41
62294	Injection into spinal artery		T	0207	7.7204	$527.05	.	$105.41
62310	Inject spine c/t		T	0207	7.7204	$527.05	.	$105.41
62311	Inject spine l/s (cd)		T	0207	7.7204	$527.05	.	$105.41
62318	Inject spine w/cath, c/t		T	0207	7.7204	$527.05	.	$105.41
62319	Inject spine w/cath l/s (cd)	CH	T	0203	13.3062	$908.37	$225.43	$181.68
62350	Implant spinal canal cath		T	0224	41.9698	$2,865.15	.	$573.03

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62351	Implant spinal canal cath		T	0208	51.7137	$3,530.34	.	$706.07
62355	Remove spinal canal catheter		T	0203	13.3062	$908.37	$225.43	$181.68
62360	Insert spine infusion device		T	0224	41.9698	$2,865.15	.	$573.03
62361	Implant spine infusion pump		T	0227	194.6115	$13,285.54	.	$2,657.11
62362	Implant spine infusion pump		T	0227	194.6115	$13,285.54	.	$2,657.11
62365	Remove spine infusion device		T	0221	37.5345	$2,562.37	.	$512.48
62367	Analyze spine infusion pump		S	0691	2.4765	$169.06	.	$33.82
62368	Analyze spine infusion pump		S	0691	2.4765	$169.06	.	$33.82
63001	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63003	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63005	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63011	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63012	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63015	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63016	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63017	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63020	Neck spine disk surgery		T	0208	51.7137	$3,530.34	.	$706.07
63030	Low back disk surgery		T	0208	51.7137	$3,530.34	.	$706.07
63035	Spinal disk surgery add-on		T	0208	51.7137	$3,530.34	.	$706.07
63040	Laminotomy, single cervical		T	0208	51.7137	$3,530.34	.	$706.07
63042	Laminotomy, single lumbar		T	0208	51.7137	$3,530.34	.	$706.07
63043	Laminotomy, addl cervical		C					
63044	Laminotomy, addl lumbar		C					
63045	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63046	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63047	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63048	Remove spinal lamina add-on		T	0208	51.7137	$3,530.34	.	$706.07
63050	Cervical laminoplasty		C					
63051	C-laminoplasty w/graft/plate		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63055	Decompress spinal cord		T	0208	51.7137	$3,530.34	.	$706.07
63056	Decompress spinal cord		T	0208	51.7137	$3,530.34	.	$706.07
63057	Decompress spine cord add-on		T	0208	51.7137	$3,530.34	.	$706.07
63064	Decompress spinal cord		T	0208	51.7137	$3,530.34	.	$706.07
63066	Decompress spine cord add-on		T	0208	51.7137	$3,530.34	.	$706.07
63075	Neck spine disk surgery		T	0208	51.7137	$3,530.34	.	$706.07
63076	Neck spine disk surgery		T	0208	51.7137	$3,530.34	.	$706.07
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63195	Incise spinal column & cord		C					
63196	Incise spinal column & cord		C					
63197	Incise spinal column & cord		C					
63198	Incise spinal column & cord		C					
63199	Incise spinal column & cord		C					
63200	Release of spinal cord		C					
63250	Revise spinal cord vessels		C					
63251	Revise spinal cord vessels		C					
63252	Revise spinal cord vessels		C					
63265	Excise intraspinal lesion		C					
63266	Excise intraspinal lesion		C					
63267	Excise intraspinal lesion		C					
63268	Excise intraspinal lesion		C					
63270	Excise intraspinal lesion		C					
63271	Excise intraspinal lesion		C					
63272	Excise intraspinal lesion		C					
63273	Excise intraspinal lesion		C					
63275	Biopsy/excise spinal tumor		C					
63276	Biopsy/excise spinal tumor		C					
63277	Biopsy/excise spinal tumor		C					
63278	Biopsy/excise spinal tumor		C					
63280	Biopsy/excise spinal tumor		C					
63281	Biopsy/excise spinal tumor		C					
63282	Biopsy/excise spinal tumor		C					
63283	Biopsy/excise spinal tumor		C					
63285	Biopsy/excise spinal tumor		C					
63286	Biopsy/excise spinal tumor		C					
63287	Biopsy/excise spinal tumor		C					
63290	Biopsy/excise spinal tumor		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63295	Repair of laminectomy defect		C					
63300	Removal of vertebral body		C					
63301	Removal of vertebral body		C					
63302	Removal of vertebral body		C					
63303	Removal of vertebral body		C					
63304	Removal of vertebral body		C					
63305	Removal of vertebral body		C					
63306	Removal of vertebral body		C					
63307	Removal of vertebral body		C					
63308	Remove vertebral body add-on		C					
63600	Remove spinal cord lesion		T	0220	19.3535	$1,321.21	.	$264.25
63610	Stimulation of spinal cord		T	0220	19.3535	$1,321.21	.	$264.25
63615	Remove lesion of spinal cord		T	0220	19.3535	$1,321.21	.	$264.25
63620	Srs, spinal lesion		B					
63621	Srs, spinal lesion, addl		B					
63650	Implant neuroelectrodes		S	0040	65.4002	$4,464.68	.	$892.94
63655	Implant neuroelectrodes		S	0061	88.8954	$6,068.62	.	$1,213.73
63661	Remove spine eltrd perq aray		T	0687	21.9323	$1,497.25	$397.37	$299.45
63662	Remove spine eltrd plate		T	0687	21.9323	$1,497.25	$397.37	$299.45
63663	Revise spine eltrd perq aray		T	0687	21.9323	$1,497.25	$397.37	$299.45
63664	Revise spine eltrd plate		T	0687	21.9323	$1,497.25	$397.37	$299.45
63685	Insrt/redo spine n generator		S	0039	210.3341	$14,358.88	.	$2,871.78
63688	Revise/remove neuroreceiver		T	0688	29.5816	$2,019.45	$768.94	$403.89
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63710	Graft repair of spine defect		C					
63740	Install spinal shunt		C					
63741	Install spinal shunt		T	0224	41.9698	$2,865.15	.	$573.03
63744	Revision of spinal shunt		T	0224	41.9698	$2,865.15	.	$573.03
63746	Removal of spinal shunt		T	0203	13.3062	$908.37	$225.43	$181.68
64400	N block inj, trigeminal		T	0204	2.666	$182.00	$40.13	$36.40
64402	N block inj, facial		T	0204	2.666	$182.00	$40.13	$36.40
64405	N block inj, occipital		T	0206	3.8796	$264.85	.	$52.97
64408	N block inj, vagus		T	0207	7.7204	$527.05	.	$105.41
64410	N block inj, phrenic		T	0207	7.7204	$527.05	.	$105.41
64412	N block inj, spinal accessor		T	0207	7.7204	$527.05	.	$105.41
64413	N block inj, cervical plexus		T	0206	3.8796	$264.85	.	$52.97
64415	N block inj, brachial plexus		T	0206	3.8796	$264.85	.	$52.97
64416	N block cont infuse, b plex		T	0207	7.7204	$527.05	.	$105.41
64417	N block inj, axillary		T	0206	3.8796	$264.85	.	$52.97
64418	N block inj, suprascapular		T	0206	3.8796	$264.85	.	$52.97
64420	N block inj, intercost, sng		T	0206	3.8796	$264.85	.	$52.97
64421	N block inj, intercost, mlt		T	0207	7.7204	$527.05	.	$105.41
64425	N block inj, ilio-ing/hypogi		T	0206	3.8796	$264.85	.	$52.97
64430	N block inj, pudendal		T	0207	7.7204	$527.05	.	$105.41
64435	N block inj, paracervical		T	0206	3.8796	$264.85	.	$52.97
64445	N block inj, sciatic, sng		T	0207	7.7204	$527.05	.	$105.41
64446	N blk inj, sciatic, cont inf		T	0207	7.7204	$527.05	.	$105.41
64447	N block inj fem, single		T	0206	3.8796	$264.85	.	$52.97
64448	N block inj fem, cont inf		T	0207	7.7204	$527.05	.	$105.41
64449	N block inj, lumbar plexus		T	0207	7.7204	$527.05	.	$105.41
64450	N block, other peripheral		T	0206	3.8796	$264.85	.	$52.97
64455	N block inj, plantar digit		T	0204	2.666	$182.00	$40.13	$36.40
64479	Inj foramen epidural c/t		T	0207	7.7204	$527.05	.	$105.41

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64480	Inj foramen epidural add-on		T	0206	3.8796	$264.85	.	$52.97
64483	Inj foramen epidural l/s		T	0207	7.7204	$527.05	.	$105.41
64484	Inj foramen epidural add-on		T	0206	3.8796	$264.85	.	$52.97
64490	Inj paravert f jnt c/t 1 lev		T	0207	7.7204	$527.05	.	$105.41
64491	Inj paravert f jnt c/t 2 lev		T	0204	2.666	$182.00	$40.13	$36.40
64492	Inj paravert f jnt c/t 3 lev		T	0204	2.666	$182.00	$40.13	$36.40
64493	Inj paravert f jnt l/s 1 lev		T	0207	7.7204	$527.05	.	$105.41
64494	Inj paravert f jnt l/s 2 lev		T	0204	2.666	$182.00	$40.13	$36.40
64495	Inj paravert f jnt l/s 3 lev		T	0204	2.666	$182.00	$40.13	$36.40
64505	N block, spenopalatine gangl		T	0204	2.666	$182.00	$40.13	$36.40
64508	N block, carotid sinus s/p		T	0204	2.666	$182.00	$40.13	$36.40
64510	N block, stellate ganglion		T	0207	7.7204	$527.05	.	$105.41
64517	N block inj, hypogas plxs		T	0207	7.7204	$527.05	.	$105.41
64520	N block, lumbar/thoracic		T	0207	7.7204	$527.05	.	$105.41
64530	N block inj, celiac pelus		T	0207	7.7204	$527.05	.	$105.41
64550	Apply neurostimulator		A					
64553	Implant neuroelectrodes		S	0040	65.4002	$4,464.68	.	$892.94
64555	Implant neuroelectrodes		S	0040	65.4002	$4,464.68	.	$892.94
64560	Implant neuroelectrodes		S	0040	65.4002	$4,464.68	.	$892.94
64561	Implant neuroelectrodes		S	0040	65.4002	$4,464.68	.	$892.94
64565	Implant neuroelectrodes		S	0040	65.4002	$4,464.68	.	$892.94
64573	Implant neuroelectrodes		S	0225	212.7796	$14,525.82	.	$2,905.17
64575	Implant neuroelectrodes		S	0061	88.8954	$6,068.62	.	$1,213.73
64577	Implant neuroelectrodes		S	0061	88.8954	$6,068.62	.	$1,213.73
64580	Implant neuroelectrodes		S	0061	88.8954	$6,068.62	.	$1,213.73
64581	Implant neuroelectrodes		S	0061	88.8954	$6,068.62	.	$1,213.73
64585	Revise/remove neuroelectrode		T	0687	21.9323	$1,497.25	$397.37	$299.45
64590	Insrt/redo pn/gastr stimul		S	0039	210.3341	$14,358.88	.	$2,871.78
64595	Revise/rmv pn/gastr stimul		T	0688	29.5816	$2,019.45	$768.94	$403.89

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64600	Injection treatment of nerve		T	0203	13.3062	$908.37	$225.43	$181.68
64605	Injection treatment of nerve		T	0220	19.3535	$1,321.21	.	$264.25
64610	Injection treatment of nerve		T	0220	19.3535	$1,321.21	.	$264.25
64612	Destroy nerve, face muscle		T	0204	2.666	$182.00	$40.13	$36.40
64613	Destroy nerve, neck muscle		T	0206	3.8796	$264.85	.	$52.97
64614	Destroy nerve, extrem musc		T	0206	3.8796	$264.85	.	$52.97
64620	Injection treatment of nerve		T	0207	7.7204	$527.05	.	$105.41
64622	Destr paravertebrl nerve l/s		T	0203	13.3062	$908.37	$225.43	$181.68
64623	Destr paravertebral n add-on		T	0207	7.7204	$527.05	.	$105.41
64626	Destr paravertebrl nerve c/t		T	0207	7.7204	$527.05	.	$105.41
64627	Destr paravertebral n add-on		T	0204	2.666	$182.00	$40.13	$36.40
64630	Injection treatment of nerve		T	0207	7.7204	$527.05	.	$105.41
64632	N block inj, common digit		T	0204	2.666	$182.00	$40.13	$36.40
64640	Injection treatment of nerve		T	0207	7.7204	$527.05	.	$105.41
64650	Chemodenerv eccrine glands		T	0204	2.666	$182.00	$40.13	$36.40
64653	Chemodenerv eccrine glands		T	0204	2.666	$182.00	$40.13	$36.40
64680	Injection treatment of nerve		T	0207	7.7204	$527.05	.	$105.41
64681	Injection treatment of nerve		T	0203	13.3062	$908.37	$225.43	$181.68
64702	Revise finger/toe nerve		T	0220	19.3535	$1,321.21	.	$264.25
64704	Revise hand/foot nerve		T	0220	19.3535	$1,321.21	.	$264.25
64708	Revise arm/leg nerve		T	0220	19.3535	$1,321.21	.	$264.25
64712	Revision of sciatic nerve		T	0220	19.3535	$1,321.21	.	$264.25
64713	Revision of arm nerve(s)		T	0220	19.3535	$1,321.21	.	$264.25
64714	Revise low back nerve(s)		T	0220	19.3535	$1,321.21	.	$264.25
64716	Revision of cranial nerve		T	0220	19.3535	$1,321.21	.	$264.25
64718	Revise ulnar nerve at elbow		T	0220	19.3535	$1,321.21	.	$264.25
64719	Revise ulnar nerve at wrist		T	0220	19.3535	$1,321.21	.	$264.25
64721	Carpal tunnel surgery		T	0220	19.3535	$1,321.21	.	$264.25
64722	Relieve pressure on nerve(s)		T	0220	19.3535	$1,321.21	.	$264.25

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64726	Release foot/toe nerve		T	0220	19.3535	$1,321.21	.	$264.25
64727	Internal nerve revision		T	0220	19.3535	$1,321.21	.	$264.25
64732	Incision of brow nerve		T	0220	19.3535	$1,321.21	.	$264.25
64734	Incision of cheek nerve		T	0220	19.3535	$1,321.21	.	$264.25
64736	Incision of chin nerve		T	0220	19.3535	$1,321.21	.	$264.25
64738	Incision of jaw nerve		T	0220	19.3535	$1,321.21	.	$264.25
64740	Incision of tongue nerve		T	0220	19.3535	$1,321.21	.	$264.25
64742	Incision of facial nerve		T	0220	19.3535	$1,321.21	.	$264.25
64744	Incise nerve, back of head		T	0220	19.3535	$1,321.21	.	$264.25
64746	Incise diaphragm nerve		T	0220	19.3535	$1,321.21	.	$264.25
64752	Incision of vagus nerve		C					
64755	Incision of stomach nerves		C					
64760	Incision of vagus nerve		C					
64761	Incision of pelvis nerve		T	0220	19.3535	$1,321.21	.	$264.25
64763	Incise hip/thigh nerve		T	0220	19.3535	$1,321.21	.	$264.25
64766	Incise hip/thigh nerve		T	0221	37.5345	$2,562.37	.	$512.48
64771	Sever cranial nerve		T	0220	19.3535	$1,321.21	.	$264.25
64772	Incision of spinal nerve		T	0220	19.3535	$1,321.21	.	$264.25
64774	Remove skin nerve lesion		T	0220	19.3535	$1,321.21	.	$264.25
64776	Remove digit nerve lesion		T	0220	19.3535	$1,321.21	.	$264.25
64778	Digit nerve surgery add-on		T	0220	19.3535	$1,321.21	.	$264.25
64782	Remove limb nerve lesion		T	0220	19.3535	$1,321.21	.	$264.25
64783	Limb nerve surgery add-on		T	0220	19.3535	$1,321.21	.	$264.25
64784	Remove nerve lesion		T	0220	19.3535	$1,321.21	.	$264.25
64786	Remove sciatic nerve lesion		T	0221	37.5345	$2,562.37	.	$512.48
64787	Implant nerve end		T	0220	19.3535	$1,321.21	.	$264.25
64788	Remove skin nerve lesion		T	0220	19.3535	$1,321.21	.	$264.25
64790	Removal of nerve lesion		T	0220	19.3535	$1,321.21	.	$264.25
64792	Removal of nerve lesion		T	0221	37.5345	$2,562.37	.	$512.48

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64795	Biopsy of nerve		T	0220	19.3535	$1,321.21	.	$264.25
64802	Remove sympathetic nerves		T	0220	19.3535	$1,321.21	.	$264.25
64804	Remove sympathetic nerves		T	0220	19.3535	$1,321.21	.	$264.25
64809	Remove sympathetic nerves		C					
64818	Remove sympathetic nerves		C					
64820	Remove sympathetic nerves		T	0220	19.3535	$1,321.21	.	$264.25
64821	Remove sympathetic nerves		T	0054	29.8184	$2,035.61	.	$407.13
64822	Remove sympathetic nerves		T	0054	29.8184	$2,035.61	.	$407.13
64823	Remove sympathetic nerves		T	0054	29.8184	$2,035.61	.	$407.13
64831	Repair of digit nerve		T	0221	37.5345	$2,562.37	.	$512.48
64832	Repair nerve add-on		T	0221	37.5345	$2,562.37	.	$512.48
64834	Repair of hand or foot nerve		T	0221	37.5345	$2,562.37	.	$512.48
64835	Repair of hand or foot nerve		T	0221	37.5345	$2,562.37	.	$512.48
64836	Repair of hand or foot nerve		T	0221	37.5345	$2,562.37	.	$512.48
64837	Repair nerve add-on		T	0221	37.5345	$2,562.37	.	$512.48
64840	Repair of leg nerve		T	0221	37.5345	$2,562.37	.	$512.48
64856	Repair/transpose nerve		T	0221	37.5345	$2,562.37	.	$512.48
64857	Repair arm/leg nerve		T	0221	37.5345	$2,562.37	.	$512.48
64858	Repair sciatic nerve		T	0221	37.5345	$2,562.37	.	$512.48
64859	Nerve surgery		T	0221	37.5345	$2,562.37	.	$512.48
64861	Repair of arm nerves		T	0221	37.5345	$2,562.37	.	$512.48
64862	Repair of low back nerves		T	0221	37.5345	$2,562.37	.	$512.48
64864	Repair of facial nerve		T	0221	37.5345	$2,562.37	.	$512.48
64865	Repair of facial nerve		T	0221	37.5345	$2,562.37	.	$512.48
64866	Fusion of facial/other nerve		C					
64868	Fusion of facial/other nerve		C					
64870	Fusion of facial/other nerve		T	0221	37.5345	$2,562.37	.	$512.48
64872	Subsequent repair of nerve		T	0221	37.5345	$2,562.37	.	$512.48
64874	Repair & revise nerve add-on		T	0221	37.5345	$2,562.37	.	$512.48

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64876	Repair nerve/shorten bone		T	0221	37.5345	$2,562.37	.	$512.48
64885	Nerve graft, head or neck		T	0221	37.5345	$2,562.37	.	$512.48
64886	Nerve graft, head or neck		T	0221	37.5345	$2,562.37	.	$512.48
64890	Nerve graft, hand or foot		T	0221	37.5345	$2,562.37	.	$512.48
64891	Nerve graft, hand or foot		T	0221	37.5345	$2,562.37	.	$512.48
64892	Nerve graft, arm or leg		T	0221	37.5345	$2,562.37	.	$512.48
64893	Nerve graft, arm or leg		T	0221	37.5345	$2,562.37	.	$512.48
64895	Nerve graft, hand or foot		T	0221	37.5345	$2,562.37	.	$512.48
64896	Nerve graft, hand or foot		T	0221	37.5345	$2,562.37	.	$512.48
64897	Nerve graft, arm or leg		T	0221	37.5345	$2,562.37	.	$512.48
64898	Nerve graft, arm or leg		T	0221	37.5345	$2,562.37	.	$512.48
64901	Nerve graft add-on		T	0221	37.5345	$2,562.37	.	$512.48
64902	Nerve graft add-on		T	0221	37.5345	$2,562.37	.	$512.48
64905	Nerve pedicle transfer		T	0221	37.5345	$2,562.37	.	$512.48
64907	Nerve pedicle transfer		T	0221	37.5345	$2,562.37	.	$512.48
64910	Nerve repair w/allograft		T	0221	37.5345	$2,562.37	.	$512.48
64911	Neurorraphy w/vein autograft		T	0221	37.5345	$2,562.37	.	$512.48
64999	Nervous system surgery		T	0204	2.666	$182.00	$40.13	$36.40
65091	Revise eye		T	0242	39.3413	$2,685.71	$597.36	$537.15
65093	Revise eye with implant		T	0242	39.3413	$2,685.71	$597.36	$537.15
65101	Removal of eye		T	0242	39.3413	$2,685.71	$597.36	$537.15
65103	Remove eye/insert implant		T	0242	39.3413	$2,685.71	$597.36	$537.15
65105	Remove eye/attach implant		T	0242	39.3413	$2,685.71	$597.36	$537.15
65110	Removal of eye		T	0242	39.3413	$2,685.71	$597.36	$537.15
65112	Remove eye/revise socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
65114	Remove eye/revise socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
65125	Revise ocular implant		T	0241	26.8719	$1,834.46	$383.45	$366.90
65130	Insert ocular implant		T	0241	26.8719	$1,834.46	$383.45	$366.90
65135	Insert ocular implant		T	0241	26.8719	$1,834.46	$383.45	$366.90

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65140	Attach ocular implant		T	0242	39.3413	$2,685.71	$597.36	$537.15
65150	Revise ocular implant		T	0241	26.8719	$1,834.46	$383.45	$366.90
65155	Reinsert ocular implant		T	0242	39.3413	$2,685.71	$597.36	$537.15
65175	Removal of ocular implant		T	0240	19.9889	$1,364.58	$296.20	$272.92
65205	Remove foreign body from eye		S	0698	0.9316	$63.60	.	$12.72
65210	Remove foreign body from eye		S	0698	0.9316	$63.60	.	$12.72
65220	Remove foreign body from eye		S	0698	0.9316	$63.60	.	$12.72
65222	Remove foreign body from eye		S	0698	0.9316	$63.60	.	$12.72
65235	Remove foreign body from eye		T	0233	17.0898	$1,166.67	$263.12	$233.34
65260	Remove foreign body from eye		T	0235	5.2921	$361.28	.	$72.26
65265	Remove foreign body from eye		T	0237	23.2772	$1,589.06	.	$317.82
65270	Repair of eye wound		T	0240	19.9889	$1,364.58	$296.20	$272.92
65272	Repair of eye wound		T	0234	24.5236	$1,674.15	$511.31	$334.83
65273	Repair of eye wound		C					
65275	Repair of eye wound		T	0234	24.5236	$1,674.15	$511.31	$334.83
65280	Repair of eye wound		T	0237	23.2772	$1,589.06	.	$317.82
65285	Repair of eye wound		T	0672	40.6474	$2,774.88	.	$554.98
65286	Repair of eye wound	CH	T	0255	7.8769	$537.73	$129.50	$107.55
65290	Repair of eye socket wound		T	0243	25.315	$1,728.18	$416.98	$345.64
65400	Removal of eye lesion		T	0233	17.0898	$1,166.67	$263.12	$233.34
65410	Biopsy of cornea		T	0233	17.0898	$1,166.67	$263.12	$233.34
65420	Removal of eye lesion		T	0233	17.0898	$1,166.67	$263.12	$233.34
65426	Removal of eye lesion		T	0234	24.5236	$1,674.15	$511.31	$334.83
65430	Corneal smear		S	0698	0.9316	$63.60	.	$12.72
65435	Curette/treat cornea		T	0239	7.783	$531.32	.	$106.27
65436	Curette/treat cornea		T	0233	17.0898	$1,166.67	$263.12	$233.34
65450	Treatment of corneal lesion		S	0231	2.2924	$156.50	.	$31.30
65600	Revision of cornea		T	0240	19.9889	$1,364.58	$296.20	$272.92
65710	Corneal transplant		T	0244	39.038	$2,665.01	$803.26	$533.01

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65730	Corneal transplant		T	0244	39.038	$2,665.01	$803.26	$533.01
65750	Corneal transplant		T	0244	39.038	$2,665.01	$803.26	$533.01
65755	Corneal transplant		T	0244	39.038	$2,665.01	$803.26	$533.01
65756	Corneal trnspl, endothelial		T	0244	39.038	$2,665.01	$803.26	$533.01
65757	Prep corneal endo allograft		N					
65760	Revision of cornea		E					
65765	Revision of cornea		E					
65767	Corneal tissue transplant		E					
65770	Revise cornea with implant		T	0293	113.4961	$7,748.04	.	$1,549.61
65771	Radial keratotomy		E					
65772	Correction of astigmatism		T	0233	17.0898	$1,166.67	$263.12	$233.34
65775	Correction of astigmatism		T	0233	17.0898	$1,166.67	$263.12	$233.34
65780	Ocular reconst, transplant		T	0244	39.038	$2,665.01	$803.26	$533.01
65781	Ocular reconst, transplant		T	0244	39.038	$2,665.01	$803.26	$533.01
65782	Ocular reconst, transplant		T	0244	39.038	$2,665.01	$803.26	$533.01
65800	Drainage of eye	CH	T	0255	7.8769	$537.73	$129.50	$107.55
65805	Drainage of eye		T	0233	17.0898	$1,166.67	$263.12	$233.34
65810	Drainage of eye		T	0234	24.5236	$1,674.15	$511.31	$334.83
65815	Drainage of eye		T	0234	24.5236	$1,674.15	$511.31	$334.83
65820	Relieve inner eye pressure	CH	T	0234	24.5236	$1,674.15	$511.31	$334.83
65850	Incision of eye		T	0234	24.5236	$1,674.15	$511.31	$334.83
65855	Laser surgery of eye		T	0247	5.5659	$379.97	$104.31	$76.00
65860	Incise inner eye adhesions		T	0247	5.5659	$379.97	$104.31	$76.00
65865	Incise inner eye adhesions		T	0233	17.0898	$1,166.67	$263.12	$233.34
65870	Incise inner eye adhesions		T	0234	24.5236	$1,674.15	$511.31	$334.83
65875	Incise inner eye adhesions		T	0234	24.5236	$1,674.15	$511.31	$334.83
65880	Incise inner eye adhesions		T	0233	17.0898	$1,166.67	$263.12	$233.34
65900	Remove eye lesion	CH	T	0232	2.4827	$169.49	$40.82	$33.90
65920	Remove implant of eye		T	0234	24.5236	$1,674.15	$511.31	$334.83

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65930	Remove blood clot from eye		T	0234	24.5236	$1,674.15	$511.31	$334.83
66020	Injection treatment of eye		T	0233	17.0898	$1,166.67	$263.12	$233.34
66030	Injection treatment of eye	CH	T	0233	17.0898	$1,166.67	$263.12	$233.34
66130	Remove eye lesion		T	0234	24.5236	$1,674.15	$511.31	$334.83
66150	Glaucoma surgery		T	0234	24.5236	$1,674.15	$511.31	$334.83
66155	Glaucoma surgery		T	0234	24.5236	$1,674.15	$511.31	$334.83
66160	Glaucoma surgery		T	0234	24.5236	$1,674.15	$511.31	$334.83
66165	Glaucoma surgery		T	0234	24.5236	$1,674.15	$511.31	$334.83
66170	Glaucoma surgery		T	0234	24.5236	$1,674.15	$511.31	$334.83
66172	Incision of eye		T	0234	24.5236	$1,674.15	$511.31	$334.83
66180	Implant eye shunt		T	0673	44.5131	$3,038.78	$649.56	$607.76
66185	Revise eye shunt		T	0234	24.5236	$1,674.15	$511.31	$334.83
66220	Repair eye lesion		T	0672	40.6474	$2,774.88	.	$554.98
66225	Repair/graft eye lesion		T	0673	44.5131	$3,038.78	$649.56	$607.76
66250	Follow-up surgery of eye		T	0233	17.0898	$1,166.67	$263.12	$233.34
66500	Incision of iris		T	0232	2.4827	$169.49	$40.82	$33.90
66505	Incision of iris	CH	T	0255	7.8769	$537.73	$129.50	$107.55
66600	Remove iris and lesion		T	0234	24.5236	$1,674.15	$511.31	$334.83
66605	Removal of iris		T	0234	24.5236	$1,674.15	$511.31	$334.83
66625	Removal of iris	CH	T	0255	7.8769	$537.73	$129.50	$107.55
66630	Removal of iris		T	0234	24.5236	$1,674.15	$511.31	$334.83
66635	Removal of iris		T	0234	24.5236	$1,674.15	$511.31	$334.83
66680	Repair iris & ciliary body		T	0234	24.5236	$1,674.15	$511.31	$334.83
66682	Repair iris & ciliary body		T	0234	24.5236	$1,674.15	$511.31	$334.83
66700	Destruction, ciliary body		T	0233	17.0898	$1,166.67	$263.12	$233.34
66710	Ciliary transsleral therapy		T	0233	17.0898	$1,166.67	$263.12	$233.34
66711	Ciliary endoscopic ablation		T	0233	17.0898	$1,166.67	$263.12	$233.34
66720	Destruction, ciliary body		T	0233	17.0898	$1,166.67	$263.12	$233.34
66740	Destruction, ciliary body		T	0234	24.5236	$1,674.15	$511.31	$334.83

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
66761	Revision of iris		T	0247	5.5659	$379.97	$104.31	$76.00
66762	Revision of iris		T	0247	5.5659	$379.97	$104.31	$76.00
66770	Removal of inner eye lesion		T	0247	5.5659	$379.97	$104.31	$76.00
66820	Incision, secondary cataract	CH	T	0255	7.8769	$537.73	$129.50	$107.55
66821	After cataract laser surgery		T	0247	5.5659	$379.97	$104.31	$76.00
66825	Reposition intraocular lens		T	0234	24.5236	$1,674.15	$511.31	$334.83
66830	Removal of lens lesion	CH	T	0255	7.8769	$537.73	$129.50	$107.55
66840	Removal of lens material		T	0245	14.3198	$977.57	$196.91	$195.52
66850	Removal of lens material		T	0249	31.0191	$2,117.58	$516.99	$423.52
66852	Removal of lens material		T	0249	31.0191	$2,117.58	$516.99	$423.52
66920	Extraction of lens		T	0249	31.0191	$2,117.58	$516.99	$423.52
66930	Extraction of lens		T	0249	31.0191	$2,117.58	$516.99	$423.52
66940	Extraction of lens		T	0245	14.3198	$977.57	$196.91	$195.52
66982	Cataract surgery, complex		T	0246	24.7788	$1,691.57	$495.96	$338.32
66983	Cataract surg w/iol, 1 stage		T	0246	24.7788	$1,691.57	$495.96	$338.32
66984	Cataract surg w/iol, 1 stage		T	0246	24.7788	$1,691.57	$495.96	$338.32
66985	Insert lens prosthesis		T	0246	24.7788	$1,691.57	$495.96	$338.32
66986	Exchange lens prosthesis		T	0246	24.7788	$1,691.57	$495.96	$338.32
66990	Ophthalmic endoscope add-on		N					
66999	Eye surgery procedure		T	0232	2.4827	$169.49	$40.82	$33.90
67005	Partial removal of eye fluid		T	0237	23.2772	$1,589.06	.	$317.82
67010	Partial removal of eye fluid		T	0672	40.6474	$2,774.88	.	$554.98
67015	Release of eye fluid		T	0672	40.6474	$2,774.88	.	$554.98
67025	Replace eye fluid	CH	T	0672	40.6474	$2,774.88	.	$554.98
67027	Implant eye drug system		T	0672	40.6474	$2,774.88	.	$554.98
67028	Injection eye drug		T	0238	3.1607	$215.77	.	$43.16
67030	Incise inner eye strands		T	0237	23.2772	$1,589.06	.	$317.82
67031	Laser surgery, eye strands		T	0247	5.5659	$379.97	$104.31	$76.00
67036	Removal of inner eye fluid		T	0672	40.6474	$2,774.88	.	$554.98

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67039	Laser treatment of retina		T	0672	40.6474	$2,774.88	.	$554.98
67040	Laser treatment of retina		T	0672	40.6474	$2,774.88	.	$554.98
67041	Vit for macular pucker		T	0672	40.6474	$2,774.88	.	$554.98
67042	Vit for macular hole		T	0672	40.6474	$2,774.88	.	$554.98
67043	Vit for membrane dissect		T	0672	40.6474	$2,774.88	.	$554.98
67101	Repair detached retina		T	0237	23.2772	$1,589.06	.	$317.82
67105	Repair detached retina		T	0247	5.5659	$379.97	$104.31	$76.00
67107	Repair detached retina		T	0672	40.6474	$2,774.88	.	$554.98
67108	Repair detached retina		T	0672	40.6474	$2,774.88	.	$554.98
67110	Repair detached retina		T	0237	23.2772	$1,589.06	.	$317.82
67112	Rerepair detached retina		T	0672	40.6474	$2,774.88	.	$554.98
67113	Repair retinal detach, cplx		T	0672	40.6474	$2,774.88	.	$554.98
67115	Release encircling material		T	0237	23.2772	$1,589.06	.	$317.82
67120	Remove eye implant material		T	0237	23.2772	$1,589.06	.	$317.82
67121	Remove eye implant material	CH	T	0672	40.6474	$2,774.88	.	$554.98
67141	Treatment of retina		T	0235	5.2921	$361.28	.	$72.26
67145	Treatment of retina		T	0247	5.5659	$379.97	$104.31	$76.00
67208	Treatment of retinal lesion		T	0235	5.2921	$361.28	.	$72.26
67210	Treatment of retinal lesion		T	0247	5.5659	$379.97	$104.31	$76.00
67218	Treatment of retinal lesion		T	0237	23.2772	$1,589.06	.	$317.82
67220	Treatment of choroid lesion		T	0235	5.2921	$361.28	.	$72.26
67221	Ocular photodynamic ther		T	0235	5.2921	$361.28	.	$72.26
67225	Eye photodynamic ther add-on		T	0235	5.2921	$361.28	.	$72.26
67227	Treatment of retinal lesion		T	0237	23.2772	$1,589.06	.	$317.82
67228	Treatment of retinal lesion		T	0247	5.5659	$379.97	$104.31	$76.00
67229	Tr retinal les preterm inf		T	0247	5.5659	$379.97	$104.31	$76.00
67250	Reinforce eye wall		T	0240	19.9889	$1,364.58	$296.20	$272.92
67255	Reinforce/graft eye wall		T	0237	23.2772	$1,589.06	.	$317.82
67299	Eye surgery procedure		T	0235	5.2921	$361.28	.	$72.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67311	Revise eye muscle		T	0243	25.315	$1,728.18	$416.98	$345.64
67312	Revise two eye muscles		T	0243	25.315	$1,728.18	$416.98	$345.64
67314	Revise eye muscle		T	0243	25.315	$1,728.18	$416.98	$345.64
67316	Revise two eye muscles		T	0243	25.315	$1,728.18	$416.98	$345.64
67318	Revise eye muscle(s)		T	0243	25.315	$1,728.18	$416.98	$345.64
67320	Revise eye muscle(s) add-on		T	0243	25.315	$1,728.18	$416.98	$345.64
67331	Eye surgery follow-up add-on		T	0243	25.315	$1,728.18	$416.98	$345.64
67332	Rerevise eye muscles add-on		T	0243	25.315	$1,728.18	$416.98	$345.64
67334	Revise eye muscle w/suture		T	0243	25.315	$1,728.18	$416.98	$345.64
67335	Eye suture during surgery		T	0243	25.315	$1,728.18	$416.98	$345.64
67340	Revise eye muscle add-on		T	0243	25.315	$1,728.18	$416.98	$345.64
67343	Release eye tissue		T	0243	25.315	$1,728.18	$416.98	$345.64
67345	Destroy nerve of eye muscle		T	0238	3.1607	$215.77	.	$43.16
67346	Biopsy, eye muscle		T	0699	16.6419	$1,136.09	.	$227.22
67399	Eye muscle surgery procedure		T	0243	25.315	$1,728.18	$416.98	$345.64
67400	Explore/biopsy eye socket		T	0240	19.9889	$1,364.58	$296.20	$272.92
67405	Explore/drain eye socket		T	0241	26.8719	$1,834.46	$383.45	$366.90
67412	Explore/treat eye socket		T	0240	19.9889	$1,364.58	$296.20	$272.92
67413	Explore/treat eye socket		T	0241	26.8719	$1,834.46	$383.45	$366.90
67414	Explr/decompress eye socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
67415	Aspiration, orbital contents		T	0240	19.9889	$1,364.58	$296.20	$272.92
67420	Explore/treat eye socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
67430	Explore/treat eye socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
67440	Explore/drain eye socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
67445	Explr/decompress eye socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
67450	Explore/biopsy eye socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
67500	Inject/treat eye socket		S	0231	2.2924	$156.50	.	$31.30
67505	Inject/treat eye socket		T	0238	3.1607	$215.77	.	$43.16
67515	Inject/treat eye socket		T	0238	3.1607	$215.77	.	$43.16

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67550	Insert eye socket implant		T	0242	39.3413	$2,685.71	$597.36	$537.15
67560	Revise eye socket implant		T	0241	26.8719	$1,834.46	$383.45	$366.90
67570	Decompress optic nerve		T	0242	39.3413	$2,685.71	$597.36	$537.15
67599	Orbit surgery procedure		T	0238	3.1607	$215.77	.	$43.16
67700	Drainage of eyelid abscess		T	0238	3.1607	$215.77	.	$43.16
67710	Incision of eyelid		T	0239	7.783	$531.32	.	$106.27
67715	Incision of eyelid fold		T	0240	19.9889	$1,364.58	$296.20	$272.92
67800	Remove eyelid lesion		T	0238	3.1607	$215.77	.	$43.16
67801	Remove eyelid lesions		T	0239	7.783	$531.32	.	$106.27
67805	Remove eyelid lesions		T	0238	3.1607	$215.77	.	$43.16
67808	Remove eyelid lesion(s)		T	0240	19.9889	$1,364.58	$296.20	$272.92
67810	Biopsy of eyelid		T	0238	3.1607	$215.77	.	$43.16
67820	Revise eyelashes		S	0698	0.9316	$63.60	.	$12.72
67825	Revise eyelashes		T	0238	3.1607	$215.77	.	$43.16
67830	Revise eyelashes		T	0239	7.783	$531.32	.	$106.27
67835	Revise eyelashes		T	0240	19.9889	$1,364.58	$296.20	$272.92
67840	Remove eyelid lesion		T	0239	7.783	$531.32	.	$106.27
67850	Treat eyelid lesion		T	0239	7.783	$531.32	.	$106.27
67875	Closure of eyelid by suture		T	0239	7.783	$531.32	.	$106.27
67880	Revision of eyelid		T	0233	17.0898	$1,166.67	$263.12	$233.34
67882	Revision of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67900	Repair brow defect		T	0241	26.8719	$1,834.46	$383.45	$366.90
67901	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67902	Repair eyelid defect		T	0241	26.8719	$1,834.46	$383.45	$366.90
67903	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67904	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67906	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67908	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67909	Revise eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67911	Revise eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67912	Correction eyelid w/implant		T	0240	19.9889	$1,364.58	$296.20	$272.92
67914	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67915	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67916	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67917	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67921	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67922	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67923	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67924	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67930	Repair eyelid wound		T	0240	19.9889	$1,364.58	$296.20	$272.92
67935	Repair eyelid wound		T	0240	19.9889	$1,364.58	$296.20	$272.92
67938	Remove eyelid foreign body		S	0231	2.2924	$156.50	.	$31.30
67950	Revision of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67961	Revision of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67966	Revision of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67971	Reconstruction of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67973	Reconstruction of eyelid		T	0241	26.8719	$1,834.46	$383.45	$366.90
67974	Reconstruction of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67975	Reconstruction of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67999	Revision of eyelid		T	0238	3.1607	$215.77	.	$43.16
68020	Incise/drain eyelid lining		T	0238	3.1607	$215.77	.	$43.16
68040	Treatment of eyelid lesions		S	0698	0.9316	$63.60	.	$12.72
68100	Biopsy of eyelid lining	CH	T	0255	7.8769	$537.73	$129.50	$107.55
68110	Remove eyelid lining lesion		T	0699	16.6419	$1,136.09	.	$227.22
68115	Remove eyelid lining lesion		T	0240	19.9889	$1,364.58	$296.20	$272.92
68130	Remove eyelid lining lesion		T	0233	17.0898	$1,166.67	$263.12	$233.34
68135	Remove eyelid lining lesion		T	0239	7.783	$531.32	.	$106.27
68200	Treat eyelid by injection		S	0698	0.9316	$63.60	.	$12.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
68320	Revise/graft eyelid lining		T	0241	26.8719	$1,834.46	$383.45	$366.90
68325	Revise/graft eyelid lining		T	0241	26.8719	$1,834.46	$383.45	$366.90
68326	Revise/graft eyelid lining		T	0240	19.9889	$1,364.58	$296.20	$272.92
68328	Revise/graft eyelid lining		T	0241	26.8719	$1,834.46	$383.45	$366.90
68330	Revise eyelid lining		T	0234	24.5236	$1,674.15	$511.31	$334.83
68335	Revise/graft eyelid lining		T	0241	26.8719	$1,834.46	$383.45	$366.90
68340	Separate eyelid adhesions		T	0240	19.9889	$1,364.58	$296.20	$272.92
68360	Revise eyelid lining		T	0234	24.5236	$1,674.15	$511.31	$334.83
68362	Revise eyelid lining		T	0234	24.5236	$1,674.15	$511.31	$334.83
68371	Harvest eye tissue, alograft		T	0233	17.0898	$1,166.67	$263.12	$233.34
68399	Eyelid lining surgery		T	0238	3.1607	$215.77	.	$43.16
68400	Incise/drain tear gland		T	0238	3.1607	$215.77	.	$43.16
68420	Incise/drain tear sac		T	0240	19.9889	$1,364.58	$296.20	$272.92
68440	Incise tear duct opening		T	0238	3.1607	$215.77	.	$43.16
68500	Removal of tear gland		T	0241	26.8719	$1,834.46	$383.45	$366.90
68505	Partial removal, tear gland		T	0241	26.8719	$1,834.46	$383.45	$366.90
68510	Biopsy of tear gland		T	0240	19.9889	$1,364.58	$296.20	$272.92
68520	Removal of tear sac		T	0241	26.8719	$1,834.46	$383.45	$366.90
68525	Biopsy of tear sac		T	0240	19.9889	$1,364.58	$296.20	$272.92
68530	Clearance of tear duct		T	0238	3.1607	$215.77	.	$43.16
68540	Remove tear gland lesion		T	0240	19.9889	$1,364.58	$296.20	$272.92
68550	Remove tear gland lesion		T	0241	26.8719	$1,834.46	$383.45	$366.90
68700	Repair tear ducts		T	0240	19.9889	$1,364.58	$296.20	$272.92
68705	Revise tear duct opening		T	0238	3.1607	$215.77	.	$43.16
68720	Create tear sac drain		T	0241	26.8719	$1,834.46	$383.45	$366.90
68745	Create tear duct drain		T	0241	26.8719	$1,834.46	$383.45	$366.90
68750	Create tear duct drain		T	0241	26.8719	$1,834.46	$383.45	$366.90
68760	Close tear duct opening		T	0238	3.1607	$215.77	.	$43.16
68761	Close tear duct opening		T	0238	3.1607	$215.77	.	$43.16

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
68770	Close tear system fistula		T	0241	26.8719	$1,834.46	$383.45	$366.90
68801	Dilate tear duct opening		S	0698	0.9316	$63.60	.	$12.72
68810	Probe nasolacrimal duct		T	0238	3.1607	$215.77	.	$43.16
68811	Probe nasolacrimal duct		T	0240	19.9889	$1,364.58	$296.20	$272.92
68815	Probe nasolacrimal duct		T	0240	19.9889	$1,364.58	$296.20	$272.92
68816	Probe nl duct w/balloon		T	0240	19.9889	$1,364.58	$296.20	$272.92
68840	Explore/irrigate tear ducts		S	0231	2.2924	$156.50	.	$31.30
68850	Injection for tear sac x-ray		N					
68899	Tear duct system surgery		T	0238	3.1607	$215.77	.	$43.16
69000	Drain external ear lesion		T	0006	1.4939	$101.98	.	$20.40
69005	Drain external ear lesion		T	0008	20.2481	$1,382.28	.	$276.46
69020	Drain outer ear canal lesion		T	0006	1.4939	$101.98	.	$20.40
69090	Pierce earlobes		E					
69100	Biopsy of external ear		T	0251	3.4369	$234.63	.	$46.93
69105	Biopsy of external ear canal		T	0253	17.4151	$1,188.88	$282.29	$237.78
69110	Remove external ear, partial		T	0021	18.2223	$1,243.98	.	$248.80
69120	Removal of external ear		T	0254	25.5397	$1,743.52	.	$348.71
69140	Remove ear canal lesion(s)		T	0254	25.5397	$1,743.52	.	$348.71
69145	Remove ear canal lesion(s)		T	0021	18.2223	$1,243.98	.	$248.80
69150	Extensive ear canal surgery		T	0252	7.8743	$537.55	$109.16	$107.51
69155	Extensive ear/neck surgery		C					
69200	Clear outer ear canal		X	0340	0.6899	$47.10	.	$9.42
69205	Clear outer ear canal		T	0022	24.1269	$1,647.07	$354.45	$329.42
69210	Remove impacted ear wax		X	0340	0.6899	$47.10	.	$9.42
69220	Clean out mastoid cavity		T	0013	0.8782	$59.95	.	$11.99
69222	Clean out mastoid cavity		T	0253	17.4151	$1,188.88	$282.29	$237.78
69300	Revise external ear		T	0254	25.5397	$1,743.52	.	$348.71
69310	Rebuild outer ear canal		T	0256	44.8441	$3,061.37	.	$612.28
69320	Rebuild outer ear canal		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69399	Outer ear surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
69400	Inflate middle ear canal		T	0251	3.4369	$234.63	.	$46.93
69401	Inflate middle ear canal		T	0251	3.4369	$234.63	.	$46.93
69405	Catheterize middle ear canal		T	0252	7.8743	$537.55	$109.16	$107.51
69420	Incision of eardrum		T	0251	3.4369	$234.63	.	$46.93
69421	Incision of eardrum		T	0253	17.4151	$1,188.88	$282.29	$237.78
69424	Remove ventilating tube		T	0253	17.4151	$1,188.88	$282.29	$237.78
69433	Create eardrum opening		T	0252	7.8743	$537.55	$109.16	$107.51
69436	Create eardrum opening		T	0253	17.4151	$1,188.88	$282.29	$237.78
69440	Exploration of middle ear		T	0254	25.5397	$1,743.52	.	$348.71
69450	Eardrum revision		T	0256	44.8441	$3,061.37	.	$612.28
69501	Mastoidectomy		T	0256	44.8441	$3,061.37	.	$612.28
69502	Mastoidectomy		T	0254	25.5397	$1,743.52	.	$348.71
69505	Remove mastoid structures		T	0256	44.8441	$3,061.37	.	$612.28
69511	Extensive mastoid surgery		T	0256	44.8441	$3,061.37	.	$612.28
69530	Extensive mastoid surgery		T	0256	44.8441	$3,061.37	.	$612.28
69535	Remove part of temporal bone		C					
69540	Remove ear lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
69550	Remove ear lesion		T	0256	44.8441	$3,061.37	.	$612.28
69552	Remove ear lesion		T	0256	44.8441	$3,061.37	.	$612.28
69554	Remove ear lesion		C					
69601	Mastoid surgery revision		T	0256	44.8441	$3,061.37	.	$612.28
69602	Mastoid surgery revision		T	0256	44.8441	$3,061.37	.	$612.28
69603	Mastoid surgery revision		T	0256	44.8441	$3,061.37	.	$612.28
69604	Mastoid surgery revision		T	0256	44.8441	$3,061.37	.	$612.28
69605	Mastoid surgery revision		T	0256	44.8441	$3,061.37	.	$612.28
69610	Repair of eardrum		T	0254	25.5397	$1,743.52	.	$348.71
69620	Repair of eardrum		T	0254	25.5397	$1,743.52	.	$348.71
69631	Repair eardrum structures		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69632	Rebuild eardrum structures		T	0256	44.8441	$3,061.37	.	$612.28
69633	Rebuild eardrum structures		T	0256	44.8441	$3,061.37	.	$612.28
69635	Repair eardrum structures		T	0256	44.8441	$3,061.37	.	$612.28
69636	Rebuild eardrum structures		T	0256	44.8441	$3,061.37	.	$612.28
69637	Rebuild eardrum structures		T	0256	44.8441	$3,061.37	.	$612.28
69641	Revise middle ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69642	Revise middle ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69643	Revise middle ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69644	Revise middle ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69645	Revise middle ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69646	Revise middle ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69650	Release middle ear bone		T	0254	25.5397	$1,743.52	.	$348.71
69660	Revise middle ear bone		T	0256	44.8441	$3,061.37	.	$612.28
69661	Revise middle ear bone		T	0256	44.8441	$3,061.37	.	$612.28
69662	Revise middle ear bone		T	0256	44.8441	$3,061.37	.	$612.28
69666	Repair middle ear structures		T	0256	44.8441	$3,061.37	.	$612.28
69667	Repair middle ear structures		T	0256	44.8441	$3,061.37	.	$612.28
69670	Remove mastoid air cells		T	0256	44.8441	$3,061.37	.	$612.28
69676	Remove middle ear nerve		T	0256	44.8441	$3,061.37	.	$612.28
69700	Close mastoid fistula		T	0256	44.8441	$3,061.37	.	$612.28
69710	Implant/replace hearing aid		E					
69711	Remove/repair hearing aid		T	0256	44.8441	$3,061.37	.	$612.28
69714	Implant temple bone w/stimul		T	0425	122.1766	$8,340.63	.	$1,668.13
69715	Temple bne implnt w/stimulat		T	0425	122.1766	$8,340.63	.	$1,668.13
69717	Temple bone implant revision		T	0425	122.1766	$8,340.63	.	$1,668.13
69718	Revise temple bone implant		T	0425	122.1766	$8,340.63	.	$1,668.13
69720	Release facial nerve		T	0256	44.8441	$3,061.37	.	$612.28
69725	Release facial nerve		T	0256	44.8441	$3,061.37	.	$612.28
69740	Repair facial nerve		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69745	Repair facial nerve		T	0256	44.8441	$3,061.37	.	$612.28
69799	Middle ear surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
69801	Incise inner ear		T	0254	25.5397	$1,743.52	.	$348.71
69802	Incise inner ear		T	0254	25.5397	$1,743.52	.	$348.71
69805	Explore inner ear		T	0256	44.8441	$3,061.37	.	$612.28
69806	Explore inner ear		T	0256	44.8441	$3,061.37	.	$612.28
69820	Establish inner ear window		T	0256	44.8441	$3,061.37	.	$612.28
69840	Revise inner ear window		T	0256	44.8441	$3,061.37	.	$612.28
69905	Remove inner ear		T	0256	44.8441	$3,061.37	.	$612.28
69910	Remove inner ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69915	Incise inner ear nerve		T	0256	44.8441	$3,061.37	.	$612.28
69930	Implant cochlear device		T	0259	454.7997	$31,047.81	$8,543.66	$6,209.57
69949	Inner ear surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
69950	Incise inner ear nerve		C					
69955	Release facial nerve		T	0256	44.8441	$3,061.37	.	$612.28
69960	Release inner ear canal		T	0256	44.8441	$3,061.37	.	$612.28
69970	Remove inner ear lesion		T	0256	44.8441	$3,061.37	.	$612.28
69979	Temporal bone surgery		T	0250	1.1743	$80.17	$25.10	$16.04
69990	Microsurgery add-on		N					
70010	Contrast x-ray of brain		Q2	0274	7.4103	$505.88	.	$101.18
70015	Contrast x-ray of brain		Q2	0274	7.4103	$505.88	.	$101.18
70030	X-ray eye for foreign body		X	0260	0.6683	$45.62	.	$9.13
70100	X-ray exam of jaw		X	0260	0.6683	$45.62	.	$9.13
70110	X-ray exam of jaw		X	0260	0.6683	$45.62	.	$9.13
70120	X-ray exam of mastoids		X	0260	0.6683	$45.62	.	$9.13
70130	X-ray exam of mastoids		X	0260	0.6683	$45.62	.	$9.13
70134	X-ray exam of middle ear		X	0261	1.1314	$77.24	.	$15.45
70140	X-ray exam of facial bones		X	0260	0.6683	$45.62	.	$9.13
70150	X-ray exam of facial bones		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
70160	X-ray exam of nasal bones		X	0260	0.6683	$45.62	.	$9.13
70170	X-ray exam of tear duct		Q2	0263	3.3875	$231.25	.	$46.25
70190	X-ray exam of eye sockets		X	0260	0.6683	$45.62	.	$9.13
70200	X-ray exam of eye sockets		X	0260	0.6683	$45.62	.	$9.13
70210	X-ray exam of sinuses		X	0260	0.6683	$45.62	.	$9.13
70220	X-ray exam of sinuses		X	0260	0.6683	$45.62	.	$9.13
70240	X-ray exam, pituitary saddle		X	0260	0.6683	$45.62	.	$9.13
70250	X-ray exam of skull		X	0260	0.6683	$45.62	.	$9.13
70260	X-ray exam of skull		X	0261	1.1314	$77.24	.	$15.45
70300	X-ray exam of teeth		X	0262	0.4853	$33.13	.	$6.63
70310	X-ray exam of teeth		X	0262	0.4853	$33.13	.	$6.63
70320	Full mouth x-ray of teeth		X	0262	0.4853	$33.13	.	$6.63
70328	X-ray exam of jaw joint		X	0260	0.6683	$45.62	.	$9.13
70330	X-ray exam of jaw joints		X	0260	0.6683	$45.62	.	$9.13
70332	X-ray exam of jaw joint		Q2	0275	4.0041	$273.35	$68.90	$54.67
70336	Magnetic image, jaw joint		Q3	0336	5.1052	$348.52	$137.34	$69.71
70350	X-ray head for orthodontia		X	0260	0.6683	$45.62	.	$9.13
70355	Panoramic x-ray of jaws	CH	X	0262	0.4853	$33.13	.	$6.63
70360	X-ray exam of neck		X	0260	0.6683	$45.62	.	$9.13
70370	Throat x-ray & fluoroscopy		X	0272	1.2472	$85.14	$31.07	$17.03
70371	Speech evaluation, complex		X	0272	1.2472	$85.14	$31.07	$17.03
70373	Contrast x-ray of larynx		Q2	0263	3.3875	$231.25	.	$46.25
70380	X-ray exam of salivary gland		X	0260	0.6683	$45.62	.	$9.13
70390	X-ray exam of salivary duct		Q2	0263	3.3875	$231.25	.	$46.25
70450	Ct head/brain w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
70460	Ct head/brain w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
70470	Ct head/brain w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
70480	Ct orbit/ear/fossa w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
70481	Ct orbit/ear/fossa w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
70482	Ct orbit/ear/fossa w/o&w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
70486	Ct maxillofacial w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
70487	Ct maxillofacial w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
70488	Ct maxillofacial w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
70490	Ct soft tissue neck w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
70491	Ct soft tissue neck w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
70492	Ct sft tsue nck w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
70496	Ct angiography, head		Q3	0662	5.0605	$345.47	$114.75	$69.10
70498	Ct angiography, neck		Q3	0662	5.0605	$345.47	$114.75	$69.10
70540	Mri orbit/face/neck w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
70542	Mri orbit/face/neck w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
70543	Mri orbt/fac/nck w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
70544	Mr angiography head w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
70545	Mr angiography head w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
70546	Mr angiograph head w/o&w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
70547	Mr angiography neck w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
70548	Mr angiography neck w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
70549	Mr angiograph neck w/o&w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
70551	Mri brain w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
70552	Mri brain w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
70553	Mri brain w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
70554	Fmri brain by tech		Q3	0336	5.1052	$348.52	$137.34	$69.71
70555	Fmri brain by phys/psych		S	0336	5.1052	$348.52	$137.34	$69.71
70557	Mri brain w/o dye		S	0336	5.1052	$348.52	$137.34	$69.71
70558	Mri brain w/dye		S	0284	6.4555	$440.70	$146.85	$88.14
70559	Mri brain w/o & w/dye		S	0337	7.9271	$541.16	$197.83	$108.24
71010	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13
71015	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13
71020	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
71021	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13
71022	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13
71023	Chest x-ray and fluoroscopy		X	0272	1.2472	$85.14	$31.07	$17.03
71030	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13
71034	Chest x-ray and fluoroscopy		X	0272	1.2472	$85.14	$31.07	$17.03
71035	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13
71040	Contrast x-ray of bronchi		Q2	0263	3.3875	$231.25	.	$46.25
71060	Contrast x-ray of bronchi		Q2	0263	3.3875	$231.25	.	$46.25
71090	X-ray & pacemaker insertion		N					
71100	X-ray exam of ribs		X	0260	0.6683	$45.62	.	$9.13
71101	X-ray exam of ribs/chest		X	0260	0.6683	$45.62	.	$9.13
71110	X-ray exam of ribs		X	0260	0.6683	$45.62	.	$9.13
71111	X-ray exam of ribs/chest		X	0261	1.1314	$77.24	.	$15.45
71120	X-ray exam of breastbone		X	0260	0.6683	$45.62	.	$9.13
71130	X-ray exam of breastbone		X	0260	0.6683	$45.62	.	$9.13
71250	Ct thorax w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
71260	Ct thorax w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
71270	Ct thorax w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
71275	Ct angiography, chest		Q3	0662	5.0605	$345.47	$114.75	$69.10
71550	Mri chest w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
71551	Mri chest w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
71552	Mri chest w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
71555	Mri angio chest w or w/o dye		B					
72010	X-ray exam of spine		X	0261	1.1314	$77.24	.	$15.45
72020	X-ray exam of spine		X	0260	0.6683	$45.62	.	$9.13
72040	X-ray exam of neck spine		X	0260	0.6683	$45.62	.	$9.13
72050	X-ray exam of neck spine		X	0261	1.1314	$77.24	.	$15.45
72052	X-ray exam of neck spine		X	0261	1.1314	$77.24	.	$15.45
72069	X-ray exam of trunk spine		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
72070	X-ray exam of thoracic spine		X	0260	0.6683	$45.62	.	$9.13
72072	X-ray exam of thoracic spine		X	0260	0.6683	$45.62	.	$9.13
72074	X-ray exam of thoracic spine		X	0260	0.6683	$45.62	.	$9.13
72080	X-ray exam of trunk spine		X	0260	0.6683	$45.62	.	$9.13
72090	X-ray exam of trunk spine		X	0261	1.1314	$77.24	.	$15.45
72100	X-ray exam of lower spine		X	0260	0.6683	$45.62	.	$9.13
72110	X-ray exam of lower spine		X	0261	1.1314	$77.24	.	$15.45
72114	X-ray exam of lower spine		X	0261	1.1314	$77.24	.	$15.45
72120	X-ray exam of lower spine	CH	X	0260	0.6683	$45.62	.	$9.13
72125	Ct neck spine w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
72126	Ct neck spine w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
72127	Ct neck spine w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
72128	Ct chest spine w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
72129	Ct chest spine w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
72130	Ct chest spine w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
72131	Ct lumbar spine w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
72132	Ct lumbar spine w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
72133	Ct lumbar spine w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
72141	Mri neck spine w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
72142	Mri neck spine w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
72146	Mri chest spine w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
72147	Mri chest spine w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
72148	Mri lumbar spine w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
72149	Mri lumbar spine w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
72156	Mri neck spine w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
72157	Mri chest spine w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
72158	Mri lumbar spine w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
72159	Mr angio spine w/o&w/dye		E					
72170	X-ray exam of pelvis		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
72190	X-ray exam of pelvis		X	0260	0.6683	$45.62	.	$9.13
72191	Ct angiograph pelv w/o&w/dye		Q3	0662	5.0605	$345.47	$114.75	$69.10
72192	Ct pelvis w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
72193	Ct pelvis w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
72194	Ct pelvis w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
72195	Mri pelvis w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
72196	Mri pelvis w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
72197	Mri pelvis w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
72198	Mr angio pelvis w/o & w/dye		B					
72200	X-ray exam sacroiliac joints		X	0260	0.6683	$45.62	.	$9.13
72202	X-ray exam sacroiliac joints		X	0260	0.6683	$45.62	.	$9.13
72220	X-ray exam of tailbone		X	0260	0.6683	$45.62	.	$9.13
72240	Contrast x-ray of neck spine		Q2	0274	7.4103	$505.88	.	$101.18
72255	Contrast x-ray, thorax spine		Q2	0274	7.4103	$505.88	.	$101.18
72265	Contrast x-ray, lower spine		Q2	0274	7.4103	$505.88	.	$101.18
72270	Contrast x-ray, spine		Q2	0274	7.4103	$505.88	.	$101.18
72275	Epidurography		N					
72285	X-ray c/t spine disk		Q2	0388	24.9242	$1,701.50	.	$340.30
72291	Perq verte/sacroplsty, fluor		N					
72292	Perq verte/sacroplsty, ct		N					
72295	X-ray of lower spine disk		Q2	0388	24.9242	$1,701.50	.	$340.30
73000	X-ray exam of collar bone		X	0260	0.6683	$45.62	.	$9.13
73010	X-ray exam of shoulder blade		X	0260	0.6683	$45.62	.	$9.13
73020	X-ray exam of shoulder		X	0260	0.6683	$45.62	.	$9.13
73030	X-ray exam of shoulder		X	0260	0.6683	$45.62	.	$9.13
73040	Contrast x-ray of shoulder		Q2	0275	4.0041	$273.35	$68.90	$54.67
73050	X-ray exam of shoulders		X	0260	0.6683	$45.62	.	$9.13
73060	X-ray exam of humerus		X	0260	0.6683	$45.62	.	$9.13
73070	X-ray exam of elbow		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
73080	X-ray exam of elbow		X	0260	0.6683	$45.62	.	$9.13
73085	Contrast x-ray of elbow		Q2	0275	4.0041	$273.35	$68.90	$54.67
73090	X-ray exam of forearm		X	0260	0.6683	$45.62	.	$9.13
73092	X-ray exam of arm, infant		X	0260	0.6683	$45.62	.	$9.13
73100	X-ray exam of wrist		X	0260	0.6683	$45.62	.	$9.13
73110	X-ray exam of wrist		X	0260	0.6683	$45.62	.	$9.13
73115	Contrast x-ray of wrist		Q2	0275	4.0041	$273.35	$68.90	$54.67
73120	X-ray exam of hand		X	0260	0.6683	$45.62	.	$9.13
73130	X-ray exam of hand		X	0260	0.6683	$45.62	.	$9.13
73140	X-ray exam of finger(s)		X	0260	0.6683	$45.62	.	$9.13
73200	Ct upper extremity w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
73201	Ct upper extremity w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
73202	Ct uppr extremity w/o&w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
73206	Ct angio upr extrm w/o&w/dye		Q3	0662	5.0605	$345.47	$114.75	$69.10
73218	Mri upper extremity w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
73219	Mri upper extremity w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
73220	Mri uppr extremity w/o&w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
73221	Mri joint upr extrem w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
73222	Mri joint upr extrem w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
73223	Mri joint upr extr w/o&w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
73225	Mr angio upr extr w/o&w/dye		E					
73500	X-ray exam of hip		X	0260	0.6683	$45.62	.	$9.13
73510	X-ray exam of hip		X	0260	0.6683	$45.62	.	$9.13
73520	X-ray exam of hips	CH	X	0260	0.6683	$45.62	.	$9.13
73525	Contrast x-ray of hip		Q2	0275	4.0041	$273.35	$68.90	$54.67
73530	X-ray exam of hip		N					
73540	X-ray exam of pelvis & hips		X	0260	0.6683	$45.62	.	$9.13
73542	X-ray exam, sacroiliac joint		Q2	0275	4.0041	$273.35	$68.90	$54.67
73550	X-ray exam of thigh		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
73560	X-ray exam of knee, 1 or 2		X	0260	0.6683	$45.62	.	$9.13
73562	X-ray exam of knee, 3		X	0260	0.6683	$45.62	.	$9.13
73564	X-ray exam, knee, 4 or more		X	0260	0.6683	$45.62	.	$9.13
73565	X-ray exam of knees		X	0260	0.6683	$45.62	.	$9.13
73580	Contrast x-ray of knee joint		Q2	0275	4.0041	$273.35	$68.90	$54.67
73590	X-ray exam of lower leg		X	0260	0.6683	$45.62	.	$9.13
73592	X-ray exam of leg, infant		X	0260	0.6683	$45.62	.	$9.13
73600	X-ray exam of ankle		X	0260	0.6683	$45.62	.	$9.13
73610	X-ray exam of ankle		X	0260	0.6683	$45.62	.	$9.13
73615	Contrast x-ray of ankle		Q2	0275	4.0041	$273.35	$68.90	$54.67
73620	X-ray exam of foot		X	0260	0.6683	$45.62	.	$9.13
73630	X-ray exam of foot		X	0260	0.6683	$45.62	.	$9.13
73650	X-ray exam of heel		X	0260	0.6683	$45.62	.	$9.13
73660	X-ray exam of toe(s)		X	0260	0.6683	$45.62	.	$9.13
73700	Ct lower extremity w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
73701	Ct lower extremity w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
73702	Ct lwr extremity w/o&w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
73706	Ct angio lwr extr w/o&w/dye		Q3	0662	5.0605	$345.47	$114.75	$69.10
73718	Mri lower extremity w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
73719	Mri lower extremity w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
73720	Mri lwr extremity w/o&w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
73721	Mri jnt of lwr extre w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
73722	Mri joint of lwr extr w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
73723	Mri joint lwr extr w/o&w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
73725	Mr ang lwr ext w or w/o dye		B					
74000	X-ray exam of abdomen		X	0260	0.6683	$45.62	.	$9.13
74010	X-ray exam of abdomen		X	0260	0.6683	$45.62	.	$9.13
74020	X-ray exam of abdomen		X	0260	0.6683	$45.62	.	$9.13
74022	X-ray exam series, abdomen		X	0261	1.1314	$77.24	.	$15.45

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
74150	Ct abdomen w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
74160	Ct abdomen w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
74170	Ct abdomen w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
74175	Ct angio abdom w/o & w/dye		Q3	0662	5.0605	$345.47	$114.75	$69.10
74181	Mri abdomen w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
74182	Mri abdomen w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
74183	Mri abdomen w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
74185	Mri angio, abdom w orw/o dye		B					
74190	X-ray exam of peritoneum		Q2	0263	3.3875	$231.25	.	$46.25
74210	Contrst x-ray exam of throat		S	0276	1.289	$88.00	$34.66	$17.60
74220	Contrast x-ray, esophagus		S	0276	1.289	$88.00	$34.66	$17.60
74230	Cine/vid x-ray, throat/esoph		S	0276	1.289	$88.00	$34.66	$17.60
74235	Remove esophagus obstruction		N					
74240	X-ray exam, upper gi tract		S	0276	1.289	$88.00	$34.66	$17.60
74241	X-ray exam, upper gi tract		S	0276	1.289	$88.00	$34.66	$17.60
74245	X-ray exam, upper gi tract		S	0277	2.0916	$142.79	$53.90	$28.56
74246	Contrst x-ray uppr gi tract		S	0276	1.289	$88.00	$34.66	$17.60
74247	Contrst x-ray uppr gi tract		S	0276	1.289	$88.00	$34.66	$17.60
74249	Contrst x-ray uppr gi tract		S	0277	2.0916	$142.79	$53.90	$28.56
74250	X-ray exam of small bowel		S	0276	1.289	$88.00	$34.66	$17.60
74251	X-ray exam of small bowel		S	0277	2.0916	$142.79	$53.90	$28.56
74260	X-ray exam of small bowel		S	0276	1.289	$88.00	$34.66	$17.60
74261	Ct colonography, w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
74262	Ct colonography, w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
74263	Ct colonography, screen		E					
74270	Contrast x-ray exam of colon		S	0276	1.289	$88.00	$34.66	$17.60
74280	Contrast x-ray exam of colon		S	0277	2.0916	$142.79	$53.90	$28.56
74283	Contrast x-ray exam of colon		S	0276	1.289	$88.00	$34.66	$17.60
74290	Contrast x-ray, gallbladder		S	0276	1.289	$88.00	$34.66	$17.60

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
74291	Contrast x-rays, gallbladder		S	0276	1.289	$88.00	$34.66	$17.60
74300	X-ray bile ducts/pancreas		N					
74301	X-rays at surgery add-on		N					
74305	X-ray bile ducts/pancreas		Q2	0263	3.3875	$231.25	.	$46.25
74320	Contrast x-ray of bile ducts		Q2	0317	5.982	$408.37	.	$81.68
74327	X-ray bile stone removal		N					
74328	X-ray bile duct endoscopy		N					
74329	X-ray for pancreas endoscopy		N					
74330	X-ray bile/panc endoscopy		N					
74340	X-ray guide for GI tube		N					
74355	X-ray guide, intestinal tube		N					
74360	X-ray guide, GI dilation		N					
74363	X-ray, bile duct dilation		N					
74400	Contrst x-ray, urinary tract		S	0278	2.591	$176.88	$58.44	$35.38
74410	Contrst x-ray, urinary tract		S	0278	2.591	$176.88	$58.44	$35.38
74415	Contrst x-ray, urinary tract		S	0278	2.591	$176.88	$58.44	$35.38
74420	Contrst x-ray, urinary tract		S	0278	2.591	$176.88	$58.44	$35.38
74425	Contrst x-ray, urinary tract		Q2	0278	2.591	$176.88	$58.44	$35.38
74430	Contrast x-ray, bladder		Q2	0278	2.591	$176.88	$58.44	$35.38
74440	X-ray, male genital tract		Q2	0278	2.591	$176.88	$58.44	$35.38
74445	X-ray exam of penis		Q2	0278	2.591	$176.88	$58.44	$35.38
74450	X-ray, urethra/bladder		Q2	0278	2.591	$176.88	$58.44	$35.38
74455	X-ray, urethra/bladder		Q2	0278	2.591	$176.88	$58.44	$35.38
74470	X-ray exam of kidney lesion		Q2	0263	3.3875	$231.25	.	$46.25
74475	X-ray control, cath insert		Q2	0161	17.7215	$1,209.79	.	$241.96
74480	X-ray control, cath insert		Q2	0161	17.7215	$1,209.79	.	$241.96
74485	X-ray guide, GU dilation		Q2	0161	17.7215	$1,209.79	.	$241.96
74710	X-ray measurement of pelvis		X	0261	1.1314	$77.24	.	$15.45
74740	X-ray, female genital tract		Q2	0263	3.3875	$231.25	.	$46.25

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
74742	X-ray, fallopian tube		N					
74775	X-ray exam of perineum		S	0278	2.591	$176.88	$58.44	$35.38
75557	Cardiac mri for morph		Q3	0336	5.1052	$348.52	$137.34	$69.71
75559	Cardiac mri w/stress img		Q3	0336	5.1052	$348.52	$137.34	$69.71
75561	Cardiac mri for morph w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
75563	Card mri w/stress img & dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
75565	Card mri vel flw map add-on		N					
75571	Ct hrt w/o dye w/ca test		X	0340	0.6899	$47.10	.	$9.42
75572	Ct hrt w/3d image		S	0383	3.7795	$258.02	.	$51.61
75573	Ct hrt w/3d image, congen		S	0383	3.7795	$258.02	.	$51.61
75574	Ct angio hrt w/3d image		S	0383	3.7795	$258.02	.	$51.61
75600	Contrast x-ray exam of aorta		Q2	0279	29.7399	$2,030.25	.	$406.05
75605	Contrast x-ray exam of aorta		Q2	0279	29.7399	$2,030.25	.	$406.05
75625	Contrast x-ray exam of aorta		Q2	0279	29.7399	$2,030.25	.	$406.05
75630	X-ray aorta, leg arteries		Q2	0279	29.7399	$2,030.25	.	$406.05
75635	Ct angio abdominal arteries		Q2	0662	5.0605	$345.47	$114.75	$69.10
75650	Artery x-rays, head & neck		Q2	0280	48.7134	$3,325.52	.	$665.11
75658	Artery x-rays, arm		Q2	0279	29.7399	$2,030.25	.	$406.05
75660	Artery x-rays, head & neck		Q2	0280	48.7134	$3,325.52	.	$665.11
75662	Artery x-rays, head & neck		Q2	0280	48.7134	$3,325.52	.	$665.11
75665	Artery x-rays, head & neck		Q2	0279	29.7399	$2,030.25	.	$406.05
75671	Artery x-rays, head & neck		Q2	0280	48.7134	$3,325.52	.	$665.11
75676	Artery x-rays, neck		Q2	0279	29.7399	$2,030.25	.	$406.05
75680	Artery x-rays, neck		Q2	0279	29.7399	$2,030.25	.	$406.05
75685	Artery x-rays, spine		Q2	0279	29.7399	$2,030.25	.	$406.05
75705	Artery x-rays, spine		Q2	0279	29.7399	$2,030.25	.	$406.05
75710	Artery x-rays, arm/leg		Q2	0279	29.7399	$2,030.25	.	$406.05
75716	Artery x-rays, arms/legs		Q2	0279	29.7399	$2,030.25	.	$406.05
75722	Artery x-rays, kidney		Q2	0279	29.7399	$2,030.25	.	$406.05

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75724	Artery x-rays, kidneys		Q2	0279	29.7399	$2,030.25	.	$406.05
75726	Artery x-rays, abdomen		Q2	0279	29.7399	$2,030.25	.	$406.05
75731	Artery x-rays, adrenal gland		Q2	0279	29.7399	$2,030.25	.	$406.05
75733	Artery x-rays, adrenals		Q2	0279	29.7399	$2,030.25	.	$406.05
75736	Artery x-rays, pelvis		Q2	0279	29.7399	$2,030.25	.	$406.05
75741	Artery x-rays, lung		Q2	0279	29.7399	$2,030.25	.	$406.05
75743	Artery x-rays, lungs		Q2	0279	29.7399	$2,030.25	.	$406.05
75746	Artery x-rays, lung		Q2	0668	10.6287	$725.59	.	$145.12
75756	Artery x-rays, chest		Q2	0668	10.6287	$725.59	.	$145.12
75774	Artery x-ray, each vessel		N					
75791	Av dialysis shunt imaging		Q2	0676	2.3844	$162.78	.	$32.56
75801	Lymph vessel x-ray, arm/leg		Q2	0317	5.982	$408.37	.	$81.68
75803	Lymph vessel x-ray,arms/legs		Q2	0317	5.982	$408.37	.	$81.68
75805	Lymph vessel x-ray, trunk		Q2	0317	5.982	$408.37	.	$81.68
75807	Lymph vessel x-ray, trunk		Q2	0317	5.982	$408.37	.	$81.68
75809	Nonvascular shunt, x-ray		Q2	0261	1.1314	$77.24	.	$15.45
75810	Vein x-ray, spleen/liver		Q2	0279	29.7399	$2,030.25	.	$406.05
75820	Vein x-ray, arm/leg		Q2	0668	10.6287	$725.59	.	$145.12
75822	Vein x-ray, arms/legs		Q2	0668	10.6287	$725.59	.	$145.12
75825	Vein x-ray, trunk		Q2	0279	29.7399	$2,030.25	.	$406.05
75827	Vein x-ray, chest		Q2	0668	10.6287	$725.59	.	$145.12
75831	Vein x-ray, kidney		Q2	0279	29.7399	$2,030.25	.	$406.05
75833	Vein x-ray, kidneys		Q2	0279	29.7399	$2,030.25	.	$406.05
75840	Vein x-ray, adrenal gland		Q2	0279	29.7399	$2,030.25	.	$406.05
75842	Vein x-ray, adrenal glands		Q2	0279	29.7399	$2,030.25	.	$406.05
75860	Vein x-ray, neck		Q2	0668	10.6287	$725.59	.	$145.12
75870	Vein x-ray, skull		Q2	0668	10.6287	$725.59	.	$145.12
75872	Vein x-ray, skull		Q2	0668	10.6287	$725.59	.	$145.12
75880	Vein x-ray, eye socket		Q2	0668	10.6287	$725.59	.	$145.12

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75885	Vein x-ray, liver		Q2	0279	29.7399	$2,030.25	.	$406.05
75887	Vein x-ray, liver		Q2	0668	10.6287	$725.59	.	$145.12
75889	Vein x-ray, liver		Q2	0279	29.7399	$2,030.25	.	$406.05
75891	Vein x-ray, liver		Q2	0279	29.7399	$2,030.25	.	$406.05
75893	Venous sampling by catheter		Q2	0279	29.7399	$2,030.25	.	$406.05
75894	X-rays, transcath therapy		N					
75896	X-rays, transcath therapy		N					
75898	Follow-up angiography		Q1	0261	1.1314	$77.24	.	$15.45
75900	Intravascular cath exchange		C					
75901	Remove cva device obstruct		N					
75902	Remove cva lumen obstruct		N					
75940	X-ray placement, vein filter		N					
75945	Intravascular us		Q2	0267	2.2748	$155.29	$60.50	$31.06
75946	Intravascular us add-on		N					
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					
75960	Transcath iv stent rs&i		N					
75961	Retrieval, broken catheter		N					
75962	Repair arterial blockage		Q2	0083	52.1947	$3,563.18	.	$712.64
75964	Repair artery blockage, each		N					
75966	Repair arterial blockage		Q2	0083	52.1947	$3,563.18	.	$712.64
75968	Repair artery blockage, each		N					
75970	Vascular biopsy		N					
75978	Repair venous blockage		Q2	0093	36.5266	$2,493.56	.	$498.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75980	Contrast xray exam bile duct		N					
75982	Contrast xray exam bile duct		N					
75984	Xray control catheter change		N					
75989	Abscess drainage under x-ray		N					
75992	Atherectomy, x-ray exam		N					
75993	Atherectomy, x-ray exam		N					
75994	Atherectomy, x-ray exam		N					
75995	Atherectomy, x-ray exam		N					
75996	Atherectomy, x-ray exam		N					
76000	Fluoroscope examination		Q1	0272	1.2472	$85.14	$31.07	$17.03
76001	Fluoroscope exam, extensive		N					
76010	X-ray, nose to rectum		X	0260	0.6683	$45.62	.	$9.13
76080	X-ray exam of fistula		Q2	0263	3.3875	$231.25	.	$46.25
76098	X-ray exam, breast specimen		Q2	0317	5.982	$408.37	.	$81.68
76100	X-ray exam of body section		X	0261	1.1314	$77.24	.	$15.45
76101	Complex body section x-ray		X	0263	3.3875	$231.25	.	$46.25
76102	Complex body section x-rays		X	0263	3.3875	$231.25	.	$46.25
76120	Cine/video x-rays		X	0272	1.2472	$85.14	$31.07	$17.03
76125	Cine/video x-rays add-on		N					
76140	X-ray consultation		E					
76150	X-ray exam, dry process		X	0260	0.6683	$45.62	.	$9.13
76350	Special x-ray contrast study		N					
76376	3d render w/o postprocess		N					
76377	3d rendering w/postprocess		N					
76380	CAT scan follow-up study		S	0282	1.7637	$120.40	$37.80	$24.08
76390	Mr spectroscopy		E					
76496	Fluoroscopic procedure		X	0272	1.2472	$85.14	$31.07	$17.03
76497	Ct procedure		S	0282	1.7637	$120.40	$37.80	$24.08
76498	Mri procedure		S	0336	5.1052	$348.52	$137.34	$69.71

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76499	Radiographic procedure		X	0260	0.6683	$45.62	.	$9.13
76506	Echo exam of head		S	0265	0.9262	$63.23	$22.28	$12.65
76510	Ophth us, b & quant a		T	0232	2.4827	$169.49	$40.82	$33.90
76511	Ophth us, quant a only		S	0266	1.4262	$97.36	$37.53	$19.48
76512	Ophth us, b w/non-quant a		S	0266	1.4262	$97.36	$37.53	$19.48
76513	Echo exam of eye, water bath		S	0266	1.4262	$97.36	$37.53	$19.48
76514	Echo exam of eye, thickness		X	0035	0.2446	$16.70	.	$3.34
76516	Echo exam of eye		S	0265	0.9262	$63.23	$22.28	$12.65
76519	Echo exam of eye		S	0266	1.4262	$97.36	$37.53	$19.48
76529	Echo exam of eye		S	0265	0.9262	$63.23	$22.28	$12.65
76536	Us exam of head and neck		S	0266	1.4262	$97.36	$37.53	$19.48
76604	Us exam, chest		Q3	0265	0.9262	$63.23	$22.28	$12.65
76645	Us exam, breast(s)		S	0265	0.9262	$63.23	$22.28	$12.65
76700	Us exam, abdom, complete		Q3	0266	1.4262	$97.36	$37.53	$19.48
76705	Echo exam of abdomen		Q3	0266	1.4262	$97.36	$37.53	$19.48
76770	Us exam abdo back wall, comp		Q3	0266	1.4262	$97.36	$37.53	$19.48
76775	Us exam abdo back wall, lim		Q3	0266	1.4262	$97.36	$37.53	$19.48
76776	Us exam k transpl w/doppler		Q3	0266	1.4262	$97.36	$37.53	$19.48
76800	Us exam, spinal canal		S	0266	1.4262	$97.36	$37.53	$19.48
76801	Ob us < 14 wks, single fetus		S	0266	1.4262	$97.36	$37.53	$19.48
76802	Ob us < 14 wks, addl fetus		S	0265	0.9262	$63.23	$22.28	$12.65
76805	Ob us >/= 14 wks, sngl fetus		S	0266	1.4262	$97.36	$37.53	$19.48
76810	Ob us >/= 14 wks, addl fetus		S	0266	1.4262	$97.36	$37.53	$19.48
76811	Ob us, detailed, sngl fetus		S	0267	2.2748	$155.29	$60.50	$31.06
76812	Ob us, detailed, addl fetus		S	0265	0.9262	$63.23	$22.28	$12.65
76813	Ob us nuchal meas, 1 gest		S	0265	0.9262	$63.23	$22.28	$12.65
76814	Ob us nuchal meas, add-on		S	0265	0.9262	$63.23	$22.28	$12.65
76815	Ob us, limited, fetus(s)		S	0265	0.9262	$63.23	$22.28	$12.65
76816	Ob us, follow-up, per fetus		S	0265	0.9262	$63.23	$22.28	$12.65

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76817	Transvaginal us, obstetric		S	0265	0.9262	$63.23	$22.28	$12.65
76818	Fetal biophys profile w/nst		S	0266	1.4262	$97.36	$37.53	$19.48
76819	Fetal biophys profil w/o nst		S	0266	1.4262	$97.36	$37.53	$19.48
76820	Umbilical artery echo		S	0265	0.9262	$63.23	$22.28	$12.65
76821	Middle cerebral artery echo		S	0265	0.9262	$63.23	$22.28	$12.65
76825	Echo exam of fetal heart		S	0270	8.1944	$559.41	$132.96	$111.89
76826	Echo exam of fetal heart		S	0269	5.7019	$389.25	.	$77.85
76827	Echo exam of fetal heart		S	0265	0.9262	$63.23	$22.28	$12.65
76828	Echo exam of fetal heart		S	0265	0.9262	$63.23	$22.28	$12.65
76830	Transvaginal us, non-ob		S	0266	1.4262	$97.36	$37.53	$19.48
76831	Echo exam, uterus		Q3	0267	2.2748	$155.29	$60.50	$31.06
76856	Us exam, pelvic, complete		Q3	0266	1.4262	$97.36	$37.53	$19.48
76857	Us exam, pelvic, limited		Q3	0265	0.9262	$63.23	$22.28	$12.65
76870	Us exam, scrotum		Q3	0266	1.4262	$97.36	$37.53	$19.48
76872	Us, transrectal		S	0266	1.4262	$97.36	$37.53	$19.48
76873	Echograp trans r, pros study		S	0266	1.4262	$97.36	$37.53	$19.48
76880	Us exam, extremity		S	0266	1.4262	$97.36	$37.53	$19.48
76885	Us exam infant hips, dynamic		S	0265	0.9262	$63.23	$22.28	$12.65
76886	Us exam infant hips, static		S	0265	0.9262	$63.23	$22.28	$12.65
76930	Echo guide, cardiocentesis		N					
76932	Echo guide for heart biopsy		N					
76936	Echo guide for artery repair		S	0096	1.571	$107.25	$37.13	$21.45
76937	Us guide, vascular access		N					
76940	Us guide, tissue ablation		N					
76941	Echo guide for transfusion		N					
76942	Echo guide for biopsy		N					
76945	Echo guide, villus sampling		N					
76946	Echo guide for amniocentesis		N					
76948	Echo guide, ova aspiration		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76950	Echo guidance radiotherapy		N					
76965	Echo guidance radiotherapy		N					
76970	Ultrasound exam follow-up		S	0265	0.9262	$63.23	$22.28	$12.65
76975	GI endoscopic ultrasound		Q2	0267	2.2748	$155.29	$60.50	$31.06
76977	Us bone density measure		X	0340	0.6899	$47.10		
76998	Us guide, intraop		N					
76999	Echo examination procedure		S	0265	0.9262	$63.23	$22.28	$12.65
77001	Fluoroguide for vein device		N					
77002	Needle localization by xray		N					
77003	Fluoroguide for spine inject		N					
77011	Ct scan for localization		N					
77012	Ct scan for needle biopsy		N					
77013	Ct guide for tissue ablation		N					
77014	Ct scan for therapy guide		N					
77021	Mr guidance for needle place		N					
77022	Mri for tissue ablation		N					
77031	Stereotact guide for brst bx		N					
77032	Guidance for needle, breast		N					
77051	Computer dx mammogram add-on		A					
77052	Comp screen mammogram add-on		A					
77053	X-ray of mammary duct		Q2	0263	3.3875	$231.25	.	$46.25
77054	X-ray of mammary ducts		Q2	0263	3.3875	$231.25	.	$46.25
77055	Mammogram, one breast		A					
77056	Mammogram, both breasts		A					
77057	Mammogram, screening		A					
77058	Mri, one breast		B					
77059	Mri, both breasts		B					
77071	X-ray stress view		X	0260	0.6683	$45.62	.	$9.13
77072	X-rays for bone age		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77073	X-rays, bone length studies		X	0260	0.6683	$45.62	.	$9.13
77074	X-rays, bone survey, limited		X	0261	1.1314	$77.24	.	$15.45
77075	X-rays, bone survey complete		X	0261	1.1314	$77.24	.	$15.45
77076	X-rays, bone survey, infant		X	0261	1.1314	$77.24	.	$15.45
77077	Joint survey, single view		X	0260	0.6683	$45.62	.	$9.13
77078	Ct bone density, axial		S	0288	1.0562	$72.10	$28.51	$14.42
77079	Ct bone density, peripheral		S	0282	1.7637	$120.40	$37.80	$24.08
77080	Dxa bone density, axial		S	0288	1.0562	$72.10	$28.51	$14.42
77081	Dxa bone density/peripheral		S	0665	0.4667	$31.86	$11.60	$6.38
77082	Dxa bone density, vert fx		X	0260	0.6683	$45.62	.	$9.13
77083	Radiographic absorptiometry		X	0261	1.1314	$77.24	.	$15.45
77084	Magnetic image, bone marrow		S	0336	5.1052	$348.52	$137.34	$69.71
77261	Radiation therapy planning		B					
77262	Radiation therapy planning		B					
77263	Radiation therapy planning		B					
77280	Set radiation therapy field		X	0304	1.5401	$105.14	$34.63	$21.03
77285	Set radiation therapy field		X	0305	4.0762	$278.27	$91.38	$55.66
77290	Set radiation therapy field		X	0305	4.0762	$278.27	$91.38	$55.66
77295	Set radiation therapy field		X	0310	13.5651	$926.05	$325.27	$185.21
77299	Radiation therapy planning		X	0304	1.5401	$105.14	$34.63	$21.03
77300	Radiation therapy dose plan		X	0304	1.5401	$105.14	$34.63	$21.03
77301	Radiotherapy dose plan, imrt		X	0310	13.5651	$926.05	$325.27	$185.21
77305	Teletx isodose plan simple		X	0304	1.5401	$105.14	$34.63	$21.03
77310	Teletx isodose plan intermed		X	0304	1.5401	$105.14	$34.63	$21.03
77315	Teletx isodose plan complex		X	0305	4.0762	$278.27	$91.38	$55.66
77321	Special teletx port plan		X	0305	4.0762	$278.27	$91.38	$55.66
77326	Brachytx isodose calc simp		X	0304	1.5401	$105.14	$34.63	$21.03
77327	Brachytx isodose calc interm		X	0305	4.0762	$278.27	$91.38	$55.66
77328	Brachytx isodose plan compl		X	0305	4.0762	$278.27	$91.38	$55.66

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77331	Special radiation dosimetry		X	0304	1.5401	$105.14	$34.63	$21.03
77332	Radiation treatment aid(s)		X	0303	2.9021	$198.12	$66.95	$39.63
77333	Radiation treatment aid(s)		X	0303	2.9021	$198.12	$66.95	$39.63
77334	Radiation treatment aid(s)		X	0303	2.9021	$198.12	$66.95	$39.63
77336	Radiation physics consult		X	0304	1.5401	$105.14	$34.63	$21.03
77338	Design mlc device for imrt		X	0303	2.9021	$198.12	$66.95	$39.63
77370	Radiation physics consult		X	0304	1.5401	$105.14	$34.63	$21.03
77371	Srs, multisource		S	0127	105.7702	$7,220.61	.	$1,444.13
77372	Srs, linear based		B					
77373	Sbrt delivery		B					
77399	External radiation dosimetry		X	0304	1.5401	$105.14	$34.63	$21.03
77401	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77402	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77403	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77404	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77406	Radiation treatment delivery	CH	S	0300	1.4418	$98.43	.	$19.69
77407	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77408	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77409	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77411	Radiation treatment delivery		S	0301	2.3741	$162.07	.	$32.42
77412	Radiation treatment delivery		S	0301	2.3741	$162.07	.	$32.42
77413	Radiation treatment delivery		S	0301	2.3741	$162.07	.	$32.42
77414	Radiation treatment delivery		S	0301	2.3741	$162.07	.	$32.42
77416	Radiation treatment delivery		S	0301	2.3741	$162.07	.	$32.42
77417	Radiology port film(s)		N					
77418	Radiation tx delivery, imrt		S	0412	6.4458	$440.04	.	$88.01
77421	Stereoscopic x-ray guidance		N					
77422	Neutron beam tx, simple		S	0301	2.3741	$162.07	.	$32.42
77423	Neutron beam tx, complex		S	0301	2.3741	$162.07	.	$32.42

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77427	Radiation tx management, x5		B					
77431	Radiation therapy management		B					
77432	Stereotactic radiation trmt		B					
77435	Sbrt management		N					
77470	Special radiation treatment		S	0299	5.7142	$390.09	.	$78.02
77499	Radiation therapy management		B					
77520	Proton trmt, simple w/o comp		S	0664	13.2159	$902.21	.	$180.45
77522	Proton trmt, simple w/comp		S	0664	13.2159	$902.21	.	$180.45
77523	Proton trmt, intermediate		S	0667	17.2884	$1,180.23	.	$236.05
77525	Proton treatment, complex		S	0667	17.2884	$1,180.23	.	$236.05
77600	Hyperthermia treatment		S	0299	5.7142	$390.09	.	$78.02
77605	Hyperthermia treatment		S	0299	5.7142	$390.09	.	$78.02
77610	Hyperthermia treatment		S	0299	5.7142	$390.09	.	$78.02
77615	Hyperthermia treatment		S	0299	5.7142	$390.09	.	$78.02
77620	Hyperthermia treatment		S	0299	5.7142	$390.09	.	$78.02
77750	Infuse radioactive materials		S	0301	2.3741	$162.07	.	$32.42
77761	Apply intrcav radiat simple		S	0312	5.0976	$348.00	.	$69.60
77762	Apply intrcav radiat interm		S	0312	5.0976	$348.00	.	$69.60
77763	Apply intrcav radiat compl		S	0312	5.0976	$348.00	.	$69.60
77776	Apply interstit radiat simpl		S	0312	5.0976	$348.00	.	$69.60
77777	Apply interstit radiat inter		S	0312	5.0976	$348.00	.	$69.60
77778	Apply interstit radiat compl		Q3	0651	14.3321	$978.41	.	$195.69
77785	Hdr brachytx, 1 channel		S	0313	10.4062	$710.40	$268.63	$142.08
77786	Hdr brachytx, 2-12 channel		S	0313	10.4062	$710.40	$268.63	$142.08
77787	Hdr brachytx over 12 chan		S	0313	10.4062	$710.40	$268.63	$142.08
77789	Apply surface radiation		S	0300	1.4418	$98.43	.	$19.69
77790	Radiation handling		N					
77799	Radium/radioisotope therapy		S	0312	5.0976	$348.00	.	$69.60
78000	Thyroid, single uptake		S	0389	1.577	$107.66	$28.71	$21.54

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78001	Thyroid, multiple uptakes		S	0389	1.577	$107.66	$28.71	$21.54
78003	Thyroid suppress/stimul		S	0389	1.577	$107.66	$28.71	$21.54
78006	Thyroid imaging with uptake		S	0391	3.2886	$224.50	$65.96	$44.90
78007	Thyroid image, mult uptakes		S	0391	3.2886	$224.50	$65.96	$44.90
78010	Thyroid imaging		S	0390	2.0375	$139.09	$49.95	$27.82
78011	Thyroid imaging with flow		S	0390	2.0375	$139.09	$49.95	$27.82
78015	Thyroid met imaging		S	0406	4.2872	$292.67	$88.01	$58.54
78016	Thyroid met imaging/studies		S	0406	4.2872	$292.67	$88.01	$58.54
78018	Thyroid met imaging, body		S	0406	4.2872	$292.67	$88.01	$58.54
78020	Thyroid met uptake		N					
78070	Parathyroid nuclear imaging		S	0391	3.2886	$224.50	$65.96	$44.90
78075	Adrenal nuclear imaging		S	0408	12.6011	$860.24	.	$172.05
78099	Endocrine nuclear procedure		S	0390	2.0375	$139.09	$49.95	$27.82
78102	Bone marrow imaging, ltd		S	0400	3.7861	$258.47	$91.52	$51.70
78103	Bone marrow imaging, mult		S	0400	3.7861	$258.47	$91.52	$51.70
78104	Bone marrow imaging, body		S	0400	3.7861	$258.47	$91.52	$51.70
78110	Plasma volume, single		S	0393	5.877	$401.21	.	$80.25
78111	Plasma volume, multiple		S	0393	5.877	$401.21	.	$80.25
78120	Red cell mass, single		S	0393	5.877	$401.21	.	$80.25
78121	Red cell mass, multiple		S	0393	5.877	$401.21	.	$80.25
78122	Blood volume		S	0393	5.877	$401.21	.	$80.25
78130	Red cell survival study		S	0393	5.877	$401.21	.	$80.25
78135	Red cell survival kinetics		S	0393	5.877	$401.21	.	$80.25
78140	Red cell sequestration		S	0393	5.877	$401.21	.	$80.25
78185	Spleen imaging		S	0400	3.7861	$258.47	$91.52	$51.70
78190	Platelet survival, kinetics		S	0392	2.6029	$177.69	$43.31	$35.54
78191	Platelet survival		S	0392	2.6029	$177.69	$43.31	$35.54
78195	Lymph system imaging		S	0400	3.7861	$258.47	$91.52	$51.70
78199	Blood/lymph nuclear exam		S	0400	3.7861	$258.47	$91.52	$51.70

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78201	Liver imaging		S	0394	4.2112	$287.49	$98.44	$57.50
78202	Liver imaging with flow		S	0394	4.2112	$287.49	$98.44	$57.50
78205	Liver imaging (3D)		S	0394	4.2112	$287.49	$98.44	$57.50
78206	Liver image (3d) with flow		S	0394	4.2112	$287.49	$98.44	$57.50
78215	Liver and spleen imaging		S	0394	4.2112	$287.49	$98.44	$57.50
78216	Liver & spleen image/flow		S	0394	4.2112	$287.49	$98.44	$57.50
78220	Liver function study		S	0394	4.2112	$287.49	$98.44	$57.50
78223	Hepatobiliary imaging		S	0394	4.2112	$287.49	$98.44	$57.50
78230	Salivary gland imaging		S	0395	3.6081	$246.31	$89.56	$49.27
78231	Serial salivary imaging		S	0395	3.6081	$246.31	$89.56	$49.27
78232	Salivary gland function exam		S	0395	3.6081	$246.31	$89.56	$49.27
78258	Esophageal motility study		S	0395	3.6081	$246.31	$89.56	$49.27
78261	Gastric mucosa imaging		S	0395	3.6081	$246.31	$89.56	$49.27
78262	Gastroesophageal reflux exam		S	0395	3.6081	$246.31	$89.56	$49.27
78264	Gastric emptying study		S	0395	3.6081	$246.31	$89.56	$49.27
78267	Breath tst attain/anal c-14		A					
78268	Breath test analysis, c-14		A					
78270	Vit B-12 absorption exam		S	0392	2.6029	$177.69	$43.31	$35.54
78271	Vit b-12 absrp exam, int fac		S	0392	2.6029	$177.69	$43.31	$35.54
78272	Vit B-12 absorp, combined		S	0392	2.6029	$177.69	$43.31	$35.54
78278	Acute GI blood loss imaging		S	0395	3.6081	$246.31	$89.56	$49.27
78282	GI protein loss exam		S	0395	3.6081	$246.31	$89.56	$49.27
78290	Meckels divert exam		S	0395	3.6081	$246.31	$89.56	$49.27
78291	Leveen/shunt patency exam		S	0395	3.6081	$246.31	$89.56	$49.27
78299	GI nuclear procedure		S	0395	3.6081	$246.31	$89.56	$49.27
78300	Bone imaging, limited area		S	0396	3.6637	$250.11	$95.02	$50.03
78305	Bone imaging, multiple areas		S	0396	3.6637	$250.11	$95.02	$50.03
78306	Bone imaging, whole body		S	0396	3.6637	$250.11	$95.02	$50.03
78315	Bone imaging, 3 phase		S	0396	3.6637	$250.11	$95.02	$50.03

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78320	Bone imaging (3D)		S	0396	3.6637	$250.11	$95.02	$50.03
78350	Bone mineral, single photon		E					
78351	Bone mineral, dual photon		E					
78399	Musculoskeletal nuclear exam		S	0396	3.6637	$250.11	$95.02	$50.03
78414	Non-imaging heart function		S	0398	4.3724	$298.49	$95.61	$59.70
78428	Cardiac shunt imaging		S	0398	4.3724	$298.49	$95.61	$59.70
78445	Vascular flow imaging		S	0397	3.5928	$245.27	.	$49.06
78451	Ht muscle image spect, sing		S	0377	11.2555	$768.38	.	$153.68
78452	Ht muscle image spect, mult		S	0377	11.2555	$768.38	.	$153.68
78453	Ht muscle image,planar,sing		S	0377	11.2555	$768.38	.	$153.68
78454	Ht musc image, planar, mult		S	0377	11.2555	$768.38	.	$153.68
78456	Acute venous thrombus image		S	0397	3.5928	$245.27	.	$49.06
78457	Venous thrombosis imaging		S	0397	3.5928	$245.27	.	$49.06
78458	Ven thrombosis images, bilat		S	0397	3.5928	$245.27	.	$49.06
78459	Heart muscle imaging (PET)		S	0307	16.1009	$1,099.16	.	$219.84
78466	Heart infarct image		S	0398	4.3724	$298.49	$95.61	$59.70
78468	Heart infarct image (ef)		S	0398	4.3724	$298.49	$95.61	$59.70
78469	Heart infarct image (3D)		S	0398	4.3724	$298.49	$95.61	$59.70
78472	Gated heart, planar, single		S	0398	4.3724	$298.49	$95.61	$59.70
78473	Gated heart, multiple		S	0398	4.3724	$298.49	$95.61	$59.70
78481	Heart first pass, single		S	0398	4.3724	$298.49	$95.61	$59.70
78483	Heart first pass, multiple		S	0398	4.3724	$298.49	$95.61	$59.70
78491	Heart image (pet), single		S	0307	16.1009	$1,099.16	.	$219.84
78492	Heart image (pet), multiple		S	0307	16.1009	$1,099.16	.	$219.84
78494	Heart image, spect		S	0398	4.3724	$298.49	$95.61	$59.70
78496	Heart first pass add-on		N					
78499	Cardiovascular nuclear exam		S	0398	4.3724	$298.49	$95.61	$59.70
78580	Lung perfusion imaging		S	0401	2.9903	$204.14	$73.80	$40.83
78584	Lung V/Q image single breath		S	0378	4.7678	$325.48	$124.64	$65.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78585	Lung V/Q imaging		S	0378	4.7678	$325.48	$124.64	$65.10
78586	Aerosol lung image, single		S	0401	2.9903	$204.14	$73.80	$40.83
78587	Aerosol lung image, multiple		S	0401	2.9903	$204.14	$73.80	$40.83
78588	Perfusion lung image		S	0378	4.7678	$325.48	$124.64	$65.10
78591	Vent image, 1 breath, 1 proj		S	0401	2.9903	$204.14	$73.80	$40.83
78593	Vent image, 1 proj, gas		S	0401	2.9903	$204.14	$73.80	$40.83
78594	Vent image, mult proj, gas		S	0401	2.9903	$204.14	$73.80	$40.83
78596	Lung differential function		S	0378	4.7678	$325.48	$124.64	$65.10
78599	Respiratory nuclear exam		S	0401	2.9903	$204.14	$73.80	$40.83
78600	Brain image < 4 views		S	0403	3.4106	$232.83	$72.42	$46.57
78601	Brain image w/flow < 4 views		S	0402	9.085	$620.21	.	$124.05
78605	Brain image 4+ views		S	0403	3.4106	$232.83	$72.42	$46.57
78606	Brain image w/flow 4 + views		S	0402	9.085	$620.21	.	$124.05
78607	Brain imaging (3D)		S	0402	9.085	$620.21	.	$124.05
78608	Brain imaging (PET)		S	0308	15.3994	$1,051.27	.	$210.26
78609	Brain imaging (PET)		E					
78610	Brain flow imaging only		S	0403	3.4106	$232.83	$72.42	$46.57
78630	Cerebrospinal fluid scan		S	0402	9.085	$620.21	.	$124.05
78635	CSF ventriculography		S	0402	9.085	$620.21	.	$124.05
78645	CSF shunt evaluation		S	0403	3.4106	$232.83	$72.42	$46.57
78647	Cerebrospinal fluid scan		S	0402	9.085	$620.21	.	$124.05
78650	CSF leakage imaging		S	0402	9.085	$620.21	.	$124.05
78660	Nuclear exam of tear flow		S	0403	3.4106	$232.83	$72.42	$46.57
78699	Nervous system nuclear exam		S	0403	3.4106	$232.83	$72.42	$46.57
78700	Kidney imaging, morphol		S	0404	4.7288	$322.82	$82.54	$64.57
78701	Kidney imaging with flow		S	0404	4.7288	$322.82	$82.54	$64.57
78707	K flow/funct image w/o drug		S	0404	4.7288	$322.82	$82.54	$64.57
78708	K flow/funct image w/drug		S	0404	4.7288	$322.82	$82.54	$64.57
78709	K flow/funct image, multiple		S	0404	4.7288	$322.82	$82.54	$64.57

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78710	Kidney imaging (3D)		S	0404	4.7288	$322.82	$82.54	$64.57
78725	Kidney function study		S	0392	2.6029	$177.69	$43.31	$35.54
78730	Urinary bladder retention		S	0389	1.577	$107.66	$28.71	$21.54
78740	Ureteral reflux study		S	0404	4.7288	$322.82	$82.54	$64.57
78761	Testicular imaging w/flow		S	0404	4.7288	$322.82	$82.54	$64.57
78799	Genitourinary nuclear exam		S	0404	4.7288	$322.82	$82.54	$64.57
78800	Tumor imaging, limited area		S	0406	4.2872	$292.67	$88.01	$58.54
78801	Tumor imaging, mult areas		S	0414	7.1451	$487.77	.	$97.56
78802	Tumor imaging, whole body		S	0414	7.1451	$487.77	.	$97.56
78803	Tumor imaging (3D)		S	0414	7.1451	$487.77	.	$97.56
78804	Tumor imaging, whole body		S	0408	12.6011	$860.24	.	$172.05
78805	Abscess imaging, ltd area		S	0414	7.1451	$487.77	.	$97.56
78806	Abscess imaging, whole body		S	0414	7.1451	$487.77	.	$97.56
78807	Nuclear localization/abscess		S	0406	4.2872	$292.67	$88.01	$58.54
78808	Iv inj ra drug dx study		Q1	0392	2.6029	$177.69	$43.31	$35.54
78811	Pet image, ltd area		S	0308	15.3994	$1,051.27	.	$210.26
78812	Pet image, skull-thigh		S	0308	15.3994	$1,051.27	.	$210.26
78813	Pet image, full body		S	0308	15.3994	$1,051.27	.	$210.26
78814	Pet image w/ct, lmtd		S	0308	15.3994	$1,051.27	.	$210.26
78815	Pet image w/ct, skull-thigh		S	0308	15.3994	$1,051.27	.	$210.26
78816	Pet image w/ct, full body		S	0308	15.3994	$1,051.27	.	$210.26
78999	Nuclear diagnostic exam		S	0389	1.577	$107.66	$28.71	$21.54
79005	Nuclear rx, oral admin		S	0407	3.2871	$224.40	$78.13	$44.88
79101	Nuclear rx, iv admin		S	0407	3.2871	$224.40	$78.13	$44.88
79200	Nuclear rx, intracav admin		S	0413	5.1912	$354.39	.	$70.88
79300	Nuclr rx, interstit colloid		S	0407	3.2871	$224.40	$78.13	$44.88
79403	Hematopoietic nuclear tx		S	0413	5.1912	$354.39	.	$70.88
79440	Nuclear rx, intra-articular		S	0413	5.1912	$354.39	.	$70.88
79445	Nuclear rx, intra-arterial		S	0407	3.2871	$224.40	$78.13	$44.88

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
79999	Nuclear medicine therapy		S	0407	3.2871	$224.40	$78.13	$44.88
80047	Metabolic panel ionized ca		A					
80048	Metabolic panel total ca		A					
80050	General health panel		E					
80051	Electrolyte panel		A					
80053	Comprehen metabolic panel		A					
80055	Obstetric panel		E					
80061	Lipid panel		A					
80069	Renal function panel		A					
80074	Acute hepatitis panel		A					
80076	Hepatic function panel		A					
80100	Drug screen, qualitate/multi		A					
80101	Drug screen, single		E					
80102	Drug confirmation		A					
80103	Drug analysis, tissue prep		N					
80150	Assay of amikacin		A					
80152	Assay of amitriptyline		A					
80154	Assay of benzodiazepines		A					
80156	Assay, carbamazepine, total		A					
80157	Assay, carbamazepine, free		A					
80158	Assay of cyclosporine		A					
80160	Assay of desipramine		A					
80162	Assay of digoxin		A					
80164	Assay, dipropylacetic acid		A					
80166	Assay of doxepin		A					
80168	Assay of ethosuximide		A					
80170	Assay of gentamicin		A					
80172	Assay of gold		A					
80173	Assay of haloperidol		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
80174	Assay of imipramine		A					
80176	Assay of lidocaine		A					
80178	Assay of lithium		A					
80182	Assay of nortriptyline		A					
80184	Assay of phenobarbital		A					
80185	Assay of phenytoin, total		A					
80186	Assay of phenytoin, free		A					
80188	Assay of primidone		A					
80190	Assay of procainamide		A					
80192	Assay of procainamide		A					
80194	Assay of quinidine		A					
80195	Assay of sirolimus		A					
80196	Assay of salicylate		A					
80197	Assay of tacrolimus		A					
80198	Assay of theophylline		A					
80200	Assay of tobramycin		A					
80201	Assay of topiramate		A					
80202	Assay of vancomycin		A					
80299	Quantitative assay, drug		A					
80400	Acth stimulation panel		A					
80402	Acth stimulation panel		A					
80406	Acth stimulation panel		A					
80408	Aldosterone suppression eval		A					
80410	Calcitonin stimul panel		A					
80412	CRH stimulation panel		A					
80414	Testosterone response		A					
80415	Estradiol response panel		A					
80416	Renin stimulation panel		A					
80417	Renin stimulation panel		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
80418	Pituitary evaluation panel		A					
80420	Dexamethasone panel		A					
80422	Glucagon tolerance panel		A					
80424	Glucagon tolerance panel		A					
80426	Gonadotropin hormone panel		A					
80428	Growth hormone panel		A					
80430	Growth hormone panel		A					
80432	Insulin suppression panel		A					
80434	Insulin tolerance panel		A					
80435	Insulin tolerance panel		A					
80436	Metyrapone panel		A					
80438	TRH stimulation panel		A					
80439	TRH stimulation panel		A					
80440	TRH stimulation panel		A					
80500	Lab pathology consultation		X	0433	0.2465	$16.83	$5.17	$3.37
80502	Lab pathology consultation		X	0342	0.1596	$10.90	.	$2.18
81000	Urinalysis, nonauto w/scope		A					
81001	Urinalysis, auto w/scope		A					
81002	Urinalysis nonauto w/o scope		A					
81003	Urinalysis, auto, w/o scope		A					
81005	Urinalysis		A					
81007	Urine screen for bacteria		A					
81015	Microscopic exam of urine		A					
81020	Urinalysis, glass test		A					
81025	Urine pregnancy test		A					
81050	Urinalysis, volume measure		A					
81099	Urinalysis test procedure		A					
82000	Assay of blood acetaldehyde		A					
82003	Assay of acetaminophen		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82009	Test for acetone/ketones		A					
82010	Acetone assay		A					
82013	Acetylcholinesterase assay		A					
82016	Acylcarnitines, qual		A					
82017	Acylcarnitines, quant		A					
82024	Assay of acth		A					
82030	Assay of adp & amp		A					
82040	Assay of serum albumin		A					
82042	Assay of urine albumin		A					
82043	Microalbumin, quantitative		A					
82044	Microalbumin, semiquant		A					
82045	Albumin, ischemia modified		A					
82055	Assay of ethanol		A					
82075	Assay of breath ethanol		A					
82085	Assay of aldolase		A					
82088	Assay of aldosterone		A					
82101	Assay of urine alkaloids		A					
82103	Alpha-1-antitrypsin, total		A					
82104	Alpha-1-antitrypsin, pheno		A					
82105	Alpha-fetoprotein, serum		A					
82106	Alpha-fetoprotein, amniotic		A					
82107	Alpha-fetoprotein l3		A					
82108	Assay of aluminum		A					
82120	Amines, vaginal fluid qual		A					
82127	Amino acid, single qual		A					
82128	Amino acids, mult qual		A					
82131	Amino acids, single quant		A					
82135	Assay, aminolevulinic acid		A					
82136	Amino acids, quant, 2-5		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82139	Amino acids, quan, 6 or more		A					
82140	Assay of ammonia		A					
82143	Amniotic fluid scan		A					
82145	Assay of amphetamines		A					
82150	Assay of amylase		A					
82154	Androstanediol glucuronide		A					
82157	Assay of androstenedione		A					
82160	Assay of androsterone		A					
82163	Assay of angiotensin II		A					
82164	Angiotensin I enzyme test		A					
82172	Assay of apolipoprotein		A					
82175	Assay of arsenic		A					
82180	Assay of ascorbic acid		A					
82190	Atomic absorption		A					
82205	Assay of barbiturates		A					
82232	Assay of beta-2 protein		A					
82239	Bile acids, total		A					
82240	Bile acids, cholylglycine		A					
82247	Bilirubin, total		A					
82248	Bilirubin, direct		A					
82252	Fecal bilirubin test		A					
82261	Assay of biotinidase		A					
82270	Occult blood, feces		A					
82271	Occult blood, other sources		A					
82272	Occult bld feces, 1-3 tests		A					
82274	Assay test for blood, fecal		A					
82286	Assay of bradykinin		A					
82300	Assay of cadmium		A					
82306	Vitamin d, 25 hydroxy		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82308	Assay of calcitonin		A					
82310	Assay of calcium		A					
82330	Assay of calcium		A					
82331	Calcium infusion test		A					
82340	Assay of calcium in urine		A					
82355	Calculus analysis, qual		A					
82360	Calculus assay, quant		A					
82365	Calculus spectroscopy		A					
82370	X-ray assay, calculus		A					
82373	Assay, c-d transfer measure		A					
82374	Assay, blood carbon dioxide		A					
82375	Assay, carboxyhb, quant		A					
82376	Assay, carboxyhb, qual		A					
82378	Carcinoembryonic antigen		A					
82379	Assay of carnitine		A					
82380	Assay of carotene		A					
82382	Assay, urine catecholamines		A					
82383	Assay, blood catecholamines		A					
82384	Assay, three catecholamines		A					
82387	Assay of cathepsin-d		A					
82390	Assay of ceruloplasmin		A					
82397	Chemiluminescent assay		A					
82415	Assay of chloramphenicol		A					
82435	Assay of blood chloride		A					
82436	Assay of urine chloride		A					
82438	Assay, other fluid chlorides		A					
82441	Test for chlorohydrocarbons		A					
82465	Assay, bld/serum cholesterol		A					
82480	Assay, serum cholinesterase		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82482	Assay, rbc cholinesterase		A					
82485	Assay, chondroitin sulfate		A					
82486	Gas/liquid chromatography		A					
82487	Paper chromatography		A					
82488	Paper chromatography		A					
82489	Thin layer chromatography		A					
82491	Chromotography, quant, sing		A					
82492	Chromotography, quant, mult		A					
82495	Assay of chromium		A					
82507	Assay of citrate		A					
82520	Assay of cocaine		A					
82523	Collagen crosslinks		A					
82525	Assay of copper		A					
82528	Assay of corticosterone		A					
82530	Cortisol, free		A					
82533	Total cortisol		A					
82540	Assay of creatine		A					
82541	Column chromotography, qual		A					
82542	Column chromotography, quant		A					
82543	Column chromotograph/isotope		A					
82544	Column chromotograph/isotope		A					
82550	Assay of ck (cpk)		A					
82552	Assay of cpk in blood		A					
82553	Creatine, MB fraction		A					
82554	Creatine, isoforms		A					
82565	Assay of creatinine		A					
82570	Assay of urine creatinine		A					
82575	Creatinine clearance test		A					
82585	Assay of cryofibrinogen		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82595	Assay of cryoglobulin		A					
82600	Assay of cyanide		A					
82607	Vitamin B-12		A					
82608	B-12 binding capacity		A					
82610	Cystatin c		A					
82615	Test for urine cystines		A					
82626	Dehydroepiandrosterone		A					
82627	Dehydroepiandrosterone		A					
82633	Desoxycorticosterone		A					
82634	Deoxycortisol		A					
82638	Assay of dibucaine number		A					
82646	Assay of dihydrocodeinone		A					
82649	Assay of dihydromorphinone		A					
82651	Assay of dihydrotestosterone		A					
82652	Vit d 1, 25-dihydroxy		A					
82654	Assay of dimethadione		A					
82656	Pancreatic elastase, fecal		A					
82657	Enzyme cell activity		A					
82658	Enzyme cell activity, ra		A					
82664	Electrophoretic test		A					
82666	Assay of epiandrosterone		A					
82668	Assay of erythropoietin		A					
82670	Assay of estradiol		A					
82671	Assay of estrogens		A					
82672	Assay of estrogen		A					
82677	Assay of estriol		A					
82679	Assay of estrone		A					
82690	Assay of ethchlorvynol		A					
82693	Assay of ethylene glycol		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82696	Assay of etiocholanolone		A					
82705	Fats/lipids, feces, qual		A					
82710	Fats/lipids, feces, quant		A					
82715	Assay of fecal fat		A					
82725	Assay of blood fatty acids		A					
82726	Long chain fatty acids		A					
82728	Assay of ferritin		A					
82731	Assay of fetal fibronectin		A					
82735	Assay of fluoride		A					
82742	Assay of flurazepam		A					
82746	Blood folic acid serum		A					
82747	Assay of folic acid, rbc		A					
82757	Assay of semen fructose		A					
82759	Assay of rbc galactokinase		A					
82760	Assay of galactose		A					
82775	Assay galactose transferase		A					
82776	Galactose transferase test		A					
82784	Assay, iga/igd/igg/igm each		A					
82785	Assay of ige		A					
82787	Igg 1, 2, 3 or 4, each		A					
82800	Blood pH		A					
82803	Blood gases: pH, pO2 & pCO2		A					
82805	Blood gases w/02 saturation		A					
82810	Blood gases, O2 sat only		A					
82820	Hemoglobin-oxygen affinity		A					
82926	Assay of gastric acid		A					
82928	Assay of gastric acid		A					
82938	Gastrin test		A					
82941	Assay of gastrin		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82943	Assay of glucagon		A					
82945	Glucose other fluid		A					
82946	Glucagon tolerance test		A					
82947	Assay, glucose, blood quant		A					
82948	Reagent strip/blood glucose		A					
82950	Glucose test		A					
82951	Glucose tolerance test (GTT)		A					
82952	GTT-added samples		A					
82953	Glucose-tolbutamide test		A					
82955	Assay of g6pd enzyme		A					
82960	Test for G6PD enzyme		A					
82962	Glucose blood test		A					
82963	Assay of glucosidase		A					
82965	Assay of gdh enzyme		A					
82975	Assay of glutamine		A					
82977	Assay of GGT		A					
82978	Assay of glutathione		A					
82979	Assay, rbc glutathione		A					
82980	Assay of glutethimide		A					
82985	Glycated protein		A					
83001	Gonadotropin (FSH)		A					
83002	Gonadotropin (LH)		A					
83003	Assay, growth hormone (hgh)		A					
83008	Assay of guanosine		A					
83009	H pylori (c-13), blood		A					
83010	Assay of haptoglobin, quant		A					
83012	Assay of haptoglobins		A					
83013	H pylori (c-13), breath		A					
83014	H pylori drug admin		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83015	Heavy metal screen		A					
83018	Quantitative screen, metals		A					
83020	Hemoglobin electrophoresis		A					
83021	Hemoglobin chromotography		A					
83026	Hemoglobin, copper sulfate		A					
83030	Fetal hemoglobin, chemical		A					
83033	Fetal hemoglobin assay, qual		A					
83036	Glycosylated hemoglobin test		A					
83037	Glycosylated hb, home device		A					
83045	Blood methemoglobin test		A					
83050	Blood methemoglobin assay		A					
83051	Assay of plasma hemoglobin		A					
83055	Blood sulfhemoglobin test		A					
83060	Blood sulfhemoglobin assay		A					
83065	Assay of hemoglobin heat		A					
83068	Hemoglobin stability screen		A					
83069	Assay of urine hemoglobin		A					
83070	Assay of hemosiderin, qual		A					
83071	Assay of hemosiderin, quant		A					
83080	Assay of b hexosaminidase		A					
83088	Assay of histamine		A					
83090	Assay of homocystine		A					
83150	Assay of for hva		A					
83491	Assay of corticosteroids		A					
83497	Assay of 5-hiaa		A					
83498	Assay of progesterone		A					
83499	Assay of progesterone		A					
83500	Assay, free hydroxyproline		A					
83505	Assay, total hydroxyproline		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83516	Immunoassay, nonantibody		A					
83518	Immunoassay, dipstick		A					
83519	Ria nonantibody		A					
83520	Immunoassay quant nos nonab		A					
83525	Assay of insulin		A					
83527	Assay of insulin		A					
83528	Assay of intrinsic factor		A					
83540	Assay of iron		A					
83550	Iron binding test		A					
83570	Assay of idh enzyme		A					
83582	Assay of ketogenic steroids		A					
83586	Assay 17- ketosteroids		A					
83593	Fractionation, ketosteroids		A					
83605	Assay of lactic acid		A					
83615	Lactate (LD) (LDH) enzyme		A					
83625	Assay of ldh enzymes		A					
83630	Lactoferrin, fecal (qual)		A					
83631	Lactoferrin, fecal (quant)		A					
83632	Placental lactogen		A					
83633	Test urine for lactose		A					
83634	Assay of urine for lactose		A					
83655	Assay of lead		A					
83661	L/s ratio, fetal lung		A					
83662	Foam stability, fetal lung		A					
83663	Fluoro polarize, fetal lung		A					
83664	Lamellar bdy, fetal lung		A					
83670	Assay of lap enzyme		A					
83690	Assay of lipase		A					
83695	Assay of lipoprotein(a)		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83698	Assay lipoprotein pla2		A					
83700	Lipopro bld, electrophoretic		A					
83701	Lipoprotein bld, hr fraction		A					
83704	Lipoprotein, bld, by nmr		A					
83718	Assay of lipoprotein		A					
83719	Assay of blood lipoprotein		A					
83721	Assay of blood lipoprotein		A					
83727	Assay of lrh hormone		A					
83735	Assay of magnesium		A					
83775	Assay of md enzyme		A					
83785	Assay of manganese		A					
83788	Mass spectrometry qual		A					
83789	Mass spectrometry quant		A					
83805	Assay of meprobamate		A					
83825	Assay of mercury		A					
83835	Assay of metanephrines		A					
83840	Assay of methadone		A					
83857	Assay of methemalbumin		A					
83858	Assay of methsuximide		A					
83864	Mucopolysaccharides		A					
83866	Mucopolysaccharides screen		A					
83872	Assay synovial fluid mucin		A					
83873	Assay of csf protein		A					
83874	Assay of myoglobin		A					
83876	Assay, myeloperoxidase		A					
83880	Natriuretic peptide		A					
83883	Assay, nephelometry not spec		A					
83885	Assay of nickel		A					
83887	Assay of nicotine		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83890	Molecule isolate		A					
83891	Molecule isolate nucleic		A					
83892	Molecular diagnostics		A					
83893	Molecule dot/slot/blot		A					
83894	Molecule gel electrophor		A					
83896	Molecular diagnostics		A					
83897	Molecule nucleic transfer		A					
83898	Molecule nucleic ampli, each		A					
83900	Molecule nucleic ampli 2 seq		A					
83901	Molecule nucleic ampli addon		A					
83902	Molecular diagnostics		A					
83903	Molecule mutation scan		A					
83904	Molecule mutation identify		A					
83905	Molecule mutation identify		A					
83906	Molecule mutation identify		A					
83907	Lyse cells for nucleic ext		A					
83908	Nucleic acid, signal ampli		A					
83909	Nucleic acid, high resolute		A					
83912	Genetic examination		A					
83913	Molecular, rna stabilization		A					
83914	Mutation ident ola/sbce/aspe		A					
83915	Assay of nucleotidase		A					
83916	Oligoclonal bands		A					
83918	Organic acids, total, quant		A					
83919	Organic acids, qual, each		A					
83921	Organic acid, single, quant		A					
83925	Assay of opiates		A					
83930	Assay of blood osmolality		A					
83935	Assay of urine osmolality		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83937	Assay of osteocalcin		A					
83945	Assay of oxalate		A					
83950	Oncoprotein, her-2/neu		A					
83951	Oncoprotein, dcp		A					
83970	Assay of parathormone		A					
83986	Assay ph body fluid nos		A					
83987	Exhaled breath condensate		A					
83992	Assay for phencyclidine		A					
83993	Assay for calprotectin fecal		A					
84022	Assay of phenothiazine		A					
84030	Assay of blood pku		A					
84035	Assay of phenylketones		A					
84060	Assay acid phosphatase		A					
84061	Phosphatase, forensic exam		A					
84066	Assay prostate phosphatase		A					
84075	Assay alkaline phosphatase		A					
84078	Assay alkaline phosphatase		A					
84080	Assay alkaline phosphatases		A					
84081	Amniotic fluid enzyme test		A					
84085	Assay of rbc pg6d enzyme		A					
84087	Assay phosphohexose enzymes		A					
84100	Assay of phosphorus		A					
84105	Assay of urine phosphorus		A					
84106	Test for porphobilinogen		A					
84110	Assay of porphobilinogen		A					
84119	Test urine for porphyrins		A					
84120	Assay of urine porphyrins		A					
84126	Assay of feces porphyrins		A					
84127	Assay of feces porphyrins		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84132	Assay of serum potassium		A					
84133	Assay of urine potassium		A					
84134	Assay of prealbumin		A					
84135	Assay of pregnanediol		A					
84138	Assay of pregnanetriol		A					
84140	Assay of pregnenolone		A					
84143	Assay of 17-hydroxypregneno		A					
84144	Assay of progesterone		A					
84145	Procalcitonin (pct)		A					
84146	Assay of prolactin		A					
84150	Assay of prostaglandin		A					
84152	Assay of psa, complexed		A					
84153	Assay of psa, total		A					
84154	Assay of psa, free		A					
84155	Assay of protein, serum		A					
84156	Assay of protein, urine		A					
84157	Assay of protein, other		A					
84160	Assay of protein, any source		A					
84163	Pappa, serum		A					
84165	Protein e-phoresis, serum		A					
84166	Protein e-phoresis/urine/csf		A					
84181	Western blot test		A					
84182	Protein, western blot test		A					
84202	Assay RBC protoporphyrin		A					
84203	Test RBC protoporphyrin		A					
84206	Assay of proinsulin		A					
84207	Assay of vitamin b-6		A					
84210	Assay of pyruvate		A					
84220	Assay of pyruvate kinase		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84228	Assay of quinine		A					
84233	Assay of estrogen		A					
84234	Assay of progesterone		A					
84235	Assay of endocrine hormone		A					
84238	Assay, nonendocrine receptor		A					
84244	Assay of renin		A					
84252	Assay of vitamin b-2		A					
84255	Assay of selenium		A					
84260	Assay of serotonin		A					
84270	Assay of sex hormone globul		A					
84275	Assay of sialic acid		A					
84285	Assay of silica		A					
84295	Assay of serum sodium		A					
84300	Assay of urine sodium		A					
84302	Assay of sweat sodium		A					
84305	Assay of somatomedin		A					
84307	Assay of somatostatin		A					
84311	Spectrophotometry		A					
84315	Body fluid specific gravity		A					
84375	Chromatogram assay, sugars		A					
84376	Sugars, single, qual		A					
84377	Sugars, multiple, qual		A					
84378	Sugars, single, quant		A					
84379	Sugars multiple quant		A					
84392	Assay of urine sulfate		A					
84402	Assay of testosterone		A					
84403	Assay of total testosterone		A					
84425	Assay of vitamin b-1		A					
84430	Assay of thiocyanate		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84431	Thromboxane, urine		A					
84432	Assay of thyroglobulin		A					
84436	Assay of total thyroxine		A					
84437	Assay of neonatal thyroxine		A					
84439	Assay of free thyroxine		A					
84442	Assay of thyroid activity		A					
84443	Assay thyroid stim hormone		A					
84445	Assay of tsi		A					
84446	Assay of vitamin e		A					
84449	Assay of transcortin		A					
84450	Transferase (AST) (SGOT)		A					
84460	Alanine amino (ALT) (SGPT)		A					
84466	Assay of transferrin		A					
84478	Assay of triglycerides		A					
84479	Assay of thyroid (t3 or t4)		A					
84480	Assay, triiodothyronine (t3)		A					
84481	Free assay (FT-3)		A					
84482	T3 reverse		A					
84484	Assay of troponin, quant		A					
84485	Assay duodenal fluid trypsin		A					
84488	Test feces for trypsin		A					
84490	Assay of feces for trypsin		A					
84510	Assay of tyrosine		A					
84512	Assay of troponin, qual		A					
84520	Assay of urea nitrogen		A					
84525	Urea nitrogen semi-quant		A					
84540	Assay of urine/urea-n		A					
84545	Urea-N clearance test		A					
84550	Assay of blood/uric acid		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84560	Assay of urine/uric acid		A					
84577	Assay of feces/urobilinogen		A					
84578	Test urine urobilinogen		A					
84580	Assay of urine urobilinogen		A					
84583	Assay of urine urobilinogen		A					
84585	Assay of urine vma		A					
84586	Assay of vip		A					
84588	Assay of vasopressin		A					
84590	Assay of vitamin a		A					
84591	Assay of nos vitamin		A					
84597	Assay of vitamin k		A					
84600	Assay of volatiles		A					
84620	Xylose tolerance test		A					
84630	Assay of zinc		A					
84681	Assay of c-peptide		A					
84702	Chorionic gonadotropin test		A					
84703	Chorionic gonadotropin assay		A					
84704	Hcg, free betachain test		A					
84830	Ovulation tests		A					
84999	Clinical chemistry test		A					
85002	Bleeding time test		A					
85004	Automated diff wbc count		A					
85007	Bl smear w/diff wbc count		A					
85008	Bl smear w/o diff wbc count		A					
85009	Manual diff wbc count b-coat		A					
85013	Spun microhematocrit		A					
85014	Hematocrit		A					
85018	Hemoglobin		A					
85025	Complete cbc w/auto diff wbc		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85027	Complete cbc, automated		A					
85032	Manual cell count, each		A					
85041	Automated rbc count		A					
85044	Manual reticulocyte count		A					
85045	Automated reticulocyte count		A					
85046	Reticyte/hgb concentrate		A					
85048	Automated leukocyte count		A					
85049	Automated platelet count		A					
85055	Reticulated platelet assay		A					
85060	Blood smear interpretation		B					
85097	Bone marrow interpretation		X	0343	0.5351	$36.53	$10.84	$7.31
85130	Chromogenic substrate assay		A					
85170	Blood clot retraction		A					
85175	Blood clot lysis time		A					
85210	Blood clot factor II test		A					
85220	Blood clot factor V test		A					
85230	Blood clot factor VII test		A					
85240	Blood clot factor VIII test		A					
85244	Blood clot factor VIII test		A					
85245	Blood clot factor VIII test		A					
85246	Blood clot factor VIII test		A					
85247	Blood clot factor VIII test		A					
85250	Blood clot factor IX test		A					
85260	Blood clot factor X test		A					
85270	Blood clot factor XI test		A					
85280	Blood clot factor XII test		A					
85290	Blood clot factor XIII test		A					
85291	Blood clot factor XIII test		A					
85292	Blood clot factor assay		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85293	Blood clot factor assay		A					
85300	Antithrombin III test		A					
85301	Antithrombin III test		A					
85302	Blood clot inhibitor antigen		A					
85303	Blood clot inhibitor test		A					
85305	Blood clot inhibitor assay		A					
85306	Blood clot inhibitor test		A					
85307	Assay activated protein c		A					
85335	Factor inhibitor test		A					
85337	Thrombomodulin		A					
85345	Coagulation time		A					
85347	Coagulation time		A					
85348	Coagulation time		A					
85360	Euglobulin lysis		A					
85362	Fibrin degradation products		A					
85366	Fibrinogen test		A					
85370	Fibrinogen test		A					
85378	Fibrin degrade, semiquant		A					
85379	Fibrin degradation, quant		A					
85380	Fibrin degradation, vte		A					
85384	Fibrinogen		A					
85385	Fibrinogen		A					
85390	Fibrinolysins screen		A					
85396	Clotting assay, whole blood		N					
85397	Clotting funct activity		A					
85400	Fibrinolytic plasmin		A					
85410	Fibrinolytic antiplasmin		A					
85415	Fibrinolytic plasminogen		A					
85420	Fibrinolytic plasminogen		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85421	Fibrinolytic plasminogen		A					
85441	Heinz bodies, direct		A					
85445	Heinz bodies, induced		A					
85460	Hemoglobin, fetal		A					
85461	Hemoglobin, fetal		A					
85475	Hemolysin		A					
85520	Heparin assay		A					
85525	Heparin neutralization		A					
85530	Heparin-protamine tolerance		A					
85536	Iron stain peripheral blood		A					
85540	Wbc alkaline phosphatase		A					
85547	RBC mechanical fragility		A					
85549	Muramidase		A					
85555	RBC osmotic fragility		A					
85557	RBC osmotic fragility		A					
85576	Blood platelet aggregation		A					
85597	Platelet neutralization		A					
85610	Prothrombin time		A					
85611	Prothrombin test		A					
85612	Viper venom prothrombin time		A					
85613	Russell viper venom, diluted		A					
85635	Reptilase test		A					
85651	Rbc sed rate, nonautomated		A					
85652	Rbc sed rate, automated		A					
85660	RBC sickle cell test		A					
85670	Thrombin time, plasma		A					
85675	Thrombin time, titer		A					
85705	Thromboplastin inhibition		A					
85730	Thromboplastin time, partial		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85732	Thromboplastin time, partial		A					
85810	Blood viscosity examination		A					
85999	Hematology procedure		A					
86000	Agglutinins, febrile		A					
86001	Allergen specific igg		A					
86003	Allergen specific IgE		A					
86005	Allergen specific IgE		A					
86021	WBC antibody identification		A					
86022	Platelet antibodies		A					
86023	Immunoglobulin assay		A					
86038	Antinuclear antibodies		A					
86039	Antinuclear antibodies (ANA)		A					
86060	Antistreptolysin o, titer		A					
86063	Antistreptolysin o, screen		A					
86077	Physician blood bank service		X	0433	0.2465	$16.83	$5.17	$3.37
86078	Physician blood bank service		X	0343	0.5351	$36.53	$10.84	$7.31
86079	Physician blood bank service		X	0433	0.2465	$16.83	$5.17	$3.37
86140	C-reactive protein		A					
86141	C-reactive protein, hs		A					
86146	Glycoprotein antibody		A					
86147	Cardiolipin antibody		A					
86148	Phospholipid antibody		A					
86155	Chemotaxis assay		A					
86156	Cold agglutinin, screen		A					
86157	Cold agglutinin, titer		A					
86160	Complement, antigen		A					
86161	Complement/function activity		A					
86162	Complement, total (CH50)		A					
86171	Complement fixation, each		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86185	Counterimmunoelectrophoresis		A					
86200	Ccp antibody		A					
86215	Deoxyribonuclease, antibody		A					
86225	DNA antibody		A					
86226	DNA antibody, single strand		A					
86235	Nuclear antigen antibody		A					
86243	Fc receptor		A					
86255	Fluorescent antibody, screen		A					
86256	Fluorescent antibody, titer		A					
86277	Growth hormone antibody		A					
86280	Hemagglutination inhibition		A					
86294	Immunoassay, tumor, qual		A					
86300	Immunoassay, tumor, ca 15-3		A					
86301	Immunoassay, tumor, ca 19-9		A					
86304	Immunoassay, tumor, ca 125		A					
86305	Human epididymis protein 4		A					
86308	Heterophile antibodies		A					
86309	Heterophile antibodies		A					
86310	Heterophile antibodies		A					
86316	Immunoassay, tumor other		A					
86317	Immunoassay,infectious agent		A					
86318	Immunoassay,infectious agent		A					
86320	Serum immunoelectrophoresis		A					
86325	Other immunoelectrophoresis		A					
86327	Immunoelectrophoresis assay		A					
86329	Immunodiffusion		A					
86331	Immunodiffusion ouchterlony		A					
86332	Immune complex assay		A					
86334	Immunofix e-phoresis, serum		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86335	Immunfix e-phorsis/urine/csf		A					
86336	Inhibin A		A					
86337	Insulin antibodies		A					
86340	Intrinsic factor antibody		A					
86341	Islet cell antibody		A					
86343	Leukocyte histamine release		A					
86344	Leukocyte phagocytosis		A					
86352	Cell function assay w/stim		A					
86353	Lymphocyte transformation		A					
86355	B cells, total count		A					
86356	Mononuclear cell antigen		A					
86357	Nk cells, total count		A					
86359	T cells, total count		A					
86360	T cell, absolute count/ratio		A					
86361	T cell, absolute count		A					
86367	Stem cells, total count		A					
86376	Microsomal antibody		A					
86378	Migration inhibitory factor		A					
86382	Neutralization test, viral		A					
86384	Nitroblue tetrazolium dye		A					
86403	Particle agglutination test		A					
86406	Particle agglutination test		A					
86430	Rheumatoid factor test		A					
86431	Rheumatoid factor, quant		A					
86480	Tb test, cell immun measure		A					
86485	Skin test, candida		X	0341	0.0804	$5.49	$2.09	$1.10
86486	Skin test, nos antigen		X	0341	0.0804	$5.49	$2.09	$1.10
86490	Coccidioidomycosis skin test		X	0341	0.0804	$5.49	$2.09	$1.10
86510	Histoplasmosis skin test		X	0341	0.0804	$5.49	$2.09	$1.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86580	TB intradermal test		X	0341	0.0804	$5.49	$2.09	$1.10
86590	Streptokinase, antibody		A					
86592	Syphilis test non-trep qual		A					
86593	Syphilis test non-trep quant		A					
86602	Antinomyces antibody		A					
86603	Adenovirus antibody		A					
86606	Aspergillus antibody		A					
86609	Bacterium antibody		A					
86611	Bartonella antibody		A					
86612	Blastomyces antibody		A					
86615	Bordetella antibody		A					
86617	Lyme disease antibody		A					
86618	Lyme disease antibody		A					
86619	Borrelia antibody		A					
86622	Brucella antibody		A					
86625	Campylobacter antibody		A					
86628	Candida antibody		A					
86631	Chlamydia antibody		A					
86632	Chlamydia igm antibody		A					
86635	Coccidioides antibody		A					
86638	Q fever antibody		A					
86641	Cryptococcus antibody		A					
86644	CMV antibody		A					
86645	CMV antibody, IgM		A					
86648	Diphtheria antibody		A					
86651	Encephalitis antibody		A					
86652	Encephalitis antibody		A					
86653	Encephalitis antibody		A					
86654	Encephalitis antibody		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86658	Enterovirus antibody		A					
86663	Epstein-barr antibody		A					
86664	Epstein-barr antibody		A					
86665	Epstein-barr antibody		A					
86666	Ehrlichia antibody		A					
86668	Francisella tularensis		A					
86671	Fungus antibody		A					
86674	Giardia lamblia antibody		A					
86677	Helicobacter pylori		A					
86682	Helminth antibody		A					
86684	Hemophilus influenza		A					
86687	Htlv-i antibody		A					
86688	Htlv-ii antibody		A					
86689	HTLV/HIV confirmatory test		A					
86692	Hepatitis, delta agent		A					
86694	Herpes simplex test		A					
86695	Herpes simplex test		A					
86696	Herpes simplex type 2		A					
86698	Histoplasma		A					
86701	HIV-1		A					
86702	HIV-2		A					
86703	HIV-1/HIV-2, single assay		A					
86704	Hep b core antibody, total		A					
86705	Hep b core antibody, igm		A					
86706	Hep b surface antibody		A					
86707	Hep be antibody		A					
86708	Hep a antibody, total		A					
86709	Hep a antibody, igm		A					
86710	Influenza virus antibody		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86713	Legionella antibody		A					
86717	Leishmania antibody		A					
86720	Leptospira antibody		A					
86723	Listeria monocytogenes ab		A					
86727	Lymph choriomeningitis ab		A					
86729	Lympho venereum antibody		A					
86732	Mucormycosis antibody		A					
86735	Mumps antibody		A					
86738	Mycoplasma antibody		A					
86741	Neisseria meningitidis		A					
86744	Nocardia antibody		A					
86747	Parvovirus antibody		A					
86750	Malaria antibody		A					
86753	Protozoa antibody nos		A					
86756	Respiratory virus antibody		A					
86757	Rickettsia antibody		A					
86759	Rotavirus antibody		A					
86762	Rubella antibody		A					
86765	Rubeola antibody		A					
86768	Salmonella antibody		A					
86771	Shigella antibody		A					
86774	Tetanus antibody		A					
86777	Toxoplasma antibody		A					
86778	Toxoplasma antibody, igm		A					
86780	Treponema pallidum		A					
86784	Trichinella antibody		A					
86787	Varicella-zoster antibody		A					
86788	West nile virus ab, igm		A					
86789	West nile virus antibody		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86790	Virus antibody nos		A					
86793	Yersinia antibody		A					
86800	Thyroglobulin antibody		A					
86803	Hepatitis c ab test		A					
86804	Hep c ab test, confirm		A					
86805	Lymphocytotoxicity assay		A					
86806	Lymphocytotoxicity assay		A					
86807	Cytotoxic antibody screening		A					
86808	Cytotoxic antibody screening		A					
86812	HLA typing, A, B, or C		A					
86813	HLA typing, A, B, or C		A					
86816	HLA typing, DR/DQ		A					
86817	HLA typing, DR/DQ		A					
86821	Lymphocyte culture, mixed		A					
86822	Lymphocyte culture, primed		A					
86825	Hla x-match, non-cytotoxic		A					
86826	Hla x-match, non-cyt add-on		A					
86849	Immunology procedure		A					
86850	RBC antibody screen		X	0345	0.2168	$14.80	.	$2.96
86860	RBC antibody elution		X	0346	0.3619	$24.71	.	$4.95
86870	RBC antibody identification		X	0346	0.3619	$24.71	.	$4.95
86880	Coombs test, direct		X	0409	0.1134	$7.74	$2.18	$1.55
86885	Coombs test, indirect, qual		X	0409	0.1134	$7.74	$2.18	$1.55
86886	Coombs test, indirect, titer		X	0409	0.1134	$7.74	$2.18	$1.55
86890	Autologous blood process		X	0347	0.6903	$47.12	$9.43	$9.43
86891	Autologous blood, op salvage		X	0345	0.2168	$14.80	.	$2.96
86900	Blood typing, ABO		X	0409	0.1134	$7.74	$2.18	$1.55
86901	Blood typing, Rh (D)		X	0409	0.1134	$7.74	$2.18	$1.55
86903	Blood typing, antigen screen		X	0345	0.2168	$14.80	.	$2.96

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86904	Blood typing, patient serum		X	0345	0.2168	$14.80	.	$2.96
86905	Blood typing, RBC antigens		X	0345	0.2168	$14.80	.	$2.96
86906	Blood typing, Rh phenotype		X	0345	0.2168	$14.80	.	$2.96
86910	Blood typing, paternity test		E					
86911	Blood typing, antigen system		E					
86920	Compatibility test, spin		X	0345	0.2168	$14.80	.	$2.96
86921	Compatibility test, incubate		X	0345	0.2168	$14.80	.	$2.96
86922	Compatibility test, antiglob		X	0346	0.3619	$24.71	.	$4.95
86923	Compatibility test, electric		X	0345	0.2168	$14.80	.	$2.96
86927	Plasma, fresh frozen		X	0345	0.2168	$14.80	.	$2.96
86930	Frozen blood prep		X	0347	0.6903	$47.12	$9.43	$9.43
86931	Frozen blood thaw		X	0347	0.6903	$47.12	$9.43	$9.43
86932	Frozen blood freeze/thaw		X	0347	0.6903	$47.12	$9.43	$9.43
86940	Hemolysins/agglutinins, auto		A					
86941	Hemolysins/agglutinins		A					
86945	Blood product/irradiation		X	0345	0.2168	$14.80	.	$2.96
86950	Leukacyte transfusion		X	0345	0.2168	$14.80	.	$2.96
86960	Vol reduction of blood/prod		X	0345	0.2168	$14.80	.	$2.96
86965	Pooling blood platelets		X	0346	0.3619	$24.71	.	$4.95
86970	RBC pretreatment		X	0345	0.2168	$14.80	.	$2.96
86971	RBC pretreatment		X	0345	0.2168	$14.80	.	$2.96
86972	RBC pretreatment		X	0345	0.2168	$14.80	.	$2.96
86975	RBC pretreatment, serum		X	0346	0.3619	$24.71	.	$4.95
86976	RBC pretreatment, serum		X	0345	0.2168	$14.80	.	$2.96
86977	RBC pretreatment, serum		X	0347	0.6903	$47.12	$9.43	$9.43
86978	RBC pretreatment, serum		X	0346	0.3619	$24.71	.	$4.95
86985	Split blood or products		X	0345	0.2168	$14.80	.	$2.96
86999	Transfusion procedure		X	0345	0.2168	$14.80	.	$2.96
87001	Small animal inoculation		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87003	Small animal inoculation		A					
87015	Specimen concentration		A					
87040	Blood culture for bacteria		A					
87045	Feces culture, bacteria		A					
87046	Stool cultr, bacteria, each		A					
87070	Culture, bacteria, other		A					
87071	Culture bacteri aerobic othr		A					
87073	Culture bacteria anaerobic		A					
87075	Cultr bacteria, except blood		A					
87076	Culture anaerobe ident, each		A					
87077	Culture aerobic identify		A					
87081	Culture screen only		A					
87084	Culture of specimen by kit		A					
87086	Urine culture/colony count		A					
87088	Urine bacteria culture		A					
87101	Skin fungi culture		A					
87102	Fungus isolation culture		A					
87103	Blood fungus culture		A					
87106	Fungi identification, yeast		A					
87107	Fungi identification, mold		A					
87109	Mycoplasma		A					
87110	Chlamydia culture		A					
87116	Mycobacteria culture		A					
87118	Mycobacteric identification		A					
87140	Culture type immunofluoresc		A					
87143	Culture typing, glc/hplc		A					
87147	Culture type, immunologic		A					
87149	Dna/rna direct probe		A					
87150	Dna/rna, amplified probe		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87152	Culture type pulse field gel		A					
87153	Dna/rna sequencing		A					
87158	Culture typing, added method		A					
87164	Dark field examination		A					
87166	Dark field examination		A					
87168	Macroscopic exam arthropod		A					
87169	Macroscopic exam parasite		A					
87172	Pinworm exam		A					
87176	Tissue homogenization, cultr		A					
87177	Ova and parasites smears		A					
87181	Microbe susceptible, diffuse		A					
87184	Microbe susceptible, disk		A					
87185	Microbe susceptible, enzyme		A					
87186	Microbe susceptible, mic		A					
87187	Microbe susceptible, mlc		A					
87188	Microbe suscept, macrobroth		A					
87190	Microbe suscept, mycobacteri		A					
87197	Bactericidal level, serum		A					
87205	Smear, gram stain		A					
87206	Smear, fluorescent/acid stai		A					
87207	Smear, special stain		A					
87209	Smear, complex stain		A					
87210	Smear, wet mount, saline/ink		A					
87220	Tissue exam for fungi		A					
87230	Assay, toxin or antitoxin		A					
87250	Virus inoculate, eggs/animal		A					
87252	Virus inoculation, tissue		A					
87253	Virus inoculate tissue, addl		A					
87254	Virus inoculation, shell via		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87255	Genet virus isolate, hsv		A					
87260	Adenovirus ag, if		A					
87265	Pertussis ag, if		A					
87267	Enterovirus antibody, dfa		A					
87269	Giardia ag, if		A					
87270	Chlamydia trachomatis ag, if		A					
87271	Cytomegalovirus dfa		A					
87272	Cryptosporidium ag, if		A					
87273	Herpes simplex 2, ag, if		A					
87274	Herpes simplex 1, ag, if		A					
87275	Influenza b, ag, if		A					
87276	Influenza a, ag, if		A					
87277	Legionella micdadei, ag, if		A					
87278	Legion pneumophilia ag, if		A					
87279	Parainfluenza, ag, if		A					
87280	Respiratory syncytial ag, if		A					
87281	Pneumocystis carinii, ag, if		A					
87283	Rubeola, ag, if		A					
87285	Treponema pallidum, ag, if		A					
87290	Varicella zoster, ag, if		A					
87299	Antibody detection, nos, if		A					
87300	Ag detection, polyval, if		A					
87301	Adenovirus ag, eia		A					
87305	Aspergillus ag, eia		A					
87320	Chylmd trach ag, eia		A					
87324	Clostridium ag, eia		A					
87327	Cryptococcus neoform ag, eia		A					
87328	Cryptosporidium ag, eia		A					
87329	Giardia ag, eia		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87332	Cytomegalovirus ag, eia		A					
87335	E coli 0157 ag, eia		A					
87336	Entamoeb hist dispr, ag, eia		A					
87337	Entamoeb hist group, ag, eia		A					
87338	Hpylori, stool, eia		A					
87339	H pylori ag, eia		A					
87340	Hepatitis b surface ag, eia		A					
87341	Hepatitis b surface, ag, eia		A					
87350	Hepatitis be ag, eia		A					
87380	Hepatitis delta ag, eia		A					
87385	Histoplasma capsul ag, eia		A					
87390	Hiv-1 ag, eia		A					
87391	Hiv-2 ag, eia		A					
87400	Influenza a/b, ag, eia		A					
87420	Resp syncytial ag, eia		A					
87425	Rotavirus ag, eia		A					
87427	Shiga-like toxin ag, eia		A					
87430	Strep a ag, eia		A					
87449	Ag detect nos, eia, mult		A					
87450	Ag detect nos, eia, single		A					
87451	Ag detect polyval, eia, mult		A					
87470	Bartonella, dna, dir probe		A					
87471	Bartonella, dna, amp probe		A					
87472	Bartonella, dna, quant		A					
87475	Lyme dis, dna, dir probe		A					
87476	Lyme dis, dna, amp probe		A					
87477	Lyme dis, dna, quant		A					
87480	Candida, dna, dir probe		A					
87481	Candida, dna, amp probe		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87482	Candida, dna, quant		A					
87485	Chylmd pneum, dna, dir probe		A					
87486	Chylmd pneum, dna, amp probe		A					
87487	Chylmd pneum, dna, quant		A					
87490	Chylmd trach, dna, dir probe		A					
87491	Chylmd trach, dna, amp probe		A					
87492	Chylmd trach, dna, quant		A					
87493	C diff amplified probe		A					
87495	Cytomeg, dna, dir probe		A					
87496	Cytomeg, dna, amp probe		A					
87497	Cytomeg, dna, quant		A					
87498	Enterovirus, dna, amp probe		A					
87500	Vanomycin, dna, amp probe		A					
87510	Gardner vag, dna, dir probe		A					
87511	Gardner vag, dna, amp probe		A					
87512	Gardner vag, dna, quant		A					
87515	Hepatitis b, dna, dir probe		A					
87516	Hepatitis b, dna, amp probe		A					
87517	Hepatitis b, dna, quant		A					
87520	Hepatitis c, rna, dir probe		A					
87521	Hepatitis c, rna, amp probe		A					
87522	Hepatitis c, rna, quant		A					
87525	Hepatitis g, dna, dir probe		A					
87526	Hepatitis g, dna, amp probe		A					
87527	Hepatitis g, dna, quant		A					
87528	Hsv, dna, dir probe		A					
87529	Hsv, dna, amp probe		A					
87530	Hsv, dna, quant		A					
87531	Hhv-6, dna, dir probe		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87532	Hhv-6, dna, amp probe		A					
87533	Hhv-6, dna, quant		A					
87534	Hiv-1, dna, dir probe		A					
87535	Hiv-1, dna, amp probe		A					
87536	Hiv-1, dna, quant		A					
87537	Hiv-2, dna, dir probe		A					
87538	Hiv-2, dna, amp probe		A					
87539	Hiv-2, dna, quant		A					
87540	Legion pneumo, dna, dir prob		A					
87541	Legion pneumo, dna, amp prob		A					
87542	Legion pneumo, dna, quant		A					
87550	Mycobacteria, dna, dir probe		A					
87551	Mycobacteria, dna, amp probe		A					
87552	Mycobacteria, dna, quant		A					
87555	M.tuberculo, dna, dir probe		A					
87556	M.tuberculo, dna, amp probe		A					
87557	M.tuberculo, dna, quant		A					
87560	M.avium-intra, dna, dir prob		A					
87561	M.avium-intra, dna, amp prob		A					
87562	M.avium-intra, dna, quant		A					
87580	M.pneumon, dna, dir probe		A					
87581	M.pneumon, dna, amp probe		A					
87582	M.pneumon, dna, quant		A					
87590	N.gonorrhoeae, dna, dir prob		A					
87591	N.gonorrhoeae, dna, amp prob		A					
87592	N.gonorrhoeae, dna, quant		A					
87620	Hpv, dna, dir probe		A					
87621	Hpv, dna, amp probe		A					
87622	Hpv, dna, quant		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87640	Staph a, dna, amp probe		A					
87641	Mr-staph, dna, amp probe		A					
87650	Strep a, dna, dir probe		A					
87651	Strep a, dna, amp probe		A					
87652	Strep a, dna, quant		A					
87653	Strep b, dna, amp probe		A					
87660	Trichomonas vagin, dir probe		A					
87797	Detect agent nos, dna, dir		A					
87798	Detect agent nos, dna, amp		A					
87799	Detect agent nos, dna, quant		A					
87800	Detect agnt mult, dna, direc		A					
87801	Detect agnt mult, dna, ampli		A					
87802	Strep b assay w/optic		A					
87803	Clostridium toxin a w/optic		A					
87804	Influenza assay w/optic		A					
87807	Rsv assay w/optic		A					
87808	Trichomonas assay w/optic		A					
87809	Adenovirus assay w/optic		A					
87810	Chylmd trach assay w/optic		A					
87850	N. gonorrhoeae assay w/optic		A					
87880	Strep a assay w/optic		A					
87899	Agent nos assay w/optic		A					
87900	Phenotype, infect agent drug		A					
87901	Genotype, dna, hiv reverse t		A					
87902	Genotype, dna, hepatitis C		A					
87903	Phenotype, dna hiv w/culture		A					
87904	Phenotype, dna hiv w/clt add		A					
87905	Sialidase enzyme assay		A					
87999	Microbiology procedure		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88000	Autopsy (necropsy), gross		E					
88005	Autopsy (necropsy), gross		E					
88007	Autopsy (necropsy), gross		E					
88012	Autopsy (necropsy), gross		E					
88014	Autopsy (necropsy), gross		E					
88016	Autopsy (necropsy), gross		E					
88020	Autopsy (necropsy), complete		E					
88025	Autopsy (necropsy), complete		E					
88027	Autopsy (necropsy), complete		E					
88028	Autopsy (necropsy), complete		E					
88029	Autopsy (necropsy), complete		E					
88036	Limited autopsy		E					
88037	Limited autopsy		E					
88040	Forensic autopsy (necropsy)		E					
88045	Coroners autopsy (necropsy)		E					
88099	Necropsy (autopsy) procedure		E					
88104	Cytopath fl nongyn, smears		X	0433	0.2465	$16.83	$5.17	$3.37
88106	Cytopath fl nongyn, filter		X	0433	0.2465	$16.83	$5.17	$3.37
88107	Cytopath fl nongyn, sm/fltr		X	0343	0.5351	$36.53	$10.84	$7.31
88108	Cytopath, concentrate tech		X	0433	0.2465	$16.83	$5.17	$3.37
88112	Cytopath, cell enhance tech		X	0343	0.5351	$36.53	$10.84	$7.31
88125	Forensic cytopathology		X	0433	0.2465	$16.83	$5.17	$3.37
88130	Sex chromatin identification		A					
88140	Sex chromatin identification		A					
88141	Cytopath, c/v, interpret		N					
88142	Cytopath, c/v, thin layer		A					
88143	Cytopath c/v thin layer redo		A					
88147	Cytopath, c/v, automated		A					
88148	Cytopath, c/v, auto rescreen		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88150	Cytopath, c/v, manual		A					
88152	Cytopath, c/v, auto redo		A					
88153	Cytopath, c/v, redo		A					
88154	Cytopath, c/v, select		A					
88155	Cytopath, c/v, index add-on		A					
88160	Cytopath smear, other source		X	0433	0.2465	$16.83	$5.17	$3.37
88161	Cytopath smear, other source		X	0433	0.2465	$16.83	$5.17	$3.37
88162	Cytopath smear, other source		X	0343	0.5351	$36.53	$10.84	$7.31
88164	Cytopath tbs, c/v, manual		A					
88165	Cytopath tbs, c/v, redo		A					
88166	Cytopath tbs, c/v, auto redo		A					
88167	Cytopath tbs, c/v, select		A					
88172	Cytopathology eval of fna		X	0343	0.5351	$36.53	$10.84	$7.31
88173	Cytopath eval, fna, report		X	0343	0.5351	$36.53	$10.84	$7.31
88174	Cytopath, c/v auto, in fluid		A					
88175	Cytopath c/v auto fluid redo		A					
88182	Cell marker study		X	0343	0.5351	$36.53	$10.84	$7.31
88184	Flowcytometry/ tc, 1 marker		X	0433	0.2465	$16.83	$5.17	$3.37
88185	Flowcytometry/tc, add-on		X	0433	0.2465	$16.83	$5.17	$3.37
88187	Flowcytometry/read, 2-8		X	0342	0.1596	$10.90	.	$2.18
88188	Flowcytometry/read, 9-15		X	0343	0.5351	$36.53	$10.84	$7.31
88189	Flowcytometry/read, 16 & >		X	0343	0.5351	$36.53	$10.84	$7.31
88199	Cytopathology procedure		X	0342	0.1596	$10.90	.	$2.18
88230	Tissue culture, lymphocyte		A					
88233	Tissue culture, skin/biopsy		A					
88235	Tissue culture, placenta		A					
88237	Tissue culture, bone marrow		A					
88239	Tissue culture, tumor		A					
88240	Cell cryopreserve/storage		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88241	Frozen cell preparation		A					
88245	Chromosome analysis, 20-25		A					
88248	Chromosome analysis, 50-100		A					
88249	Chromosome analysis, 100		A					
88261	Chromosome analysis, 5		A					
88262	Chromosome analysis, 15-20		A					
88263	Chromosome analysis, 45		A					
88264	Chromosome analysis, 20-25		A					
88267	Chromosome analys, placenta		A					
88269	Chromosome analys, amniotic		A					
88271	Cytogenetics, dna probe		A					
88272	Cytogenetics, 3-5		A					
88273	Cytogenetics, 10-30		A					
88274	Cytogenetics, 25-99		A					
88275	Cytogenetics, 100-300		A					
88280	Chromosome karyotype study		A					
88283	Chromosome banding study		A					
88285	Chromosome count, additional		A					
88289	Chromosome study, additional		A					
88291	Cyto/molecular report		M					
88299	Cytogenetic study		X	0342	0.1596	$10.90	.	$2.18
88300	Surgical path, gross		X	0433	0.2465	$16.83	$5.17	$3.37
88302	Tissue exam by pathologist		X	0433	0.2465	$16.83	$5.17	$3.37
88304	Tissue exam by pathologist		X	0343	0.5351	$36.53	$10.84	$7.31
88305	Tissue exam by pathologist		X	0343	0.5351	$36.53	$10.84	$7.31
88307	Tissue exam by pathologist		X	0344	0.8227	$56.16	$15.56	$11.24
88309	Tissue exam by pathologist		X	0344	0.8227	$56.16	$15.56	$11.24
88311	Decalcify tissue		X	0342	0.1596	$10.90	.	$2.18
88312	Special stains group 1		X	0433	0.2465	$16.83	$5.17	$3.37

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88313	Special stains group 2		X	0433	0.2465	$16.83	$5.17	$3.37
88314	Histochemical stain add-on		X	0433	0.2465	$16.83	$5.17	$3.37
88318	Chemical histochemistry		X	0433	0.2465	$16.83	$5.17	$3.37
88319	Enzyme histochemistry		X	0344	0.8227	$56.16	$15.56	$11.24
88321	Microslide consultation		X	0433	0.2465	$16.83	$5.17	$3.37
88323	Microslide consultation		X	0343	0.5351	$36.53	$10.84	$7.31
88325	Comprehensive review of data		X	0344	0.8227	$56.16	$15.56	$11.24
88329	Path consult introp		X	0433	0.2465	$16.83	$5.17	$3.37
88331	Path consult intraop, 1 bloc		X	0343	0.5351	$36.53	$10.84	$7.31
88332	Path consult intraop, addl		X	0433	0.2465	$16.83	$5.17	$3.37
88333	Intraop cyto path consult, 1		X	0433	0.2465	$16.83	$5.17	$3.37
88334	Intraop cyto path consult, 2		X	0433	0.2465	$16.83	$5.17	$3.37
88342	Immunohistochemistry		X	0343	0.5351	$36.53	$10.84	$7.31
88346	Immunofluorescent study		X	0343	0.5351	$36.53	$10.84	$7.31
88347	Immunofluorescent study		X	0343	0.5351	$36.53	$10.84	$7.31
88348	Electron microscopy		X	0661	2.3687	$161.70	.	$32.34
88349	Scanning electron microscopy		X	0661	2.3687	$161.70	.	$32.34
88355	Analysis, skeletal muscle		X	0343	0.5351	$36.53	$10.84	$7.31
88356	Analysis, nerve		X	0344	0.8227	$56.16	$15.56	$11.24
88358	Analysis, tumor		X	0343	0.5351	$36.53	$10.84	$7.31
88360	Tumor immunohistochem/manual		X	0343	0.5351	$36.53	$10.84	$7.31
88361	Tumor immunohistochem/comput		X	0344	0.8227	$56.16	$15.56	$11.24
88362	Nerve teasing preparations		X	0344	0.8227	$56.16	$15.56	$11.24
88365	Insitu hybridization (fish)		X	0344	0.8227	$56.16	$15.56	$11.24
88367	Insitu hybridization, auto		X	0344	0.8227	$56.16	$15.56	$11.24
88368	Insitu hybridization, manual		X	0344	0.8227	$56.16	$15.56	$11.24
88371	Protein, western blot tissue		A					
88372	Protein analysis w/probe		A					
88380	Microdissection, laser		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88381	Microdissection, manual		N					
88384	Eval molecular probes, 11-50		X	0433	0.2465	$16.83	$5.17	$3.37
88385	Eval molecul probes, 51-250		X	0343	0.5351	$36.53	$10.84	$7.31
88386	Eval molecul probes, 251-500		X	0344	0.8227	$56.16	$15.56	$11.24
88387	Tiss exam molecular study		N					
88388	Tiss ex molecul study add-on		N					
88399	Surgical pathology procedure		X	0342	0.1596	$10.90	.	$2.18
88720	Bilirubin total transcut		A					
88738	Hgb quant transcutaneous		A					
88740	Transcutaneous carboxyhb		A					
88741	Transcutaneous methb		A					
89049	Chct for mal hyperthermia		X	0342	0.1596	$10.90	.	$2.18
89050	Body fluid cell count		A					
89051	Body fluid cell count		A					
89055	Leukocyte assessment, fecal		A					
89060	Exam,synovial fluid crystals		A					
89100	Sample intestinal contents		X	0360	1.7011	$116.13	$33.88	$23.23
89105	Sample intestinal contents		X	0360	1.7011	$116.13	$33.88	$23.23
89125	Specimen fat stain		A					
89130	Sample stomach contents		X	0360	1.7011	$116.13	$33.88	$23.23
89132	Sample stomach contents		X	0360	1.7011	$116.13	$33.88	$23.23
89135	Sample stomach contents		X	0360	1.7011	$116.13	$33.88	$23.23
89136	Sample stomach contents		X	0360	1.7011	$116.13	$33.88	$23.23
89140	Sample stomach contents		X	0360	1.7011	$116.13	$33.88	$23.23
89141	Sample stomach contents		X	0360	1.7011	$116.13	$33.88	$23.23
89160	Exam feces for meat fibers		A					
89190	Nasal smear for eosinophils		A					
89220	Sputum specimen collection		X	0433	0.2465	$16.83	$5.17	$3.37
89225	Starch granules, feces		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
89230	Collect sweat for test		X	0343	0.5351	$36.53	$10.84	$7.31
89235	Water load test		A					
89240	Pathology lab procedure		X	0342	0.1596	$10.90	.	$2.18
89250	Cultr oocyte/embryo <4 days		X	0344	0.8227	$56.16	$15.56	$11.24
89251	Cultr oocyte/embryo <4 days		X	0344	0.8227	$56.16	$15.56	$11.24
89253	Embryo hatching		X	0344	0.8227	$56.16	$15.56	$11.24
89254	Oocyte identification		X	0344	0.8227	$56.16	$15.56	$11.24
89255	Prepare embryo for transfer		X	0344	0.8227	$56.16	$15.56	$11.24
89257	Sperm identification		X	0344	0.8227	$56.16	$15.56	$11.24
89258	Cryopreservation; embryo(s)		X	0344	0.8227	$56.16	$15.56	$11.24
89259	Cryopreservation, sperm		X	0344	0.8227	$56.16	$15.56	$11.24
89260	Sperm isolation, simple		X	0344	0.8227	$56.16	$15.56	$11.24
89261	Sperm isolation, complex		X	0344	0.8227	$56.16	$15.56	$11.24
89264	Identify sperm tissue		X	0344	0.8227	$56.16	$15.56	$11.24
89268	Insemination of oocytes		X	0344	0.8227	$56.16	$15.56	$11.24
89272	Extended culture of oocytes		X	0344	0.8227	$56.16	$15.56	$11.24
89280	Assist oocyte fertilization		X	0344	0.8227	$56.16	$15.56	$11.24
89281	Assist oocyte fertilization		X	0344	0.8227	$56.16	$15.56	$11.24
89290	Biopsy, oocyte polar body		X	0344	0.8227	$56.16	$15.56	$11.24
89291	Biopsy, oocyte polar body		X	0344	0.8227	$56.16	$15.56	$11.24
89300	Semen analysis w/huhner		A					
89310	Semen analysis w/count		A					
89320	Semen anal vol/count/mot		A					
89321	Semen anal, sperm detection		A					
89322	Semen anal, strict criteria		A					
89325	Sperm antibody test		A					
89329	Sperm evaluation test		A					
89330	Evaluation, cervical mucus		A					
89331	Retrograde ejaculation anal		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
89335	Cryopreserve testicular tiss		X	0344	0.8227	$56.16	$15.56	$11.24
89342	Storage/year; embryo(s)		X	0344	0.8227	$56.16	$15.56	$11.24
89343	Storage/year; sperm/semen		X	0344	0.8227	$56.16	$15.56	$11.24
89344	Storage/year; reprod tissue		X	0344	0.8227	$56.16	$15.56	$11.24
89346	Storage/year; oocyte(s)		X	0344	0.8227	$56.16	$15.56	$11.24
89352	Thawing cryopresrved; embryo		X	0344	0.8227	$56.16	$15.56	$11.24
89353	Thawing cryopresrved; sperm		X	0344	0.8227	$56.16	$15.56	$11.24
89354	Thaw cryoprsvrd; reprod tiss		X	0344	0.8227	$56.16	$15.56	$11.24
89356	Thawing cryopresrved; oocyte		X	0344	0.8227	$56.16	$15.56	$11.24
89398	Unlisted reprod med lab proc		X	0342	0.1596	$10.90	.	$2.18
90281	Human ig, im		E					
90283	Human ig, iv		E					
90284	Human ig, sc		E					
90287	Botulinum antitoxin		E					
90288	Botulism ig, iv		E					
90291	Cmv ig, iv		E					
90296	Diphtheria antitoxin		E					
90371	Hep b ig, im		K	1630		$115.97	.	$23.20
90375	Rabies ig, im/sc		K	9133		$139.75	.	$27.95
90376	Rabies ig, heat treated		K	9134		$152.38	.	$30.48
90378	Rsv, mab, im, 50mg		K	9003		$510.69	.	$102.14
90384	Rh ig, full-dose, im		E					
90385	Rh ig, minidose, im		N					
90386	Rh ig, iv		E					
90389	Tetanus ig, im		E					
90393	Vaccina ig, im		E					
90396	Varicella-zoster ig, im		K	9135		$147.58	.	$29.52
90399	Immune globulin		E					
90465	Immune admin 1 inj, < 8 yrs		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90466	Immune admin addl inj, < 8 y		B					
90467	Immune admin o or n, < 8 yrs		B					
90468	Immune admin o/n, addl < 8 y		B					
90470	Immune admin H1N1 im/nasal		E					
90471	Immunization admin		S	0436	0.3853	$26.30	.	$5.26
90472	Immunization admin, each add		S	0436	0.3853	$26.30	.	$5.26
90473	Immune admin oral/nasal		S	0436	0.3853	$26.30	.	$5.26
90474	Immune admin oral/nasal addl		S	0436	0.3853	$26.30	.	$5.26
90476	Adenovirus vaccine, type 4		K	1254		$173.84	.	$34.77
90477	Adenovirus vaccine, type 7		E					
90581	Anthrax vaccine, sc		E					
90585	Bcg vaccine, percut		K	9137		$109.47	.	$21.90
90586	Bcg vaccine, intravesical		B					
90632	Hep a vaccine, adult im		N					
90633	Hep a vacc, ped/adol, 2 dose		N					
90634	Hep a vacc, ped/adol, 3 dose		N					
90636	Hep a/hep b vacc, adult im		N					
90644	HIB/men/tt vaccine, im		E					
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	Hpv vaccine 4 valent, im		M					
90650	Hpv vaccine 2 valent, im		M					
90655	Flu vaccine no preserv 6-35m		L					
90656	Flu vaccine no preserv 3 & >		L					
90657	Flu vaccine, 3 yrs, im		L					
90658	Flu vaccine, 3 yrs & >, im		L					
90660	Flu vaccine, nasal		L					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90661	Flu vacc cell cult prsv free		E					
90662	Flu vacc prsv free inc antig		E					
90663	Flu vacc pandemic H1N1		E					
90665	Lyme disease vaccine, im	CH	N					
90669	Pneumococcal vacc, 7 val im		L					
90670	Pneumococcal vacc, 13 val im	CH	L					
90675	Rabies vaccine, im		K	9139		$181.27	.	$36.26
90676	Rabies vaccine, id		K	9140		$98.12	.	$19.63
90680	Rotovirus vacc 3 dose, oral		K	1255		$73.76	.	$14.76
90681	Rotavirus vacc 2 dose oral		K	1239		$102.50	.	$20.50
90690	Typhoid vaccine, oral		N					
90691	Typhoid vaccine, im		N					
90692	Typhoid vaccine, h-p, sc/id		N					
90693	Typhoid vaccine, akd, sc		B					
90696	Dtap-ipv vacc 4-6 yr im		N					
90698	Dtap-hib-ip vaccine, im		N					
90700	Dtap vaccine, < 7 yrs, im		N					
90701	Dtp vaccine, im		N					
90702	Dt vaccine < 7, im		N					
90703	Tetanus vaccine, im		N					
90704	Mumps vaccine, sc		N					
90705	Measles vaccine, sc		N					
90706	Rubella vaccine, sc		N					
90707	Mmr vaccine, sc		N					
90708	Measles-rubella vaccine, sc		N					
90710	Mmrv vaccine, sc		N					
90712	Oral poliovirus vaccine		N					
90713	Poliovirus, ipv, sc/im		N					
90714	Td vaccine no prsrv >/= 7 im		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90715	Tdap vaccine >7 im		N					
90716	Chicken pox vaccine, sc		M					
90717	Yellow fever vaccine, sc		N					
90718	Td vaccine > 7, im		N					
90719	Diphtheria vaccine, im		N					
90720	Dtp/hib vaccine, im		N					
90721	Dtap/hib vaccine, im		N					
90723	Dtap-hep b-ipv vaccine, im		E					
90725	Cholera vaccine, injectable		K	1271		$103.90	.	$20.78
90727	Plague vaccine, im		E					
90732	Pneumococcal vaccine		L					
90733	Meningococcal vaccine, sc		K	9143		$103.41	.	$20.69
90734	Meningococcal vaccine, im		K	9145		$103.41	.	$20.69
90735	Encephalitis vaccine, sc		K	9144		$102.08	.	$20.42
90736	Zoster vacc, sc		M					
90738	Inactivated je vacc im		M					
90740	Hepb vacc, ill pat 3 dose im		F					
90743	Hep b vacc, adol, 2 dose, im		F					
90744	Hepb vacc ped/adol 3 dose im		F					
90746	Hep b vaccine, adult, im		F					
90747	Hepb vacc, ill pat 4 dose im		F					
90748	Hep b/hib vaccine, im		E					
90749	Vaccine toxoid		N					
90801	Psy dx interview		Q3	0323	1.6309	$111.34	.	$22.27
90802	Intac psy dx interview		Q3	0323	1.6309	$111.34	.	$22.27
90804	Psytx, office, 20-30 min		Q3	0322	1.1744	$80.17	.	$16.04
90805	Psytx, off, 20-30 min w/e&m		Q3	0322	1.1744	$80.17	.	$16.04
90806	Psytx, off, 45-50 min		Q3	0323	1.6309	$111.34	.	$22.27
90807	Psytx, off, 45-50 min w/e&m		Q3	0323	1.6309	$111.34	.	$22.27

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90808	Psytx, office, 75-80 min		Q3	0323	1.6309	$111.34	.	$22.27
90809	Psytx, off, 75-80, w/e&m		Q3	0323	1.6309	$111.34	.	$22.27
90810	Intac psytx, off, 20-30 min		Q3	0322	1.1744	$80.17	.	$16.04
90811	Intac psytx, 20-30, w/e&m		Q3	0322	1.1744	$80.17	.	$16.04
90812	Intac psytx, off, 45-50 min		Q3	0323	1.6309	$111.34	.	$22.27
90813	Intac psytx, 45-50 min w/e&m		Q3	0323	1.6309	$111.34	.	$22.27
90814	Intac psytx, off, 75-80 min		Q3	0323	1.6309	$111.34	.	$22.27
90815	Intac psytx, 75-80 w/e&m		Q3	0323	1.6309	$111.34	.	$22.27
90816	Psytx, hosp, 20-30 min		P					
90817	Psytx, hosp, 20-30 min w/e&m		P					
90818	Psytx, hosp, 45-50 min		P					
90819	Psytx, hosp, 45-50 min w/e&m		P					
90821	Psytx, hosp, 75-80 min		P					
90822	Psytx, hosp, 75-80 min w/e&m		P					
90823	Intac psytx, hosp, 20-30 min		P					
90824	Intac psytx, hsp 20-30 w/e&m		P					
90826	Intac psytx, hosp, 45-50 min		P					
90827	Intac psytx, hsp 45-50 w/e&m		P					
90828	Intac psytx, hosp, 75-80 min		P					
90829	Intac psytx, hsp 75-80 w/e&m		P					
90845	Psychoanalysis		Q3	0323	1.6309	$111.34	.	$22.27
90846	Family psytx w/o patient		Q3	0324	1.8392	$125.56	.	$25.12
90847	Family psytx w/patient		Q3	0324	1.8392	$125.56	.	$25.12
90849	Multiple family group psytx		Q3	0325	0.788	$53.79	$11.47	$10.76
90853	Group psychotherapy		Q3	0325	0.788	$53.79	$11.47	$10.76
90857	Intac group psytx		Q3	0325	0.788	$53.79	$11.47	$10.76
90862	Medication management	CH	Q3	0605	1.0573	$72.18	.	$14.44
90865	Narcosynthesis		Q3	0323	1.6309	$111.34	.	$22.27
90870	Electroconvulsive therapy		S	0320	6.0291	$411.59	.	$82.32

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90875	Psychophysiological therapy		E					
90876	Psychophysiological therapy		E					
90880	Hypnotherapy		Q3	0323	1.6309	$111.34	.	$22.27
90882	Environmental manipulation		E					
90885	Psy evaluation of records		N					
90887	Consultation with family		N					
90889	Preparation of report		N					
90899	Psychiatric service/therapy		Q3	0322	1.1744	$80.17	.	$16.04
90901	Biofeedback train, any meth		A					
90911	Biofeedback peri/uro/rectal		T	0126	1.0983	$74.98	$16.21	$15.00
90935	Hemodialysis, one evaluation		S	0170	7.0059	$478.27	.	$95.66
90937	Hemodialysis, repeated eval		B					
90940	Hemodialysis access study		N					
90945	Dialysis, one evaluation		V	0608	2.4657	$168.33	.	$33.67
90947	Dialysis, repeated eval		B					
90951	Esrd serv, 4 visits p mo, <2		M					
90952	Esrd serv, 2-3 vsts p mo, <2		M					
90953	Esrd serv, 1 visit p mo, <2		M					
90954	Esrd serv, 4 vsts p mo, 2-11		M					
90955	Esrd srv 2-3 vsts p mo, 2-11		M					
90956	Esrd srv, 1 visit p mo, 2-11		M					
90957	Esrd srv, 4 vsts p mo, 12-19		M					
90958	Esrd srv 2-3 vsts p mo 12-19		M					
90959	Esrd serv, 1 vst p mo, 12-19		M					
90960	Esrd srv, 4 visits p mo, 20+		M					
90961	Esrd srv, 2-3 vsts p mo, 20+		M					
90962	Esrd serv, 1 visit p mo, 20+		M					
90963	Esrd home pt, serv p mo, <2		M					
90964	Esrd home pt serv p mo, 2-11		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90965	Esrd home pt serv p mo 12-19		M					
90966	Esrd home pt, serv p mo, 20+		M					
90967	Esrd home pt serv p day, <2		M					
90968	Esrd home pt srv p day, 2-11		M					
90969	Esrd home pt srv p day 12-19		M					
90970	Esrd home pt serv p day, 20+		M					
90989	Dialysis training, complete		B					
90993	Dialysis training, incompl		B					
90997	Hemoperfusion		B					
90999	Dialysis procedure		B					
91000	Esophageal intubation		X	0361	4.0753	$278.21	$83.23	$55.65
91010	Esophagus motility study		X	0361	4.0753	$278.21	$83.23	$55.65
91011	Esophagus motility study		X	0361	4.0753	$278.21	$83.23	$55.65
91012	Esophagus motility study		X	0361	4.0753	$278.21	$83.23	$55.65
91020	Gastric motility studies		X	0361	4.0753	$278.21	$83.23	$55.65
91022	Duodenal motility study		X	0361	4.0753	$278.21	$83.23	$55.65
91030	Acid perfusion of esophagus		X	0361	4.0753	$278.21	$83.23	$55.65
91034	Gastroesophageal reflux test		X	0361	4.0753	$278.21	$83.23	$55.65
91035	G-esoph reflx tst w/electrod		X	0361	4.0753	$278.21	$83.23	$55.65
91037	Esoph imped function test	CH	X	0360	1.7011	$116.13	$33.88	$23.23
91038	Esoph imped funct test > 1h		X	0361	4.0753	$278.21	$83.23	$55.65
91040	Esoph balloon distension tst		X	0360	1.7011	$116.13	$33.88	$23.23
91052	Gastric analysis test		X	0361	4.0753	$278.21	$83.23	$55.65
91055	Gastric intubation for smear		X	0360	1.7011	$116.13	$33.88	$23.23
91065	Breath hydrogen test		X	0360	1.7011	$116.13	$33.88	$23.23
91105	Gastric intubation treatment	CH	T	0250	1.1743	$80.17	$25.10	$16.04
91110	Gi tract capsule endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
91111	Esophageal capsule endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
91120	Rectal sensation test		T	0126	1.0983	$74.98	$16.21	$15.00

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
91122	Anal pressure record		T	0156	3.0859	$210.67	.	$42.14
91123	Irrigate fecal impaction		N					
91132	Electrogastrography		X	0360	1.7011	$116.13	$33.88	$23.23
91133	Electrogastrography w/test		X	0360	1.7011	$116.13	$33.88	$23.23
91299	Gastroenterology procedure		X	0360	1.7011	$116.13	$33.88	$23.23
92002	Eye exam, new patient		V	0606	1.365	$93.18	.	$18.64
92004	Eye exam, new patient		V	0606	1.365	$93.18	.	$18.64
92012	Eye exam established pat	CH	V	0605	1.0573	$72.18	.	$14.44
92014	Eye exam & treatment		V	0605	1.0573	$72.18	.	$14.44
92015	Refraction		E					
92018	New eye exam & treatment		T	0699	16.6419	$1,136.09	.	$227.22
92019	Eye exam & treatment		T	0699	16.6419	$1,136.09	.	$227.22
92020	Special eye evaluation		S	0230	0.5913	$40.37	.	$8.08
92025	Corneal topography		S	0698	0.9316	$63.60	.	$12.72
92060	Special eye evaluation		S	0698	0.9316	$63.60	.	$12.72
92065	Orthoptic/pleoptic training		S	0698	0.9316	$63.60	.	$12.72
92070	Fitting of contact lens		N					
92081	Visual field examination(s)		S	0230	0.5913	$40.37	.	$8.08
92082	Visual field examination(s)		S	0698	0.9316	$63.60	.	$12.72
92083	Visual field examination(s)		S	0698	0.9316	$63.60	.	$12.72
92100	Serial tonometry exam(s)		N					
92120	Tonography & eye evaluation		S	0698	0.9316	$63.60	.	$12.72
92130	Water provocation tonography		S	0230	0.5913	$40.37	.	$8.08
92135	Ophth dx imaging post seg		S	0230	0.5913	$40.37	.	$8.08
92136	Ophthalmic biometry		S	0698	0.9316	$63.60	.	$12.72
92140	Glaucoma provocative tests		S	0230	0.5913	$40.37	.	$8.08
92225	Special eye exam, initial		S	0230	0.5913	$40.37	.	$8.08
92226	Special eye exam, subsequent		S	0698	0.9316	$63.60	.	$12.72
92230	Eye exam with photos		S	0231	2.2924	$156.50	.	$31.30

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92235	Eye exam with photos		S	0231	2.2924	$156.50	.	$31.30
92240	Icg angiography		S	0231	2.2924	$156.50	.	$31.30
92250	Eye exam with photos		S	0698	0.9316	$63.60	.	$12.72
92260	Ophthalmoscopy/dynamometry		S	0230	0.5913	$40.37	.	$8.08
92265	Eye muscle evaluation		S	0698	0.9316	$63.60	.	$12.72
92270	Electro-oculography		S	0230	0.5913	$40.37	.	$8.08
92275	Electroretinography		S	0231	2.2924	$156.50	.	$31.30
92283	Color vision examination		S	0230	0.5913	$40.37	.	$8.08
92284	Dark adaptation eye exam		S	0698	0.9316	$63.60	.	$12.72
92285	Eye photography		S	0698	0.9316	$63.60	.	$12.72
92286	Internal eye photography		S	0231	2.2924	$156.50	.	$31.30
92287	Internal eye photography		S	0231	2.2924	$156.50	.	$31.30
92310	Contact lens fitting		E					
92311	Contact lens fitting		S	0698	0.9316	$63.60	.	$12.72
92312	Contact lens fitting		S	0698	0.9316	$63.60	.	$12.72
92313	Contact lens fitting		S	0230	0.5913	$40.37	.	$8.08
92314	Prescription of contact lens		E					
92315	Prescription of contact lens		S	0230	0.5913	$40.37	.	$8.08
92316	Prescription of contact lens		S	0698	0.9316	$63.60	.	$12.72
92317	Prescription of contact lens		S	0230	0.5913	$40.37	.	$8.08
92325	Modification of contact lens		S	0230	0.5913	$40.37	.	$8.08
92326	Replacement of contact lens		S	0698	0.9316	$63.60	.	$12.72
92340	Fitting of spectacles		E					
92341	Fitting of spectacles		E					
92342	Fitting of spectacles		E					
92352	Special spectacles fitting		S	0698	0.9316	$63.60	.	$12.72
92353	Special spectacles fitting		S	0230	0.5913	$40.37	.	$8.08
92354	Special spectacles fitting		S	0230	0.5913	$40.37	.	$8.08
92355	Special spectacles fitting		S	0230	0.5913	$40.37	.	$8.08

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92358	Eye prosthesis service		S	0230	0.5913	$40.37	.	$8.08
92370	Repair & adjust spectacles		E					
92371	Repair & adjust spectacles		S	0230	0.5913	$40.37	.	$8.08
92499	Eye service or procedure		S	0230	0.5913	$40.37	.	$8.08
92502	Ear and throat examination		T	0251	3.4369	$234.63	.	$46.93
92504	Ear microscopy examination		N					
92506	Speech/hearing evaluation		A					
92507	Speech/hearing therapy		A					
92508	Speech/hearing therapy		A					
92511	Nasopharyngoscopy		T	0071	0.9225	$62.98	.	$12.60
92512	Nasal function studies		X	0363	0.8721	$59.54	$16.71	$11.91
92516	Facial nerve function test		X	0660	1.4013	$95.66	$25.67	$19.14
92520	Laryngeal function studies		X	0660	1.4013	$95.66	$25.67	$19.14
92526	Oral function therapy		A					
92531	Spontaneous nystagmus study		N					
92532	Positional nystagmus test		N					
92533	Caloric vestibular test		N					
92534	Optokinetic nystagmus test		N					
92540	Basic vestibular evaluation		X	0660	1.4013	$95.66	$25.67	$19.14
92541	Spontaneous nystagmus test		X	0363	0.8721	$59.54	$16.71	$11.91
92542	Positional nystagmus test		X	0363	0.8721	$59.54	$16.71	$11.91
92543	Caloric vestibular test		X	0660	1.4013	$95.66	$25.67	$19.14
92544	Optokinetic nystagmus test		X	0363	0.8721	$59.54	$16.71	$11.91
92545	Oscillating tracking test		X	0363	0.8721	$59.54	$16.71	$11.91
92546	Sinusoidal rotational test		X	0660	1.4013	$95.66	$25.67	$19.14
92547	Supplemental electrical test		N					
92548	Posturography		X	0660	1.4013	$95.66	$25.67	$19.14
92550	Tympanometry & reflex thresh		X	0364	0.4612	$31.48	$7.03	$6.30
92551	Pure tone hearing test, air		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92552	Pure tone audiometry, air		X	0364	0.4612	$31.48	$7.03	$6.30
92553	Audiometry, air & bone		X	0365	1.2498	$85.32	$18.52	$17.07
92555	Speech threshold audiometry		X	0364	0.4612	$31.48	$7.03	$6.30
92556	Speech audiometry, complete		X	0364	0.4612	$31.48	$7.03	$6.30
92557	Comprehensive hearing test		X	0365	1.2498	$85.32	$18.52	$17.07
92559	Group audiometric testing		E					
92560	Bekesy audiometry, screen		E					
92561	Bekesy audiometry, diagnosis		X	0364	0.4612	$31.48	$7.03	$6.30
92562	Loudness balance test		X	0364	0.4612	$31.48	$7.03	$6.30
92563	Tone decay hearing test		X	0364	0.4612	$31.48	$7.03	$6.30
92564	Sisi hearing test		X	0364	0.4612	$31.48	$7.03	$6.30
92565	Stenger test, pure tone		X	0364	0.4612	$31.48	$7.03	$6.30
92567	Tympanometry		X	0364	0.4612	$31.48	$7.03	$6.30
92568	Acoustic refl threshold tst		X	0364	0.4612	$31.48	$7.03	$6.30
92570	Acoustic immittance testing		X	0364	0.4612	$31.48	$7.03	$6.30
92571	Filtered speech hearing test		X	0364	0.4612	$31.48	$7.03	$6.30
92572	Staggered spondaic word test		X	0366	1.5786	$107.77	$24.61	$21.56
92575	Sensorineural acuity test		X	0364	0.4612	$31.48	$7.03	$6.30
92576	Synthetic sentence test		X	0364	0.4612	$31.48	$7.03	$6.30
92577	Stenger test, speech		X	0366	1.5786	$107.77	$24.61	$21.56
92579	Visual audiometry (vra)		X	0365	1.2498	$85.32	$18.52	$17.07
92582	Conditioning play audiometry		X	0365	1.2498	$85.32	$18.52	$17.07
92583	Select picture audiometry		X	0364	0.4612	$31.48	$7.03	$6.30
92584	Electrocochleography		S	0216	2.7192	$185.63	.	$37.13
92585	Auditor evoke potent, compre		S	0216	2.7192	$185.63	.	$37.13
92586	Auditor evoke potent, limit		S	0218	1.1923	$81.39	.	$16.28
92587	Evoked auditory test		X	0363	0.8721	$59.54	$16.71	$11.91
92588	Evoked auditory test		X	0363	0.8721	$59.54	$16.71	$11.91
92590	Hearing aid exam, one ear		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92591	Hearing aid exam, both ears		E					
92592	Hearing aid check, one ear		E					
92593	Hearing aid check, both ears		E					
92594	Electro hearng aid test, one		E					
92595	Electro hearng aid tst, both		E					
92596	Ear protector evaluation		X	0364	0.4612	$31.48	$7.03	$6.30
92597	Oral speech device eval		A					
92601	Cochlear implt f/up exam < 7		X	0366	1.5786	$107.77	$24.61	$21.56
92602	Reprogram cochlear implt < 7		X	0366	1.5786	$107.77	$24.61	$21.56
92603	Cochlear implt f/up exam 7 >		X	0366	1.5786	$107.77	$24.61	$21.56
92604	Reprogram cochlear implt 7 >		X	0366	1.5786	$107.77	$24.61	$21.56
92605	Eval for nonspeech device rx		A					
92606	Non-speech device service		A					
92607	Ex for speech device rx, 1hr		A					
92608	Ex for speech device rx addl		A					
92609	Use of speech device service		A					
92610	Evaluate swallowing function		A					
92611	Motion fluoroscopy/swallow		A					
92612	Endoscopy swallow tst (fees)		A					
92613	Endoscopy swallow tst (fees)		B					
92614	Laryngoscopic sensory test		A					
92615	Eval laryngoscopy sense tst		E					
92616	Fees w/laryngeal sense test		A					
92617	Interprt fees/laryngeal test		E					
92620	Auditory function, 60 min		X	0365	1.2498	$85.32	$18.52	$17.07
92621	Auditory function, + 15 min		N					
92625	Tinnitus assessment		X	0365	1.2498	$85.32	$18.52	$17.07
92626	Eval aud rehab status		X	0366	1.5786	$107.77	$24.61	$21.56
92627	Eval aud status rehab add-on		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92630	Aud rehab pre-ling hear loss		E					
92633	Aud rehab postling hear loss		E					
92640	Aud brainstem implt programg		X	0365	1.2498	$85.32	$18.52	$17.07
92700	Ent procedure/service		X	0364	0.4612	$31.48	$7.03	$6.30
92950	Heart/lung resuscitation cpr		S	0094	2.4281	$165.76	$46.29	$33.16
92953	Temporary external pacing		S	0094	2.4281	$165.76	$46.29	$33.16
92960	Cardioversion electric, ext		S	0679	5.4877	$374.63	$95.30	$74.93
92961	Cardioversion, electric, int		S	0679	5.4877	$374.63	$95.30	$74.93
92970	Cardioassist, internal		C					
92971	Cardioassist, external		C					
92973	Percut coronary thrombectomy		T	0088	41.8116	$2,854.35	$655.22	$570.87
92974	Cath place, cardio brachytx		T	0103	19.1796	$1,309.33	.	$261.87
92975	Dissolve clot, heart vessel		C					
92977	Dissolve clot, heart vessel		T	0676	2.3844	$162.78	.	$32.56
92978	Intravasc us, heart add-on		N					
92979	Intravasc us, heart add-on		N					
92980	Insert intracoronary stent		T	0104	81.9089	$5,591.67	.	$1,118.34
92981	Insert intracoronary stent		T	0104	81.9089	$5,591.67	.	$1,118.34
92982	Coronary artery dilation		T	0083	52.1947	$3,563.18	.	$712.64
92984	Coronary artery dilation		T	0083	52.1947	$3,563.18	.	$712.64
92986	Revision of aortic valve		T	0083	52.1947	$3,563.18	.	$712.64
92987	Revision of mitral valve		T	0083	52.1947	$3,563.18	.	$712.64
92990	Revision of pulmonary valve		T	0083	52.1947	$3,563.18	.	$712.64
92992	Revision of heart chamber		C					
92993	Revision of heart chamber		C					
92995	Coronary atherectomy		T	0082	97.8929	$6,682.85	.	$1,336.57
92996	Coronary atherectomy add-on		T	0082	97.8929	$6,682.85	.	$1,336.57
92997	Pul art balloon repr, percut		T	0083	52.1947	$3,563.18	.	$712.64
92998	Pul art balloon repr, percut		T	0083	52.1947	$3,563.18	.	$712.64

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93000	Electrocardiogram, complete		M					
93005	Electrocardiogram, tracing		S	0099	0.3998	$27.29	.	$5.46
93010	Electrocardiogram report		B					
93012	Transmission of ecg		N					
93014	Report on transmitted ecg		B					
93015	Cardiovascular stress test		B					
93016	Cardiovascular stress test		B					
93017	Cardiovascular stress test		X	0100	2.6301	$179.55	$41.44	$35.91
93018	Cardiovascular stress test		B					
93024	Cardiac drug stress test		X	0100	2.6301	$179.55	$41.44	$35.91
93025	Microvolt t-wave assess		X	0100	2.6301	$179.55	$41.44	$35.91
93040	Rhythm ECG with report		B					
93041	Rhythm ECG, tracing		X	0035	0.2446	$16.70	.	$3.34
93042	Rhythm ECG, report		B					
93224	ECG monitor/report, 24 hrs		M					
93225	ECG monitor/record, 24 hrs		S	0097	0.9646	$65.85	$23.66	$13.17
93226	ECG monitor/report, 24 hrs		S	0097	0.9646	$65.85	$23.66	$13.17
93227	ECG monitor/review, 24 hrs		M					
93228	Remote 30 day ecg rev/report		M					
93229	Remote 30 day ecg tech supp		S	0209	11.462	$782.48	$268.73	$156.50
93230	ECG monitor/report, 24 hrs		M					
93231	Ecg monitor/record, 24 hrs		S	0097	0.9646	$65.85	$23.66	$13.17
93232	ECG monitor/report, 24 hrs		S	0097	0.9646	$65.85	$23.66	$13.17
93233	ECG monitor/review, 24 hrs		M					
93235	ECG monitor/report, 24 hrs		M					
93236	ECG monitor/report, 24 hrs		S	0097	0.9646	$65.85	$23.66	$13.17
93237	ECG monitor/review, 24 hrs		M					
93268	ECG record/review		M					
93270	ECG recording		S	0097	0.9646	$65.85	$23.66	$13.17

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93271	Ecg/monitoring and analysis		S	0692	1.6175	$110.42	.	$22.09
93272	Ecg/review, interpret only		M					
93278	ECG/signal-averaged		X	0035	0.2446	$16.70	.	$3.34
93279	Pm device progr eval, sngl		S	0690	0.5225	$35.67	$8.67	$7.14
93280	Pm device progr eval, dual		S	0690	0.5225	$35.67	$8.67	$7.14
93281	Pm device progr eval, multi		S	0690	0.5225	$35.67	$8.67	$7.14
93282	Icd device prog eval, 1 sngl	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93283	Icd device progr eval, dual	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93284	Icd device progr eval, mult	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93285	Ilr device eval progr		S	0690	0.5225	$35.67	$8.67	$7.14
93286	Pre-op pm device eval		N					
93287	Pre-op icd device eval		N					
93288	Pm device eval in person		S	0690	0.5225	$35.67	$8.67	$7.14
93289	Icd device interrogate	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93290	Icm device eval	CH	X	0035	0.2446	$16.70	.	$3.34
93291	Ilr device interrogate		S	0690	0.5225	$35.67	$8.67	$7.14
93292	Wcd device interrogate	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93293	Pm phone r-strip device eval	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93294	Pm device interrogate remote		M					
93295	Icd device interrogat remote		M					
93296	Pm/icd remote tech serv	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93297	Icm device interrogat remote		M					
93298	Ilr device interrogat remote		M					
93299	Icm/ilr remote tech serv	CH	S	0691	2.4765	$169.06	.	$33.82
93303	Echo transthoracic		S	0270	8.1944	$559.41	$132.96	$111.89
93304	Echo transthoracic		S	0269	5.7019	$389.25	.	$77.85
93306	Tte w/doppler, complete		S	0269	5.7019	$389.25	.	$77.85
93307	Tte w/o doppler, complete	CH	S	0269	5.7019	$389.25	.	$77.85
93308	Tte, f-up or lmtd		S	0697	3.163	$215.93	.	$43.19

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93312	Echo transesophageal		S	0270	8.1944	$559.41	$132.96	$111.89
93313	Echo transesophageal		S	0269	5.7019	$389.25	.	$77.85
93314	Echo transesophageal		N					
93315	Echo transesophageal		S	0270	8.1944	$559.41	$132.96	$111.89
93316	Echo transesophageal		S	0270	8.1944	$559.41	$132.96	$111.89
93317	Echo transesophageal		N					
93318	Echo transesophageal intraop		S	0270	8.1944	$559.41	$132.96	$111.89
93320	Doppler echo exam, heart		N					
93321	Doppler echo exam, heart		N					
93325	Doppler color flow add-on		N					
93350	Stress tte only		S	0269	5.7019	$389.25	.	$77.85
93351	Stress tte complete		S	0270	8.1944	$559.41	$132.96	$111.89
93352	Admin ecg contrast agent		M					
93501	Right heart catheterization		T	0080	39.8374	$2,719.58	$838.92	$543.92
93503	Insert/place heart catheter		T	0103	19.1796	$1,309.33	.	$261.87
93505	Biopsy of heart lining		T	0103	19.1796	$1,309.33	.	$261.87
93508	Cath placement, angiography		T	0080	39.8374	$2,719.58	$838.92	$543.92
93510	Left heart catheterization		T	0080	39.8374	$2,719.58	$838.92	$543.92
93511	Left heart catheterization		T	0080	39.8374	$2,719.58	$838.92	$543.92
93514	Left heart catheterization		T	0080	39.8374	$2,719.58	$838.92	$543.92
93524	Left heart catheterization		T	0080	39.8374	$2,719.58	$838.92	$543.92
93526	Rt & Lt heart catheters		T	0080	39.8374	$2,719.58	$838.92	$543.92
93527	Rt & Lt heart catheters		T	0080	39.8374	$2,719.58	$838.92	$543.92
93528	Rt & Lt heart catheters		T	0080	39.8374	$2,719.58	$838.92	$543.92
93529	Rt, lt heart catheterization		T	0080	39.8374	$2,719.58	$838.92	$543.92
93530	Rt heart cath, congenital		T	0080	39.8374	$2,719.58	$838.92	$543.92
93531	R & l heart cath, congenital		T	0080	39.8374	$2,719.58	$838.92	$543.92
93532	R & l heart cath, congenital		T	0080	39.8374	$2,719.58	$838.92	$543.92
93533	R & l heart cath, congenital		T	0080	39.8374	$2,719.58	$838.92	$543.92

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93539	Injection, cardiac cath		N					
93540	Injection, cardiac cath		N					
93541	Injection for lung angiogram		N					
93542	Injection for heart x-rays		N					
93543	Injection for heart x-rays		N					
93544	Injection for aortography		N					
93545	Inject for coronary x-rays		N					
93555	Imaging, cardiac cath		N					
93556	Imaging, cardiac cath		N					
93561	Cardiac output measurement		N					
93562	Cardiac output measurement		N					
93571	Heart flow reserve measure		N					
93572	Heart flow reserve measure		N					
93580	Transcath closure of asd		T	0434	158.2753	$10,804.98	.	$2,161.00
93581	Transcath closure of vsd		T	0434	158.2753	$10,804.98	.	$2,161.00
93600	Bundle of His recording		S	0084	10.1429	$692.43	.	$138.49
93602	Intra-atrial recording		S	0084	10.1429	$692.43	.	$138.49
93603	Right ventricular recording		S	0084	10.1429	$692.43	.	$138.49
93609	Map tachycardia, add-on		N					
93610	Intra-atrial pacing		S	0084	10.1429	$692.43	.	$138.49
93612	Intraventricular pacing		S	0084	10.1429	$692.43	.	$138.49
93613	Electrophys map 3d, add-on		N					
93615	Esophageal recording		S	0084	10.1429	$692.43	.	$138.49
93616	Esophageal recording		S	0084	10.1429	$692.43	.	$138.49
93618	Heart rhythm pacing		S	0084	10.1429	$692.43	.	$138.49
93619	Electrophysiology evaluation		Q3	0085	53.4167	$3,646.60	.	$729.32
93620	Electrophysiology evaluation		Q3	0085	53.4167	$3,646.60	.	$729.32
93621	Electrophysiology evaluation		N					
93622	Electrophysiology evaluation		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93623	Stimulation, pacing heart		N					
93624	Electrophysiologic study		T	0085	53.4167	$3,646.60	.	$729.32
93631	Heart pacing, mapping		N					
93640	Evaluation heart device		N					
93641	Electrophysiology evaluation		N					
93642	Electrophysiology evaluation		S	0084	10.1429	$692.43	.	$138.49
93650	Ablate heart dysrhythm focus		Q3	0085	53.4167	$3,646.60	.	$729.32
93651	Ablate heart dysrhythm focus		Q3	0086	116.6136	$7,960.86	.	$1,592.18
93652	Ablate heart dysrhythm focus		Q3	0086	116.6136	$7,960.86	.	$1,592.18
93660	Tilt table evaluation		S	0101	4.359	$297.58	$100.24	$59.52
93662	Intracardiac ecg (ice)		N					
93668	Peripheral vascular rehab		E					
93701	Bioimpedance, cv analysis		S	0099	0.3998	$27.29	.	$5.46
93720	Total body plethysmography		B					
93721	Plethysmography tracing		X	0368	0.8679	$59.25	$20.93	$11.85
93722	Plethysmography report		B					
93724	Analyze pacemaker system		S	0690	0.5225	$35.67	$8.67	$7.14
93740	Temperature gradient studies		X	0368	0.8679	$59.25	$20.93	$11.85
93745	Set-up cardiovert-defibrill	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93750	Interrogation vad, in person		S	0692	1.6175	$110.42	.	$22.09
93770	Measure venous pressure		N					
93784	Ambulatory BP monitoring		E					
93786	Ambulatory BP recording		S	0097	0.9646	$65.85	$23.66	$13.17
93788	Ambulatory BP analysis		S	0097	0.9646	$65.85	$23.66	$13.17
93790	Review/report BP recording		M					
93797	Cardiac rehab		S	0095	0.5678	$38.76	$13.86	$7.76
93798	Cardiac rehab/monitor		S	0095	0.5678	$38.76	$13.86	$7.76
93799	Cardiovascular procedure		S	0097	0.9646	$65.85	$23.66	$13.17
93875	Extracranial study		S	0096	1.571	$107.25	$37.13	$21.45

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93880	Extracranial study		S	0267	2.2748	$155.29	$60.50	$31.06
93882	Extracranial study		S	0267	2.2748	$155.29	$60.50	$31.06
93886	Intracranial study		S	0267	2.2748	$155.29	$60.50	$31.06
93888	Intracranial study		S	0265	0.9262	$63.23	$22.28	$12.65
93890	Tcd, vasoreactivity study		S	0266	1.4262	$97.36	$37.53	$19.48
93892	Tcd, emboli detect w/o inj		S	0266	1.4262	$97.36	$37.53	$19.48
93893	Tcd, emboli detect w/inj		S	0266	1.4262	$97.36	$37.53	$19.48
93922	Extremity study		S	0097	0.9646	$65.85	$23.66	$13.17
93923	Extremity study		S	0096	1.571	$107.25	$37.13	$21.45
93924	Extremity study		S	0096	1.571	$107.25	$37.13	$21.45
93925	Lower extremity study		S	0267	2.2748	$155.29	$60.50	$31.06
93926	Lower extremity study		S	0266	1.4262	$97.36	$37.53	$19.48
93930	Upper extremity study		S	0267	2.2748	$155.29	$60.50	$31.06
93931	Upper extremity study		S	0266	1.4262	$97.36	$37.53	$19.48
93965	Extremity study		S	0096	1.571	$107.25	$37.13	$21.45
93970	Extremity study		S	0267	2.2748	$155.29	$60.50	$31.06
93971	Extremity study		S	0266	1.4262	$97.36	$37.53	$19.48
93975	Vascular study		S	0267	2.2748	$155.29	$60.50	$31.06
93976	Vascular study		S	0267	2.2748	$155.29	$60.50	$31.06
93978	Vascular study		S	0267	2.2748	$155.29	$60.50	$31.06
93979	Vascular study		S	0266	1.4262	$97.36	$37.53	$19.48
93980	Penile vascular study		S	0267	2.2748	$155.29	$60.50	$31.06
93981	Penile vascular study		S	0267	2.2748	$155.29	$60.50	$31.06
93982	Aneurysm pressure sens study		S	0097	0.9646	$65.85	$23.66	$13.17
93990	Doppler flow testing		S	0266	1.4262	$97.36	$37.53	$19.48
94002	Vent mgmt inpat, init day		S	0079	2.8784	$196.50	.	$39.30
94003	Vent mgmt inpat, subq day		S	0079	2.8784	$196.50	.	$39.30
94004	Vent mgmt nf per day		B					
94005	Home vent mgmt supervision		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
94010	Breathing capacity test		X	0368	0.8679	$59.25	$20.93	$11.85
94011	Up to 2 yrs old, spirometry		X	0368	0.8679	$59.25	$20.93	$11.85
94012	= 2 yrs, spiromtry w/dilator		X	0368	0.8679	$59.25	$20.93	$11.85
94013	= 2 yrs, lung volumes		X	0369	3.0374	$207.35	$42.19	$41.47
94014	Patient recorded spirometry		X	0367	0.5872	$40.09	$13.75	$8.02
94015	Patient recorded spirometry		X	0367	0.5872	$40.09	$13.75	$8.02
94016	Review patient spirometry		A					
94060	Evaluation of wheezing		S	0078	1.4237	$97.19	.	$19.44
94070	Evaluation of wheezing		X	0369	3.0374	$207.35	$42.19	$41.47
94150	Vital capacity test		X	0367	0.5872	$40.09	$13.75	$8.02
94200	Lung function test (MBC/MVV)		X	0367	0.5872	$40.09	$13.75	$8.02
94240	Residual lung capacity		X	0368	0.8679	$59.25	$20.93	$11.85
94250	Expired gas collection	CH	X	0367	0.5872	$40.09	$13.75	$8.02
94260	Thoracic gas volume		X	0368	0.8679	$59.25	$20.93	$11.85
94350	Lung nitrogen washout curve		X	0368	0.8679	$59.25	$20.93	$11.85
94360	Measure airflow resistance		X	0367	0.5872	$40.09	$13.75	$8.02
94370	Breath airway closing volume		X	0035	0.2446	$16.70	.	$3.34
94375	Respiratory flow volume loop		X	0368	0.8679	$59.25	$20.93	$11.85
94400	CO2 breathing response curve		X	0367	0.5872	$40.09	$13.75	$8.02
94450	Hypoxia response curve		X	0368	0.8679	$59.25	$20.93	$11.85
94452	Hast w/report		X	0368	0.8679	$59.25	$20.93	$11.85
94453	Hast w/oxygen titrate		X	0368	0.8679	$59.25	$20.93	$11.85
94610	Surfactant admin thru tube		S	0077	0.418	$28.54	$7.74	$5.71
94620	Pulmonary stress test/simple		X	0368	0.8679	$59.25	$20.93	$11.85
94621	Pulm stress test/complex		X	0369	3.0374	$207.35	$42.19	$41.47
94640	Airway inhalation treatment		S	0077	0.418	$28.54	$7.74	$5.71
94642	Aerosol inhalation treatment		S	0078	1.4237	$97.19	.	$19.44
94644	Cbt, 1st hour		X	0340	0.6899	$47.10	.	$9.42
94645	Cbt, each addl hour		X	0340	0.6899	$47.10	.	$9.42

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
94660	Pos airway pressure, CPAP		S	0078	1.4237	$97.19	.	$19.44
94662	Neg press ventilation, cnp		S	0079	2.8784	$196.50	.	$39.30
94664	Evaluate pt use of inhaler		S	0077	0.418	$28.54	$7.74	$5.71
94667	Chest wall manipulation		S	0077	0.418	$28.54	$7.74	$5.71
94668	Chest wall manipulation		S	0077	0.418	$28.54	$7.74	$5.71
94680	Exhaled air analysis, o2	CH	X	0368	0.8679	$59.25	$20.93	$11.85
94681	Exhaled air analysis, o2/co2		X	0368	0.8679	$59.25	$20.93	$11.85
94690	Exhaled air analysis		X	0367	0.5872	$40.09	$13.75	$8.02
94720	Monoxide diffusing capacity		X	0368	0.8679	$59.25	$20.93	$11.85
94725	Membrane diffusion capacity		X	0368	0.8679	$59.25	$20.93	$11.85
94750	Pulmonary compliance study		X	0367	0.5872	$40.09	$13.75	$8.02
94760	Measure blood oxygen level		N					
94761	Measure blood oxygen level		N					
94762	Measure blood oxygen level		Q1	0097	0.9646	$65.85	$23.66	$13.17
94770	Exhaled carbon dioxide test	CH	X	0368	0.8679	$59.25	$20.93	$11.85
94772	Breath recording, infant		X	0369	3.0374	$207.35	$42.19	$41.47
94774	Ped home apnea rec, compl		B					
94775	Ped home apnea rec, hk-up		S	0097	0.9646	$65.85	$23.66	$13.17
94776	Ped home apnea rec, downld		S	0097	0.9646	$65.85	$23.66	$13.17
94777	Ped home apnea rec, report		B					
94799	Pulmonary service/procedure		X	0367	0.5872	$40.09	$13.75	$8.02
95004	Percut allergy skin tests		X	0381	0.4215	$28.77	.	$5.76
95010	Percut allergy titrate test		X	0381	0.4215	$28.77	.	$5.76
95012	Exhaled nitric oxide meas		X	0367	0.5872	$40.09	$13.75	$8.02
95015	Id allergy titrate-drug/bug		X	0381	0.4215	$28.77	.	$5.76
95024	Id allergy test, drug/bug		X	0381	0.4215	$28.77	.	$5.76
95027	Id allergy titrate-airborne		X	0381	0.4215	$28.77	.	$5.76
95028	Id allergy test-delayed type		X	0381	0.4215	$28.77	.	$5.76
95044	Allergy patch tests		X	0381	0.4215	$28.77	.	$5.76

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95052	Photo patch test		X	0381	0.4215	$28.77	.	$5.76
95056	Photosensitivity tests		X	0370	1.4793	$100.99	.	$20.20
95060	Eye allergy tests		X	0370	1.4793	$100.99	.	$20.20
95065	Nose allergy test		X	0381	0.4215	$28.77	.	$5.76
95070	Bronchial allergy tests		X	0369	3.0374	$207.35	$42.19	$41.47
95071	Bronchial allergy tests		X	0369	3.0374	$207.35	$42.19	$41.47
95075	Ingestion challenge test		X	0361	4.0753	$278.21	$83.23	$55.65
95115	Immunotherapy, one injection		S	0436	0.3853	$26.30	.	$5.26
95117	Immunotherapy injections		S	0436	0.3853	$26.30	.	$5.26
95120	Immunotherapy, one injection		E					
95125	Immunotherapy, many antigens		E					
95130	Immunotherapy, insect venom		E					
95131	Immunotherapy, insect venoms		E					
95132	Immunotherapy, insect venoms		E					
95133	Immunotherapy, insect venoms		E					
95134	Immunotherapy, insect venoms		E					
95144	Antigen therapy services		S	0437	0.5491	$37.49	.	$7.50
95145	Antigen therapy services		S	0437	0.5491	$37.49	.	$7.50
95146	Antigen therapy services		S	0438	1.1156	$76.16	.	$15.24
95147	Antigen therapy services		S	0438	1.1156	$76.16	.	$15.24
95148	Antigen therapy services		S	0437	0.5491	$37.49	.	$7.50
95149	Antigen therapy services		S	0437	0.5491	$37.49	.	$7.50
95165	Antigen therapy services		S	0436	0.3853	$26.30	.	$5.26
95170	Antigen therapy services		S	0437	0.5491	$37.49	.	$7.50
95180	Rapid desensitization		X	0370	1.4793	$100.99	.	$20.20
95199	Allergy immunology services		X	0381	0.4215	$28.77	.	$5.76
95250	Glucose monitoring, cont		V	0607	1.7939	$122.46	.	$24.50
95251	Gluc monitor, cont, phys i&r		B					
95803	Actigraphy testing		S	0218	1.1923	$81.39	.	$16.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95805	Multiple sleep latency test		S	0209	11.462	$782.48	$268.73	$156.50
95806	Sleep study unatt&resp efft		S	0213	2.4455	$166.95	$53.58	$33.39
95807	Sleep study, attended		S	0209	11.462	$782.48	$268.73	$156.50
95808	Polysomnography, 1-3		S	0209	11.462	$782.48	$268.73	$156.50
95810	Polysomnography, 4 or more		S	0209	11.462	$782.48	$268.73	$156.50
95811	Polysomnography w/cpap		S	0209	11.462	$782.48	$268.73	$156.50
95812	Eeg, 41-60 minutes		S	0213	2.4455	$166.95	$53.58	$33.39
95813	Eeg, over 1 hour		S	0213	2.4455	$166.95	$53.58	$33.39
95816	Eeg, awake and drowsy		S	0213	2.4455	$166.95	$53.58	$33.39
95819	Eeg, awake and asleep		S	0213	2.4455	$166.95	$53.58	$33.39
95822	Eeg, coma or sleep only		S	0213	2.4455	$166.95	$53.58	$33.39
95824	Eeg, cerebral death only		S	0216	2.7192	$185.63	.	$37.13
95827	Eeg, all night recording		S	0213	2.4455	$166.95	$53.58	$33.39
95829	Surgery electrocorticogram		N					
95830	Insert electrodes for EEG		B					
95831	Limb muscle testing, manual		A					
95832	Hand muscle testing, manual		A					
95833	Body muscle testing, manual		A					
95834	Body muscle testing, manual		A					
95851	Range of motion measurements		A					
95852	Range of motion measurements		A					
95857	Tensilon test		S	0218	1.1923	$81.39	.	$16.28
95860	Muscle test, one limb		S	0218	1.1923	$81.39	.	$16.28
95861	Muscle test, 2 limbs		S	0218	1.1923	$81.39	.	$16.28
95863	Muscle test, 3 limbs		S	0218	1.1923	$81.39	.	$16.28
95864	Muscle test, 4 limbs		S	0218	1.1923	$81.39	.	$16.28
95865	Muscle test, larynx		S	0218	1.1923	$81.39	.	$16.28
95866	Muscle test, hemidiaphragm		S	0218	1.1923	$81.39	.	$16.28
95867	Muscle test cran nerv unilat		S	0218	1.1923	$81.39	.	$16.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95868	Muscle test cran nerve bilat		S	0218	1.1923	$81.39	.	$16.28
95869	Muscle test, thor paraspinal		S	0215	0.6295	$42.97	.	$8.60
95870	Muscle test, nonparaspinal		S	0215	0.6295	$42.97	.	$8.60
95872	Muscle test, one fiber		S	0218	1.1923	$81.39	.	$16.28
95873	Guide nerv destr, elec stim		N					
95874	Guide nerv destr, needle emg		N					
95875	Limb exercise test	CH	S	0218	1.1923	$81.39	.	$16.28
95900	Motor nerve conduction test		S	0215	0.6295	$42.97	.	$8.60
95903	Motor nerve conduction test		S	0215	0.6295	$42.97	.	$8.60
95904	Sense nerve conduction test		S	0215	0.6295	$42.97	.	$8.60
95905	Motor/sens nrve conduct test		S	0215	0.6295	$42.97	.	$8.60
95920	Intraop nerve test add-on		N					
95921	Autonomic nerv function test		S	0218	1.1923	$81.39	.	$16.28
95922	Autonomic nerv function test	CH	S	0218	1.1923	$81.39	.	$16.28
95923	Autonomic nerv function test		S	0218	1.1923	$81.39	.	$16.28
95925	Somatosensory testing		S	0216	2.7192	$185.63	.	$37.13
95926	Somatosensory testing		S	0216	2.7192	$185.63	.	$37.13
95927	Somatosensory testing		S	0216	2.7192	$185.63	.	$37.13
95928	C motor evoked, uppr limbs		S	0218	1.1923	$81.39	.	$16.28
95929	C motor evoked, lwr limbs		S	0218	1.1923	$81.39	.	$16.28
95930	Visual evoked potential test		S	0216	2.7192	$185.63	.	$37.13
95933	Blink reflex test		S	0215	0.6295	$42.97	.	$8.60
95934	H-reflex test		S	0215	0.6295	$42.97	.	$8.60
95936	H-reflex test		S	0215	0.6295	$42.97	.	$8.60
95937	Neuromuscular junction test		S	0218	1.1923	$81.39	.	$16.28
95950	Ambulatory eeg monitoring		S	0209	11.462	$782.48	$268.73	$156.50
95951	EEG monitoring/videorecord		S	0209	11.462	$782.48	$268.73	$156.50
95953	EEG monitoring/computer		S	0209	11.462	$782.48	$268.73	$156.50
95954	EEG monitoring/giving drugs		S	0218	1.1923	$81.39	.	$16.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95955	EEG during surgery		N					
95956	Eeg monitoring, cable/radio		S	0209	11.462	$782.48	$268.73	$156.50
95957	EEG digital analysis		N					
95958	EEG monitoring/function test		S	0213	2.4455	$166.95	$53.58	$33.39
95961	Electrode stimulation, brain		S	0216	2.7192	$185.63	.	$37.13
95962	Electrode stim, brain add-on		S	0216	2.7192	$185.63	.	$37.13
95965	Meg, spontaneous		S	0067	50.0116	$3,414.14	.	$682.83
95966	Meg, evoked, single		S	0065	13.7821	$940.86	.	$188.18
95967	Meg, evoked, each addl		S	0065	13.7821	$940.86	.	$188.18
95970	Analyze neurostim, no prog		S	0218	1.1923	$81.39	.	$16.28
95971	Analyze neurostim, simple		S	0692	1.6175	$110.42	.	$22.09
95972	Analyze neurostim, complex		S	0692	1.6175	$110.42	.	$22.09
95973	Analyze neurostim, complex		S	0692	1.6175	$110.42	.	$22.09
95974	Cranial neurostim, complex		S	0692	1.6175	$110.42	.	$22.09
95975	Cranial neurostim, complex		S	0692	1.6175	$110.42	.	$22.09
95978	Analyze neurostim brain/1h		S	0692	1.6175	$110.42	.	$22.09
95979	Analyz neurostim brain addon		S	0692	1.6175	$110.42	.	$22.09
95980	Io anal gast n-stim init		N					
95981	Io anal gast n-stim subsq		S	0218	1.1923	$81.39	.	$16.28
95982	Io ga n-stim subsq w/reprog		S	0692	1.6175	$110.42	.	$22.09
95990	Spin/brain pump refil & main		S	0439	1.8498	$126.28	.	$25.26
95991	Spin/brain pump refil & main		S	0439	1.8498	$126.28	.	$25.26
95992	Canalith repositioning proc	CH	A					
95999	Neurological procedure		S	0215	0.6295	$42.97	.	$8.60
96000	Motion analysis, video/3d		S	0216	2.7192	$185.63	.	$37.13
96001	Motion test w/ft press meas		S	0216	2.7192	$185.63	.	$37.13
96002	Dynamic surface emg		S	0218	1.1923	$81.39	.	$16.28
96003	Dynamic fine wire emg	CH	S	0218	1.1923	$81.39	.	$16.28
96004	Phys review of motion tests		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
96020	Functional brain mapping		N					
96040	Genetic counseling, 30 min		B					
96101	Psycho testing by psych/phys		Q3	0382	2.5561	$174.50	.	$34.90
96102	Psycho testing by technician		Q3	0382	2.5561	$174.50	.	$34.90
96103	Psycho testing admin by comp		Q3	0373	1.1738	$80.13	.	$16.03
96105	Assessment of aphasia		A					
96110	Developmental test, lim		Q3	0373	1.1738	$80.13	.	$16.03
96111	Developmental test, extend		Q3	0373	1.1738	$80.13	.	$16.03
96116	Neurobehavioral status exam		Q3	0382	2.5561	$174.50	.	$34.90
96118	Neuropsych tst by psych/phys		Q3	0382	2.5561	$174.50	.	$34.90
96119	Neuropsych testing by tec		Q3	0382	2.5561	$174.50	.	$34.90
96120	Neuropsych tst admin w/comp		Q3	0382	2.5561	$174.50	.	$34.90
96125	Cognitive test by hc pro		A					
96150	Assess hlth/behave, init		Q3	0432	0.4597	$31.38	.	$6.28
96151	Assess hlth/behave, subseq		Q3	0432	0.4597	$31.38	.	$6.28
96152	Intervene hlth/behave, indiv		Q3	0432	0.4597	$31.38	.	$6.28
96153	Intervene hlth/behave, group		Q3	0432	0.4597	$31.38	.	$6.28
96154	Interv hlth/behav, fam w/pt		Q3	0432	0.4597	$31.38	.	$6.28
96155	Interv hlth/behav fam no pt		E					
96360	Hydration iv infusion, init		S	0438	1.1156	$76.16	.	$15.24
96361	Hydrate iv infusion, add-on		S	0436	0.3853	$26.30	.	$5.26
96365	Ther/proph/diag iv inf, init		S	0439	1.8498	$126.28	.	$25.26
96366	Ther/proph/diag iv inf addon		S	0436	0.3853	$26.30	.	$5.26
96367	Tx/proph/dg addl seq iv inf		S	0437	0.5491	$37.49	.	$7.50
96368	Ther/diag concurrent inf		N					
96369	Sc ther infusion, up to 1 hr		S	0439	1.8498	$126.28	.	$25.26
96370	Sc ther infusion, addl hr		S	0437	0.5491	$37.49	.	$7.50
96371	Sc ther infusion, reset pump		S	0436	0.3853	$26.30	.	$5.26
96372	Ther/proph/diag inj, sc/im		S	0436	0.3853	$26.30	.	$5.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
96373	Ther/proph/diag inj, ia		S	0437	0.5491	$37.49	.	$7.50
96374	Ther/proph/diag inj, iv push		S	0437	0.5491	$37.49	.	$7.50
96375	Tx/pro/dx inj new drug addon		S	0437	0.5491	$37.49	.	$7.50
96376	Tx/pro/dx inj new drug adon		N					
96379	Ther/prop/diag inj/inf proc		S	0436	0.3853	$26.30	.	$5.26
96401	Chemo, anti-neopl, sq/im		S	0437	0.5491	$37.49	.	$7.50
96402	Chemo hormon antineopl sq/im		S	0437	0.5491	$37.49	.	$7.50
96405	Chemo intralesional, up to 7		S	0437	0.5491	$37.49	.	$7.50
96406	Chemo intralesional over 7		S	0439	1.8498	$126.28	.	$25.26
96409	Chemo, iv push, sngl drug		S	0439	1.8498	$126.28	.	$25.26
96411	Chemo, iv push, addl drug		S	0438	1.1156	$76.16	.	$15.24
96413	Chemo, iv infusion, 1 hr		S	0440	2.9855	$203.81	.	$40.77
96415	Chemo, iv infusion, addl hr		S	0437	0.5491	$37.49	.	$7.50
96416	Chemo prolong infuse w/pump		S	0440	2.9855	$203.81	.	$40.77
96417	Chemo iv infus each addl seq		S	0438	1.1156	$76.16	.	$15.24
96420	Chemo, ia, push tecnique		S	0438	1.1156	$76.16	.	$15.24
96422	Chemo ia infusion up to 1 hr		S	0440	2.9855	$203.81	.	$40.77
96423	Chemo ia infuse each addl hr		S	0438	1.1156	$76.16	.	$15.24
96425	Chemotherapy,infusion method		S	0440	2.9855	$203.81	.	$40.77
96440	Chemotherapy, intracavitary		S	0439	1.8498	$126.28	.	$25.26
96445	Chemotherapy, intracavitary		S	0440	2.9855	$203.81	.	$40.77
96450	Chemotherapy, into CNS		S	0440	2.9855	$203.81	.	$40.77
96521	Refill/maint, portable pump		S	0439	1.8498	$126.28	.	$25.26
96522	Refill/maint pump/resvr syst		S	0439	1.8498	$126.28	.	$25.26
96523	Irrig drug delivery device		Q1	0624	0.6338	$43.27	$12.65	$8.66
96542	Chemotherapy injection		S	0438	1.1156	$76.16	.	$15.24
96549	Chemotherapy, unspecified		S	0436	0.3853	$26.30	.	$5.26
96567	Photodynamic tx, skin	CH	T	0015	1.5303	$104.47	.	$20.90
96570	Photodynmc tx, 30 min add-on		T	0015	1.5303	$104.47	.	$20.90

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
96571	Photodynamic tx, addl 15 min		T	0015	1.5303	$104.47	.	$20.90
96900	Ultraviolet light therapy		S	0001	0.5422	$37.01	.	$7.41
96902	Trichogram		N					
96904	Whole body photography		N					
96910	Photochemotherapy with UV-B		S	0001	0.5422	$37.01	.	$7.41
96912	Photochemotherapy with UV-A		S	0001	0.5422	$37.01	.	$7.41
96913	Photochemotherapy, UV-A or B		S	0683	2.8503	$194.58	.	$38.92
96920	Laser tx, skin < 250 sq cm		T	0015	1.5303	$104.47	.	$20.90
96921	Laser tx, skin 250-500 sq cm		T	0015	1.5303	$104.47	.	$20.90
96922	Laser tx, skin > 500 sq cm		T	0015	1.5303	$104.47	.	$20.90
96999	Dermatological procedure		T	0012	0.4253	$29.03	.	$5.81
97001	Pt evaluation		A					
97002	Pt re-evaluation		A					
97003	Ot evaluation		A					
97004	Ot re-evaluation		A					
97005	Athletic train eval		E					
97006	Athletic train reeval		E					
97010	Hot or cold packs therapy		A					
97012	Mechanical traction therapy		A					
97014	Electric stimulation therapy		E					
97016	Vasopneumatic device therapy		A					
97018	Paraffin bath therapy		A					
97022	Whirlpool therapy		A					
97024	Diathermy eg, microwave		A					
97026	Infrared therapy		A					
97028	Ultraviolet therapy		A					
97032	Electrical stimulation		A					
97033	Electric current therapy		A					
97034	Contrast bath therapy		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
97035	Ultrasound therapy		A					
97036	Hydrotherapy		A					
97039	Physical therapy treatment		A					
97110	Therapeutic exercises		A					
97112	Neuromuscular reeducation		A					
97113	Aquatic therapy/exercises		A					
97116	Gait training therapy		A					
97124	Massage therapy		A					
97139	Physical medicine procedure		A					
97140	Manual therapy		A					
97150	Group therapeutic procedures		A					
97530	Therapeutic activities		A					
97532	Cognitive skills development		A					
97533	Sensory integration		A					
97535	Self care mngment training		A					
97537	Community/work reintegration		A					
97542	Wheelchair mngment training		A					
97545	Work hardening		A					
97546	Work hardening add-on		A					
97597	Active wound care/20 cm or <		T	0015	1.5303	$104.47	.	$20.90
97598	Active wound care > 20 cm		T	0015	1.5303	$104.47	.	$20.90
97602	Wound(s) care non-selective		T	0013	0.8782	$59.95	.	$11.99
97605	Neg press wound tx, < 50 cm		T	0013	0.8782	$59.95	.	$11.99
97606	Neg press wound tx, > 50 cm		T	0015	1.5303	$104.47	.	$20.90
97750	Physical performance test		A					
97755	Assistive technology assess		A					
97760	Orthotic mgmt and training		A					
97761	Prosthetic training		A					
97762	C/o for orthotic/prosth use		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
97799	Physical medicine procedure		A					
97802	Medical nutrition, indiv, in		A					
97803	Med nutrition, indiv, subseq		A					
97804	Medical nutrition, group		A					
97810	Acupunct w/o stimul 15 min		E					
97811	Acupunct w/o stimul addl 15m		E					
97813	Acupunct w/stimul 15 min		E					
97814	Acupunct w/stimul addl 15m		E					
98925	Osteopathic manipulation		S	0060	0.3636	$24.82	.	$4.97
98926	Osteopathic manipulation		S	0060	0.3636	$24.82	.	$4.97
98927	Osteopathic manipulation		S	0060	0.3636	$24.82	.	$4.97
98928	Osteopathic manipulation		S	0060	0.3636	$24.82	.	$4.97
98929	Osteopathic manipulation		S	0060	0.3636	$24.82	.	$4.97
98940	Chiropractic manipulation		S	0060	0.3636	$24.82	.	$4.97
98941	Chiropractic manipulation		S	0060	0.3636	$24.82	.	$4.97
98942	Chiropractic manipulation		S	0060	0.3636	$24.82	.	$4.97
98943	Chiropractic manipulation		E					
98960	Self-mgmt educ & train, 1 pt		E					
98961	Self-mgmt educ/train, 2-4 pt		E					
98962	Self-mgmt educ/train, 5-8 pt		E					
98966	Hc pro phone call 5-10 min		E					
98967	Hc pro phone call 11-20 min		E					
98968	Hc pro phone call 21-30 min		E					
98969	Online service by hc pro		E					
99000	Specimen handling		E					
99001	Specimen handling		E					
99002	Device handling		B					
99024	Postop follow-up visit		B					
99026	In-hospital on call service		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99027	Out-of-hosp on call service		E					
99050	Medical services after hrs		B					
99051	Med serv, eve/wkend/holiday		B					
99053	Med serv 10pm-8am, 24 hr fac		B					
99056	Med service out of office		B					
99058	Office emergency care		B					
99060	Out of office emerg med serv		B					
99070	Special supplies		B					
99071	Patient education materials		B					
99075	Medical testimony		E					
99078	Group health education		N					
99080	Special reports or forms		B					
99082	Unusual physician travel		B					
99090	Computer data analysis		B					
99091	Collect/review data from pt		N					
99100	Special anesthesia service		B					
99116	Anesthesia with hypothermia		B					
99135	Special anesthesia procedure		B					
99140	Emergency anesthesia		B					
99143	Mod cs by same phys, < 5 yrs		N					
99144	Mod cs by same phys, 5 yrs +		N					
99145	Mod cs by same phys add-on		N					
99148	Mod cs diff phys < 5 yrs		N					
99149	Mod cs diff phys 5 yrs +		N					
99150	Mod cs diff phys add-on		N					
99170	Anogenital exam, child		T	0191	0.1514	$10.34	$2.08	$2.07
99172	Ocular function screen		E					
99173	Visual acuity screen		E					
99174	Ocular photoscreening		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99175	Induction of vomiting		N					
99183	Hyperbaric oxygen therapy		B					
99190	Special pump services		C					
99191	Special pump services		C					
99192	Special pump services		C					
99195	Phlebotomy		X	0624	0.6338	$43.27	$12.65	$8.66
99199	Special service/proc/report		B					
99201	Office/outpatient visit, new		V	0604	0.7431	$50.73	.	$10.15
99202	Office/outpatient visit, new		V	0605	1.0573	$72.18	.	$14.44
99203	Office/outpatient visit, new		V	0606	1.365	$93.18	.	$18.64
99204	Office/outpatient visit, new		V	0607	1.7939	$122.46	.	$24.50
99205	Office/outpatient visit, new		Q3	0608	2.4657	$168.33	.	$33.67
99211	Office/outpatient visit, est		V	0604	0.7431	$50.73	.	$10.15
99212	Office/outpatient visit, est		V	0605	1.0573	$72.18	.	$14.44
99213	Office/outpatient visit, est		V	0605	1.0573	$72.18	.	$14.44
99214	Office/outpatient visit, est		V	0606	1.365	$93.18	.	$18.64
99215	Office/outpatient visit, est		Q3	0607	1.7939	$122.46	.	$24.50
99217	Observation care discharge		B					
99218	Observation care		B					
99219	Observation care		B					
99220	Observation care		B					
99221	Initial hospital care		B					
99222	Initial hospital care		B					
99223	Initial hospital care		B					
99231	Subsequent hospital care		B					
99232	Subsequent hospital care		B					
99233	Subsequent hospital care		B					
99234	Observ/hosp same date		B					
99235	Observ/hosp same date		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99236	Observ/hosp same date		B					
99238	Hospital discharge day		B					
99239	Hospital discharge day		B					
99241	Office consultation		E					
99242	Office consultation		E					
99243	Office consultation		E					
99244	Office consultation		E					
99245	Office consultation		E					
99251	Inpatient consultation		E					
99252	Inpatient consultation		E					
99253	Inpatient consultation		E					
99254	Inpatient consultation		E					
99255	Inpatient consultation		E					
99281	Emergency dept visit		V	0609	0.7735	$52.80	$12.64	$10.56
99282	Emergency dept visit		V	0613	1.315	$89.77	$21.06	$17.96
99283	Emergency dept visit		V	0614	2.1031	$143.57	$34.50	$28.72
99284	Emergency dept visit		Q3	0615	3.3549	$229.03	$48.49	$45.81
99285	Emergency dept visit		Q3	0616	4.9888	$340.57	$72.86	$68.12
99288	Direct advanced life support		B					
99291	Critical care, first hour		Q3	0617	7.7626	$529.93	$111.59	$105.99
99292	Critical care, addl 30 min		N					
99304	Nursing facility care, init		B					
99305	Nursing facility care, init		B					
99306	Nursing facility care, init		B					
99307	Nursing fac care, subseq		B					
99308	Nursing fac care, subseq		B					
99309	Nursing fac care, subseq		B					
99310	Nursing fac care, subseq		B					
99315	Nursing fac discharge day		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99316	Nursing fac discharge day		B					
99318	Annual nursing fac assessmnt		B					
99324	Domicil/r-home visit new pat		B					
99325	Domicil/r-home visit new pat		B					
99326	Domicil/r-home visit new pat		B					
99327	Domicil/r-home visit new pat		B					
99328	Domicil/r-home visit new pat		B					
99334	Domicil/r-home visit est pat		B					
99335	Domicil/r-home visit est pat		B					
99336	Domicil/r-home visit est pat		B					
99337	Domicil/r-home visit est pat		B					
99339	Domicil/r-home care supervis		B					
99340	Domicil/r-home care supervis		B					
99341	Home visit, new patient		B					
99342	Home visit, new patient		B					
99343	Home visit, new patient		B					
99344	Home visit, new patient		B					
99345	Home visit, new patient		B					
99347	Home visit, est patient		B					
99348	Home visit, est patient		B					
99349	Home visit, est patient		B					
99350	Home visit, est patient		B					
99354	Prolonged service, office		N					
99355	Prolonged service, office		N					
99356	Prolonged service, inpatient		C					
99357	Prolonged service, inpatient		C					
99358	Prolong service w/o contact		N					
99359	Prolong serv w/o contact add		N					
99360	Physician standby services		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99363	Anticoag mgmt, init		B					
99364	Anticoag mgmt, subseq		B					
99366	Team conf w/pat by hc pro		N					
99367	Team conf w/o pat by phys		N					
99368	Team conf w/o pat by hc pro		N					
99374	Home health care supervision		B					
99375	Home health care supervision		E					
99377	Hospice care supervision		B					
99378	Hospice care supervision		E					
99379	Nursing fac care supervision		B					
99380	Nursing fac care supervision		B					
99381	Init pm e/m, new pat, inf		E					
99382	Init pm e/m, new pat 1-4 yrs		E					
99383	Prev visit, new, age 5-11		E					
99384	Prev visit, new, age 12-17		E					
99385	Prev visit, new, age 18-39		E					
99386	Prev visit, new, age 40-64		E					
99387	Init pm e/m, new pat 65+ yrs		E					
99391	Per pm reeval, est pat, inf		E					
99392	Prev visit, est, age 1-4		E					
99393	Prev visit, est, age 5-11		E					
99394	Prev visit, est, age 12-17		E					
99395	Prev visit, est, age 18-39		E					
99396	Prev visit, est, age 40-64		E					
99397	Per pm reeval est pat 65+ yr		E					
99401	Preventive counseling, indiv		E					
99402	Preventive counseling, indiv		E					
99403	Preventive counseling, indiv		E					
99404	Preventive counseling, indiv		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99406	Behav chng smoking 3-10 min		X	0031	0.3066	$20.93	.	$4.19
99407	Behav chng smoking > 10 min		X	0031	0.3066	$20.93	.	$4.19
99408	Audit/dast, 15-30 min		E					
99409	Audit/dast, over 30 min		E					
99411	Preventive counseling, group		E					
99412	Preventive counseling, group		E					
99420	Health risk assessment test		E					
99429	Unlisted preventive service		E					
99441	Phone e/m by phys 5-10 min		E					
99442	Phone e/m by phys 11-20 min		E					
99443	Phone e/m by phys 21-30 min		E					
99444	Online e/m by phys		E					
99450	Basic life disability exam		E					
99455	Work related disability exam		B					
99456	Disability examination		B					
99460	Init nb em per day, hosp		V	0605	1.0573	$72.18	.	$14.44
99461	Init nb em per day, non-fac		M					
99462	Sbsq nb em per day, hosp		C					
99463	Same day nb discharge		V	0605	1.0573	$72.18	.	$14.44
99464	Attendance at delivery		N					
99465	Nb resuscitation		S	0094	2.4281	$165.76	$46.29	$33.16
99466	Ped crit care transport		N					
99467	Ped crit care transport addl		N					
99468	Neonate crit care, initial		C					
99469	Neonate crit care, subsq		C					
99471	Ped critical care, initial		C					
99472	Ped critical care, subsq		C					
99475	Ped crit care age 2-5, init		C					
99476	Ped crit care age 2-5, subsq		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99477	Init day hosp neonate care		C					
99478	Ic, lbw inf < 1500 gm subsq		C					
99479	Ic lbw inf 1500-2500 g subsq		C					
99480	Ic inf pbw 2501-5000 g subsq		C					
99499	Unlisted e&m service		B					
99500	Home visit, prenatal		E					
99501	Home visit, postnatal		E					
99502	Home visit, nb care		E					
99503	Home visit, resp therapy		E					
99504	Home visit mech ventilator		E					
99505	Home visit, stoma care		E					
99506	Home visit, im injection		E					
99507	Home visit, cath maintain		E					
99509	Home visit day life activity		E					
99510	Home visit, sing/m/fam couns		E					
99511	Home visit, fecal/enema mgmt		E					
99512	Home visit for hemodialysis		E					
99600	Home visit nos		E					
99601	Home infusion/visit, 2 hrs		E					
99602	Home infusion, each addtl hr		E					
99605	Mtms by pharm, np, 15 min		E					
99606	Mtms by pharm, est, 15 min		E					
99607	Mtms by pharm, addl 15 min		E					
0001F	Heart failure composite		M					
0005F	Osteoarthritis composite		M					
0012F	Cap bacterial assess		M					
0014F	Comp preop assess cat surg		M					
0015F	Melan follow-up complete		M					
0016T	Thermotx choroid vasc lesion		T	0235	5.2921	$361.28	.	$72.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0017T	Photocoagulat macular drusen		T	0235	5.2921	$361.28	.	$72.26
0019T	Extracorp shock wv tx,ms nos		A					
0030T	Antiprothrombin antibody		A					
0042T	Ct perfusion w/contrast, cbf		N					
0048T	Implant ventricular device		C					
0050T	Removal circulation assist		C					
0051T	Implant total heart system		C					
0052T	Replace component heart syst		C					
0053T	Replace component heart syst		C					
0054T	Bone surgery using computer		N					
0055T	Bone surgery using computer		N					
0071T	U/s leiomyomata ablate <200		S	0067	50.0116	$3,414.14	.	$682.83
0072T	U/s leiomyomata ablate >200		S	0067	50.0116	$3,414.14	.	$682.83
0073T	Delivery, comp imrt		S	0412	6.4458	$440.04	.	$88.01
0075T	Perq stent/chest vert art		C					
0076T	S&i stent/chest vert art		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					
0085T	Breath test heart reject		E					
0092T	Artific disc addl		C					
0095T	Artific diskectomy addl		C					
0098T	Rev artific disc addl		C					
0099T	Implant corneal ring		T	0233	17.0898	$1,166.67	$263.12	$233.34
0100T	Prosth retina receive&gen		T	0672	40.6474	$2,774.88	.	$554.98
0101T	Extracorp shockwv tx,hi enrg		T	0050	32.4253	$2,213.58	.	$442.72
0102T	Extracorp shockwv tx,anesth		T	0050	32.4253	$2,213.58	.	$442.72
0103T	Holotranscobalamin		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0104T	At rest cardio gas rebreathe		A					
0105T	Exerc cardio gas rebreathe		A					
0106T	Touch quant sensory test		X	0341	0.0804	$5.49	$2.09	$1.10
0107T	Vibrate quant sensory test		X	0341	0.0804	$5.49	$2.09	$1.10
0108T	Cool quant sensory test		X	0341	0.0804	$5.49	$2.09	$1.10
0109T	Heat quant sensory test		X	0341	0.0804	$5.49	$2.09	$1.10
0110T	Nos quant sensory test		X	0341	0.0804	$5.49	$2.09	$1.10
0111T	Rbc membranes fatty acids		A					
0123T	Scleral fistulization		T	0234	24.5236	$1,674.15	$511.31	$334.83
0124T	Conjunctival drug placement		T	0232	2.4827	$169.49	$40.82	$33.90
0126T	Chd risk imt study		Q1	0340	0.6899	$47.10	.	$9.42
0130T	Chron care drug investigatn		B					
0140T	Exhaled breath condensate ph		A					
0141T	Perq islet transplant		E					
0142T	Open islet transplant		E					
0143T	Laparoscopic islet transplnt		E					
0155T	Lap impl gast curve electrd		T	0130	38.7195	$2,643.26	$659.53	$528.66
0156T	Lap remv gast curve electrd		T	0130	38.7195	$2,643.26	$659.53	$528.66
0157T	Open impl gast curve electrd		C					
0158T	Open remv gast curve electrd		C					
0159T	Cad breast mri		N					
0160T	Tcranial magn stim tx plan		S	0216	2.7192	$185.63	.	$37.13
0161T	Tcranial magn stim tx deliv		S	0216	2.7192	$185.63	.	$37.13
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					
0168T	Rhinophototx light app bilat		T	0251	3.4369	$234.63	.	$46.93

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0169T	Place stereo cath brain		C					
0171T	Lumbar spine proces distract		T	0052	88.5249	$6,043.33	.	$1,208.67
0172T	Lumbar spine process addl		T	0052	88.5249	$6,043.33	.	$1,208.67
0173T	Iop monit io pressure		N					
0174T	Cad cxr with interp		N					
0175T	Cad cxr remote		N					
0176T	Aqu canal dilat w/o retent		T	0673	44.5131	$3,038.78	$649.56	$607.76
0177T	Aqu canal dilat w retent		T	0673	44.5131	$3,038.78	$649.56	$607.76
0178T	64 lead ecg w i&r		B					
0179T	64 lead ecg w tracing		X	0100	2.6301	$179.55	$41.44	$35.91
0180T	64 lead ecg w i&r only		B					
0181T	Corneal hysteresis		S	0230	0.5913	$40.37	.	$8.08
0182T	Hdr elect brachytherapy		S	0313	10.4062	$710.40	$268.63	$142.08
0183T	Wound ultrasound	CH	T	0015	1.5303	$104.47	.	$20.90
0184T	Exc rectal tumor endoscopic		C					
0185T	Comptr probability analysis		N					
0186T	Suprachoroidal drug delivery		T	0237	23.2772	$1,589.06	.	$317.82
0187T	Ophthalmic dx image anterior		S	0230	0.5913	$40.37	.	$8.08
0188T	Videoconf crit care 74 min		M					
0189T	Videoconf crit care addl 30		M					
0190T	Place intraoc radiation src		T	0237	23.2772	$1,589.06	.	$317.82
0191T	Insert ant segment drain int		T	0234	24.5236	$1,674.15	$511.31	$334.83
0192T	Insert ant segment drain ext		T	0673	44.5131	$3,038.78	$649.56	$607.76
0193T	Rf bladder neck microremodel		T	0165	20.5471	$1,402.69	.	$280.54
0195T	Arthrod presac interbody		C					
0196T	Arthrod presac interbody eac		C					
0197T	Intrafraction track motion		N					
0198T	Ocular blood flow measure		S	0230	0.5913	$40.37	.	$8.08
0199T	Physiologic tremor record		S	0215	0.6295	$42.97	.	$8.60

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0200T	Perq sacral augmt unilat inj		T	0049	23.2249	$1,585.49	.	$317.10
0201T	Perq sacral augmt bilat inj		T	0050	32.4253	$2,213.58	.	$442.72
0202T	Post vert arthrplst 1 lumbar		C					
0203T	Unattend sleep study w/time		S	0213	2.4455	$166.95	$53.58	$33.39
0204T	Unattended sleep study		S	0213	2.4455	$166.95	$53.58	$33.39
0205T	Inirs each vessel add-on		N					
0206T	Remote algorithm analys ecg		Q1	0340	0.6899	$47.10	.	$9.42
0207T	Clear eyelid gland w/heat		S	0230	0.5913	$40.37	.	$8.08
0208T	Automated audiometry air		X	0035	0.2446	$16.70	.	$3.34
0209T	Auto audiometry air/bone		X	0035	0.2446	$16.70	.	$3.34
0210T	Auto audiometry sp thresh		X	0035	0.2446	$16.70	.	$3.34
0211T	Auto audiometry sp thresh		X	0035	0.2446	$16.70	.	$3.34
0212T	Comprehen auto audiometry		X	0364	0.4612	$31.48	$7.03	$6.30
0213T	Us facet jt inj cerv/t 1 lev		T	0207	7.7204	$527.05	.	$105.41
0214T	Us facet jt inj cerv/t 2 lev		T	0204	2.666	$182.00	$40.13	$36.40
0215T	Us facet jt inj cerv/t 3 lev		T	0204	2.666	$182.00	$40.13	$36.40
0216T	Us facet jt inj ls 1 level		T	0207	7.7204	$527.05	.	$105.41
0217T	Us facet jt inj ls 2 level		T	0204	2.666	$182.00	$40.13	$36.40
0218T	Us facet jt inj ls 3 level		T	0204	2.666	$182.00	$40.13	$36.40
0219T	Fuse spine facet jt cerv		C					
0220T	Fuse spine facet jt thor		C					
0221T	Fuse spine facet jt lumbar		T	0050	32.4253	$2,213.58	.	$442.72
0222T	Fuse spine facet jt add seg		T	0050	32.4253	$2,213.58	.	$442.72
0500F	Initial prenatal care visit		M					
0501F	Prenatal flow sheet		M					
0502F	Subsequent prenatal care		M					
0503F	Postpartum care visit		M					
0505F	Hemodialysis plan docd		M					
0507F	Periton dialysis plan docd		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0509F	Urine incon plan docd		M					
0513F	Elev bp plan of care docd		M					
0514F	Care plan hgb docd esa pt		M					
0516F	Anemia plan of care docd		M					
0517F	Glaucoma plan of care docd		M					
0518F	Fall plan of care docd		M					
0519F	Pland chemo docd b/4 txmnt		M					
0520F	Rad dos limts b/4 3d rad		M					
0521F	Plan of care 4 pain docd		M					
0525F	Initial visit for episode		M					
0526F	Subs visit for episode		M					
0528F	Rcmnd flw-up 10 yrs docd		E					
0529F	Intrvl 3+yrs pts clnscp docd		M					
0535F	Dyspnea mngmnt plan docd		E					
0540F	Gluco mngmnt plan docd		M					
0545F	Follow up care plan mdd docd		E					
0575F	HIV rna plan care docd		M					
1000F	Tobacco use assessed		M					
1002F	Assess anginal symptom/level		M					
1003F	Level of activity assess		M					
1004F	Clin symp vol ovrld assess		M					
1005F	Asthma symptoms evaluate		M					
1006F	Osteoarthritis assess		M					
1007F	Anti-inflm/anlgsc otc assess		M					
1008F	Gi/renal risk assess		M					
1015F	Copd symptoms assess		M					
1018F	Assess dyspnea not present		M					
1019F	Assess dyspnea present		M					
1022F	Pneumo imm status assess		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1026F	Co-morbid condition assess		M					
1030F	Influenza imm status assess		M					
1034F	Current tobacco smoker		M					
1035F	Smokeless tobacco user		M					
1036F	Tobacco non-user		M					
1038F	Persistent asthma		M					
1039F	Intermittent asthma		M					
1040F	Dsm-ivtm info mdd docd		M					
1050F	History of mole changes		M					
1055F	Visual funct status assess		M					
1060F	Doc perm/cont/parox atr fib		M					
1061F	Doc lack perm+cont+parox fib		M					
1065F	Ischm stroke symp lt3 hrsb/4		M					
1066F	Ischm stroke symp ge3 hrsb/4		M					
1070F	Alarm symp assessed-absent		M					
1071F	Alarm symp assessed-1+ prsnt		M					
1090F	Pres/absn urine incon assess		M					
1091F	Urine incon characterized		M					
1100F	Ptfalls assess-docd ge2+/yr		M					
1101F	Pt falls assess-docd le1/yr		M					
1110F	Pt lft inpt fac w/in 60 days		M					
1111F	Dschrg med/current med merge		M					
1116F	Auric/peri pain assessed		M					
1118F	GERD symps assessed 12 month		M					
1119F	Init eval for condition		M					
1121F	Subs eval for condition		M					
1123F	Acp discuss/dscn mkr docd		M					
1124F	Acp discuss-no dscnmkr docd		M					
1125F	Amnt pain noted pain prsnt		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1126F	Amnt pain noted none prsnt		M					
1130F	Bk pain + fxn assessed		M					
1134F	Epsd bk pain for =< 6 wks		M					
1135F	Epsd bk pain for > 6 wks		M					
1136F	Epsd bk pain for <= 12 wks		M					
1137F	Epsd bk pain for > 12 wks		M					
1150F	Doc pt rsk death w/in 1yr		E					
1151F	Doc no pt rsk death w/in 1yr		E					
1152F	Doc advncd dis comfort 1st		E					
1153F	Doc advncd dis cmfrt not 1st		E					
1157F	Advnc care plan in rcrd		E					
1158F	Advnc care plan tlk docd		M					
1159F	Med list docd in rcrd		E					
1160F	Rvw meds by rx/dr in rcrd		E					
1170F	Fxnl status assessed		M					
1180F	Thromboemb risk assessed		E					
1200F	Seizure type(s)+ frq docd		E					
1205F	EPI etiol synd rvwd and docd		E					
1220F	Pt screened for depression		M					
2000F	Blood pressure measure		M					
2001F	Weight record		M					
2002F	Clin sign vol ovrld assess		M					
2004F	Initial exam involved joints		M					
2010F	Vital signs recorded		M					
2014F	Mental status assess		M					
2018F	Hydration status assess		M					
2019F	Dilated macul exam done		M					
2020F	Dilated fundus eval done		M					
2021F	Dilat macul+ exam done		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
2022F	Dil retina exam interp rev		M					
2024F	7 field photo interp doc rev		M					
2026F	Eye image valid to dx rev		M					
2027F	Optic nerve head eval done		M					
2028F	Foot exam performed		M					
2029F	Complete phys skin exam done		M					
2030F	H2o stat docd, normal		M					
2031F	H2o stat docd, dehydrated		M					
2035F	Tymp memb motion examd		M					
2040F	Bk pn xm on init visit date		M					
2044F	Doc mntl tst b/4 bk trxmnt		M					
2050F	Wound char size etc docd		E					
2060F	Pt talk eval hlthwkr re mdd		E					
3006F	Cxr doc rev		M					
3008F	Body mass index docd		E					
3011F	Lipid panel doc rev		M					
3014F	Screen mammo doc rev		M					
3015F	Cerv cancer screen docd		E					
3016F	Pt scrnd unhlthy OH use		M					
3017F	Colorectal ca screen doc rev		M					
3018F	Pre-prxd rsk et al docd		E					
3020F	Lvf assess		M					
3021F	Lvef mod/sever deprs syst		M					
3022F	Lvef >=40% systolic		M					
3023F	Spirom doc rev		M					
3025F	Spirom fev/fvc<70% w copd		M					
3027F	Spirom fev/fvc>=70%/w/o copd		M					
3028F	O2 saturation doc rev		M					
3035F	O2 saturation<=88% /pao<=55		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3037F	O2 saturation> 88% /pao>55		M					
3038F	Pulm fx w/in 12 mon b/4 surg		E					
3040F	Fev<40% predicted value		M					
3042F	Fev>=40% predicted value		M					
3044F	Hg a1c level lt 7.0%		M					
3045F	Hg a1c level 7.0-9.0%		M					
3046F	Hemoglobin a1c level > 9.0%		M					
3048F	Ldl-c <100 mg/dl		M					
3049F	Ldl-c 100-129 mg/dl		M					
3050F	Ldl-c >= 130 mg/dl		M					
3060F	Pos microalbuminuria rev		M					
3061F	Neg microalbuminuria rev		M					
3062F	Pos macroalbuminuria rev		M					
3066F	Nephropathy doc tx		M					
3072F	Low risk for retinopathy		M					
3073F	Pre-surg eye measures docd		M					
3074F	Syst bp lt 130 mm hg		M					
3075F	Syst bp ge 130 - 139mm hg		M					
3077F	Syst bp >= 140 mm hg6 it		M					
3078F	Diast bp < 80 mm hg		M					
3079F	Diast bp 80-89 mm hg		M					
3080F	Diast bp >= 90 mm hg		M					
3082F	Kt/v lt1.2		M					
3083F	Kt/v ge 1.2 and <1.7		M					
3084F	Kt/v ge 1.7		M					
3085F	Suicide risk assessed		M					
3088F	MDD, mild		M					
3089F	MDD, moderate		M					
3090F	MDD, severe; w/o psych		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3091F	Mdd, severe; w/ psych		M					
3092F	MDD, in remission		M					
3093F	Doc new diag 1st/addl mdd		M					
3095F	Central dexa results docd		M					
3096F	Central dexa ordered		M					
3100F	Image test ref carot diam		M					
3110F	Doc pres/absn hmrhg/lesion		M					
3111F	Ct/mri brain done w/in 24hrs		M					
3112F	Ct/Mri brain done gt 24 hrs		M					
3120F	12-lead ecg performed		M					
3130F	Upper gi endoscopy performed		M					
3132F	Doc ref upper gi endoscopy		M					
3140F	Upper gi endo shows barrtts		M					
3141F	Upper gi endo not barrtts		M					
3142F	Barium swallow test ordered		M					
3150F	Forceps esoph biopsy done		M					
3155F	Cytogen test marrow b/4 tx		M					
3160F	Doc fe+ stores b/4 epo thx		M					
3170F	Flow cyto done b/4 tx		M					
3200F	Barium swallow test not req		M					
3210F	Grp a strep test performed		M					
3215F	Pt immunity to hep a docd		M					
3216F	Pt immunity to hep b docd		M					
3218F	Rna tstng hep c docd-done		M					
3220F	Hep c quant rna tstng docd		M					
3230F	Note hring tst w/in 6 mon		M					
3250F	Nonprim loc anat bx site tum		M					
3260F	Pt cat/pn cat/hist grd docd		M					
3265F	Rna tstng hepc vir ord/docd		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3266F	Hepc gn tstng docd b/4txmnt		M					
3268F	Psa/t/glsc docd b/4 txmnt		M					
3269F	Bone scn b/4 txmnt/aftr Dx		M					
3270F	No bone scn b/4 txmnt/aftrDx		M					
3271F	Low risk prostate cancer		M					
3272F	Med risk prostate cancer		M					
3273F	High risk prostate cancer		M					
3274F	Prost Cncr rsk not lw/md/hgh		M					
3278F	Serum lvls CA/iPTH/lpd ord		M					
3279F	Hgb lvl >/= 13 g/dl		M					
3280F	Hgb lvl 11-12.9 g/dL		M					
3281F	Hgb lvl < 11 g/dl		M					
3284F	IOP down>=15% of pre-svc lvl		M					
3285F	IOP down <15% of pre-svc lvl		M					
3288F	Fall risk assessment docd		M					
3290F	Pt=D(Rh)- and unsensitized		M					
3291F	Pt=d(rh)+ or sensitized		M					
3292F	Hiv tstng asked/docd/revwd		M					
3293F	Abo rh blood typing docd		E					
3294F	Grp b strep screening docd		E					
3300F	AJCC stage docd b/4 thxpy		M					
3301F	Cancer stage docd metast		M					
3315F	Er+ or pr+ breast cancer		M					
3316F	ER- or PR- breast cancer		M					
3317F	Path rpt malig cancer docd		M					
3318F	Path rpt malig cancer docd		M					
3319F	X-ray/ct/ultrsnd et al ord		M					
3320F	No xray/ct/ et al ordd		M					
3321F	AJCC cncr 0/IA melan docd		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3322F	Melan >AJCC stage 0 or IA		E					
3323F	Clin node stgng docdb/4 surg		M					
3324F	Mri ct scan ord rvwd rqstd		E					
3325F	Preop asses 4 cataract surg		M					
3328F	Prfrmnc docd 2 wks b/4 surg		E					
3330F	Imaging study ordered (bkp)		M					
3331F	Bk imaging tst not ordered		M					
3340F	Mammo assess inc xray docd		M					
3341F	Mammo assess negative docd		M					
3342F	Mammo assess bengn docd		M					
3343F	Mammo probably bengn docd		M					
3344F	Mammo assess susp, docd		M					
3345F	Mammo assess hghlymalig doc		M					
3350F	Mammo bx proven malig docd		M					
3351F	Neg scrn dep symp by deptool		E					
3352F	No sig dep symp by dep tool		E					
3353F	Mild-mod dep symp by deptool		E					
3354F	Clin sig dep sym by dep tool		E					
3370F	AJCC brst cncr stage 0 docd		M					
3372F	Ajcc brst cncr stage 1+docd		M					
3374F	Ajcc brst cncr stage 1+docd		M					
3376F	AJCC brstcncr stage 2 docd		M					
3378F	AJCC brstcncr stage 3 docd		M					
3380F	AJCC brstcncr stage 4 docd		M					
3382F	AJCC cln cncr stage 0 docd		M					
3384F	AJCC cln cncr stage 1 docd		M					
3386F	AJCC cln cncr stage 2 docd		M					
3388F	AJCC cln cncr stage 3 docd		M					
3390F	AJCC cln cncr stage 4 docd		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3450F	Dyspnea scrnd, no-mild dysp		E					
3451F	Dyspnea scrnd mod-high dysp		E					
3452F	Dyspnea not screened		E					
3455F	TB scrng done-interpd 6mon		M					
3470F	RA disease activity, low		M					
3471F	RA disease activity, mod		M					
3472F	RA disease activity, high		M					
3475F	Disease progn RA poor docd		M					
3476F	Disease progn RA good docd		M					
3490F	History - AIDS-defining cond		M					
3491F	HIV unsure baby of HIV+moms		E					
3492F	History cd4+ cell count <350		M					
3493F	No hist cd4+cell cnt<350		M					
3494F	CD4+cell count <200cells/mm3		M					
3495F	Cd4+cell cnt 200-499 cells		M					
3496F	Cd4+ cell count =500 cells		M					
3497F	CD4+ cell percentage <15%		E					
3498F	CD4+ cell percentage >=15%		E					
3500F	Cd4+cell cnt/% docd as done		M					
3502F	HIV rna vrl ld <lmts quantif		M					
3503F	HIV rna vrl ldnot<lmts quntf		M					
3510F	Doc tb scrng-rslts interpd		E					
3511F	Chlmyd/gonrh tsts docd done		M					
3512F	Syph scrng docd as done		M					
3513F	Hep B scrng docd as done		E					
3514F	Hep C scrng docd as done		E					
3515F	Pt has docd immun to hep C		E					
3550F	Low rsk thromboembolism		E					
3551F	Intrmed rsk thromboembolism		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3552F	Hgh risk for thromboembolism		E					
3555F	Pt inr measurement performed		E					
3570F	Rprt bone scint xref w xray		M					
3572F	Pt consid poss risk fx		E					
3573F	Pt not consid poss risk fx		E					
3650F	Eeg ordered rvwd reqstd		E					
4000F	Tobacco use txmnt counseling		M					
4001F	Tobacco use txmnt, pharmacol		M					
4002F	Statin therapy, rx		M					
4003F	Pt ed write/oral, pts w/ hf		M					
4004F	Pt tobacco use done rcvd tlk		E					
4005F	Pharm thx for op rxd		M					
4006F	Beta-blocker therapy rx		M					
4009F	Ace/arb inhibitor therapy rx		M					
4011F	Oral antiplatelet therapy rx		M					
4012F	Warfarin therapy rx		M					
4014F	Written discharge instr prvd		M					
4015F	Persist asthma medicine ctrl		M					
4016F	Anti-inflm/anlgsc agent rx		M					
4017F	Gi prophylaxis for nsaid rx		M					
4018F	Therapy exercise joint rx		M					
4019F	Doc recpt counsl vit d/calc+		M					
4025F	Inhaled bronchodilator rx		M					
4030F	Oxygen therapy rx		M					
4033F	Pulmonary rehab rec		M					
4035F	Influenza imm rec		M					
4037F	Influenza imm order/admin		M					
4040F	Pneumoc vac/admin/rcvd		M					
4041F	Doc order cefazolin/cefurox		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4042F	Doc antibio not given		M					
4043F	Doc order given stop antibio		M					
4044F	Doc order given vte prophylx		M					
4045F	Empiric antibiotic rx		M					
4046F	Doc antibio given b/4 surg		M					
4047F	Doc antibio given b/4 surg		M					
4048F	Doc antibio given b/4 surg		M					
4049F	Doc order given stop antibio		M					
4050F	Ht care plan doc		M					
4051F	Referred for an AV fistula		M					
4052F	Hemodialysis via AV fistula		M					
4053F	Hemodialysis via AV graft		M					
4054F	Hemodialysis via catheter		M					
4055F	Pt rcvng periton dialysis		M					
4056F	Approp oral rehyd recommd		M					
4058F	Ped gastro ed given, caregvr		M					
4060F	Psych svcs provided		M					
4062F	Pt referral psych docd		M					
4063F	Antidepres rxthxpy not rxd		E					
4064F	Antidepressant rx		M					
4065F	Antipsychotic rx		M					
4066F	ECT provided		M					
4067F	Pt referral for ect docd		M					
4070F	Dvt prophylx recvd day 2		M					
4073F	Oral antiplat thx rx dischrg		M					
4075F	Anticoag thx rx at dischrg		M					
4077F	Doc t-pa admin considered		M					
4079F	Doc rehab svcs considered		M					
4084F	Aspirin recvd w/in 24 hrs		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4090F	Pt rcvng epo thxpy		M					
4095F	Pt not rcvng epo thxpy		M					
4100F	Biphos thxpy vein ord/recvd		M					
4110F	Int mam art used for cabg		M					
4115F	Beta blckr admin w/in 24 hrs		M					
4120F	Antibiot rxd/given		M					
4124F	Antibiot not rxd/given		M					
4130F	Topical prep rx aoe		M					
4131F	Syst antimicrobial thx rx		M					
4132F	No syst antimicrobial thx rx		M					
4133F	Antihist/decong rx/recom		M					
4134F	No antihist/decong rx/recom		M					
4135F	Systemic corticosteroids rx		M					
4136F	Syst corticosteroids not rx		M					
4148F	Hep A vac injxn admin/recvd		M					
4149F	Hep B vac injxn admin/recvd		M					
4150F	Pt recvng antivir txmnt hepc		M					
4151F	Pt not recvng antiv hep c		M					
4153F	Combo pegintf/rib rx		M					
4155F	Hep A vac series prev recvd		M					
4157F	Hep B vac series prev recvd		M					
4158F	Pt edu re alcoh drnkng done		M					
4159F	Contrcp talk b/4 antiv txmnt		M					
4163F	Pt couns 4 txmnt opt prost		M					
4164F	Adjv hrmnl thxpy rxd		M					
4165F	3d-crt/imrt) received		M					
4167F	Hd bed tilted 1st day vent		M					
4168F	Pt care icu&vent w/in 24hrs		M					
4169F	No pt care ICU/vent in 24hrs		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4171F	Pt rcvng esa thxpy		M					
4172F	Pt not rcvng esa thxpy		M					
4174F	Couns potent glauc impct		M					
4175F	Vis of >= 20/40 w/in 90 days		M					
4176F	Talk re uv light pt/crgvr		M					
4177F	Talk pt/crgvr re areds prev		M					
4178F	Antid glbln rcvd w/in 26wks		M					
4179F	Tamoxifen/AI prescribed		M					
4180F	Adjv thxpyrxd/rcvd stg3a-c		M					
4181F	Conformal radn thxpy rcvd		M					
4182F	No conformal radn thxpy		M					
4185F	Continuous ppi or h2ra rcvd		M					
4186F	No cont ppi or h2ra rcvd		M					
4187F	Anti rheum drugthxpyrxd/gvn		M					
4188F	Approp ACE/ARB tstng done		M					
4189F	Approp digoxin tstng done		M					
4190F	Approp diuretic tstng done		M					
4191F	Approp anticonvuls tstng		M					
4192F	Pt not rcvng glucoco thxpy		M					
4193F	Pt rcvng<10mg daily predniso		M					
4194F	Pt rec>=10mg prednison qd		M					
4195F	Pt rcvng anti-rheum thxpy RA		M					
4196F	Ptnot rcvng anti-rhm thxpyRA		M					
4200F	External beam to prost only		M					
4201F	Extrnl beam other than prost		M					
4210F	ACE/ARB thxpy for >= 6 mons		M					
4220F	Digoxin thxpy for >= 6 mons		M					
4221F	Diuretic thxpy for >= 6 mons		M					
4230F	Anticonv thxpy for >= 6 mons		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4240F	Instr xrcz 4bk pn >12 weeks		M					
4242F	Sprvsd xrcz bk pn >12 weeks		M					
4245F	Pt instr nrml lifest		M					
4248F	Pt instr-no bd rest>= 4 days		M					
4250F	Wrmng 4 surg - normothermia		M					
4255F	Anesth >= 60 min as docd		M					
4256F	Anesth < 60 min as docd		M					
4260F	Wound srfc culturetech used		E					
4261F	Tech other than surfc cultr		E					
4265F	Wet-dry dressings Rx-recmd		E					
4266F	No wet-dry drssings Rx-recmd		E					
4267F	Comprssion thxpy prescribed		M					
4268F	Pt ed re comp thxpy rcvd		E					
4269F	Appropos mthd offloading Rxd		E					
4270F	Pt rcvng anti r-viral thxpy		M					
4271F	Pt rcvng anti r-viral thxpy		M					
4274F	Flu immuno admind rcvd		M					
4275F	Hep b vac inj admin/ rcvd		E					
4276F	Potent antivir thxpy Rxd		M					
4279F	PCP prophylaxis Rxd		E					
4280F	PCP prophylax Rxd 3mon low %		M					
4290F	Pt scrned for inj drug use		M					
4293F	Pt scrnd - hgh-rsk sex behav		M					
4300F	Pt rcvng warf thxpy		E					
4301F	Pt not rcvng warf thxpy		E					
4305F	Pt ed re ft care inspct rcvd		E					
4306F	Pt tlk psych & Rx opd addic		E					
4320F	Pt talk psychsoc+rx oh dpnd		E					
4330F	Cnslng epi spec sfty issues		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4340F	Cnslng chldbrng+ women epi		E					
5005F	Pt counsld on exam for moles		M					
5010F	Macul+ fndngs to dr mng dm		M					
5015F	Doc fx & test/txmnt for op		M					
5020F	Txmnts 2 main Dr by 1 mon		E					
5050F	Plan 2 main dr by 1 month		M					
5060F	Fndngs mammo 2pt w/in 3 days		M					
5062F	Doc f2fmammo fndng in 5 days		M					
5100F	Rsk fx ref w/n 24 hrs x-ray		E					
5200F	Eval appros surg thxpy epi		E					
6005F	Care level rationale doc		M					
6010F	Dysphag test done b/4 eating		M					
6015F	Dysphag test done b/4 eating		M					
6020F	Npo (nothing-mouth) ordered		M					
6030F	Max sterile barriers follwd		M					
6040F	Appro rad ds dvcs techs docd		M					
6045F	Radxps in end rprt4fluro pxd		M					
6070F	Pt asked/cnsld aed effects		E					
7010F	Pt info into recall system		M					
7020F	Mammo assess cat in dbase		M					
7025F	Pt infosys alarm 4 nxt mammo		M					
A0021	Outside state ambulance serv		E					
A0080	Noninterest escort in non er		E					
A0090	Interest escort in non er		E					
A0100	Nonemergency transport taxi		E					
A0110	Nonemergency transport bus		E					
A0120	Noner transport mini-bus		E					
A0130	Noner transport wheelch van		E					
A0140	Nonemergency transport air		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A0160	Noner transport case worker		E					
A0170	Transport parking fees/tolls		E					
A0180	Noner transport lodgng recip		E					
A0190	Noner transport meals recip		E					
A0200	Noner transport lodgng escrt		E					
A0210	Noner transport meals escort		E					
A0225	Neonatal emergency transport		E					
A0380	Basic life support mileage		E					
A0382	Basic support routine suppls		A					
A0384	Bls defibrillation supplies		A					
A0390	Advanced life support mileag		E					
A0392	Als defibrillation supplies		A					
A0394	Als IV drug therapy supplies		A					
A0396	Als esophageal intub suppls		A					
A0398	Als routine disposble suppls		A					
A0420	Ambulance waiting 1/2 hr		A					
A0422	Ambulance 02 life sustaining		A					
A0424	Extra ambulance attendant		A					
A0425	Ground mileage		A					
A0426	Als 1		A					
A0427	ALS1-emergency		A					
A0428	bls		A					
A0429	BLS-emergency		A					
A0430	Fixed wing air transport		A					
A0431	Rotary wing air transport		A					
A0432	PI volunteer ambulance co		A					
A0433	als 2		A					
A0434	Specialty care transport		A					
A0435	Fixed wing air mileage		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A0436	Rotary wing air mileage		A					
A0888	Noncovered ambulance mileage		E					
A0998	Ambulance response/treatment		E					
A0999	Unlisted ambulance service		A					
A4206	1 CC sterile syringe&needle		E					
A4207	2 CC sterile syringe&needle		E					
A4208	3 CC sterile syringe&needle		E					
A4209	5+ CC sterile syringe&needle		E					
A4210	Nonneedle injection device		E					
A4211	Supp for self-adm injections		E					
A4212	Non coring needle or stylet		B					
A4213	20+ CC syringe only		E					
A4215	Sterile needle		E					
A4216	Sterile water/saline, 10 ml		A					
A4217	Sterile water/saline, 500 ml		A					
A4218	Sterile saline or water		N					
A4220	Infusion pump refill kit		N					
A4221	Maint drug infus cath per wk		Y					
A4222	Infusion supplies with pump		Y					
A4223	Infusion supplies w/o pump		E					
A4230	Infus insulin pump non needl		N					
A4231	Infusion insulin pump needle		N					
A4232	Syringe w/needle insulin 3cc		E					
A4233	Alkalin batt for glucose mon		Y					
A4234	J-cell batt for glucose mon		Y					
A4235	Lithium batt for glucose mon		Y					
A4236	Silvr oxide batt glucose mon		Y					
A4244	Alcohol or peroxide per pint		E					
A4245	Alcohol wipes per box		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4246	Betadine/phisohex solution		E					
A4247	Betadine/iodine swabs/wipes		E					
A4248	Chlorhexidine antisept		N					
A4250	Urine reagent strips/tablets		E					
A4252	Blood ketone test or strip		E					
A4253	Blood glucose/reagent strips		Y					
A4255	Glucose monitor platforms		Y					
A4256	Calibrator solution/chips		Y					
A4257	Replace Lensshield Cartridge		Y					
A4258	Lancet device each		Y					
A4259	Lancets per box		Y					
A4261	Cervical cap contraceptive		E					
A4262	Temporary tear duct plug		N					
A4263	Permanent tear duct plug		N					
A4264	Intratubal occlusion device		E					
A4265	Paraffin		Y					
A4266	Diaphragm		E					
A4267	Male condom		E					
A4268	Female condom		E					
A4269	Spermicide		E					
A4270	Disposable endoscope sheath		N					
A4280	Brst prsths adhsv attchmnt		A					
A4281	Replacement breastpump tube		E					
A4282	Replacement breastpump adpt		E					
A4283	Replacement breastpump cap		E					
A4284	Replcmnt breast pump shield		E					
A4285	Replcmnt breast pump bottle		E					
A4286	Replcmnt breastpump lok ring		E					
A4290	Sacral nerve stim test lead		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4300	Cath impl vasc access portal		N					
A4301	Implantable access syst perc		N					
A4305	Drug delivery system >=50 ML		N					
A4306	Drug delivery system <=50 ml		N					
A4310	Insert tray w/o bag/cath		A					
A4311	Catheter w/o bag 2-way latex		A					
A4312	Cath w/o bag 2-way silicone		A					
A4313	Catheter w/bag 3-way		A					
A4314	Cath w/drainage 2-way latex		A					
A4315	Cath w/drainage 2-way silcne		A					
A4316	Cath w/drainage 3-way		A					
A4320	Irrigation tray		A					
A4321	Cath therapeutic irrig agent		A					
A4322	Irrigation syringe		A					
A4326	Male external catheter		A					
A4327	Fem urinary collect dev cup		A					
A4328	Fem urinary collect pouch		A					
A4330	Stool collection pouch		A					
A4331	Extension drainage tubing		A					
A4332	Lube sterile packet		A					
A4333	Urinary cath anchor device		A					
A4334	Urinary cath leg strap		A					
A4335	Incontinence supply		A					
A4336	Urethral insert		A					
A4338	Indwelling catheter latex		A					
A4340	Indwelling catheter special		A					
A4344	Cath indw foley 2 way silicn		A					
A4346	Cath indw foley 3 way		A					
A4349	Disposable male external cat		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4351	Straight tip urine catheter		A					
A4352	Coude tip urinary catheter		A					
A4353	Intermittent urinary cath		A					
A4354	Cath insertion tray w/bag		A					
A4355	Bladder irrigation tubing		A					
A4356	Ext ureth clmp or compr dvc		A					
A4357	Bedside drainage bag		A					
A4358	Urinary leg or abdomen bag		A					
A4360	Disposable ext urethral dev		A					
A4361	Ostomy face plate		A					
A4362	Solid skin barrier		A					
A4363	Ostomy clamp, replacement		A					
A4364	Adhesive, liquid or equal		A					
A4366	Ostomy vent		A					
A4367	Ostomy belt		A					
A4368	Ostomy filter		A					
A4369	Skin barrier liquid per oz		A					
A4371	Skin barrier powder per oz		A					
A4372	Skin barrier solid 4x4 equiv		A					
A4373	Skin barrier with flange		A					
A4375	Drainable plastic pch w fcpl		A					
A4376	Drainable rubber pch w fcplt		A					
A4377	Drainable plstic pch w/o fp		A					
A4378	Drainable rubber pch w/o fp		A					
A4379	Urinary plastic pouch w fcpl		A					
A4380	Urinary rubber pouch w fcplt		A					
A4381	Urinary plastic pouch w/o fp		A					
A4382	Urinary hvy plstc pch w/o fp		A					
A4383	Urinary rubber pouch w/o fp		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4384	Ostomy faceplt/silicone ring		A					
A4385	Ost skn barrier sld ext wear		A					
A4387	Ost clsd pouch w att st barr		A					
A4388	Drainable pch w ex wear barr		A					
A4389	Drainable pch w st wear barr		A					
A4390	Drainable pch ex wear convex		A					
A4391	Urinary pouch w ex wear barr		A					
A4392	Urinary pouch w st wear barr		A					
A4393	Urine pch w ex wear bar conv		A					
A4394	Ostomy pouch liq deodorant		A					
A4395	Ostomy pouch solid deodorant		A					
A4396	Peristomal hernia supprt blt		A					
A4397	Irrigation supply sleeve		A					
A4398	Ostomy irrigation bag		A					
A4399	Ostomy irrig cone/cath w brs		A					
A4400	Ostomy irrigation set		A					
A4402	Lubricant per ounce		A					
A4404	Ostomy ring each		A					
A4405	Nonpectin based ostomy paste		A					
A4406	Pectin based ostomy paste		A					
A4407	Ext wear ost skn barr <=4sq"		A					
A4408	Ext wear ost skn barr >4sq"		A					
A4409	Ost skn barr convex <=4 sq i		A					
A4410	Ost skn barr extnd >4 sq		A					
A4411	Ost skn barr extnd =4sq		A					
A4412	Ost pouch drain high output		A					
A4413	2 pc drainable ost pouch		A					
A4414	Ost sknbar w/o conv<=4 sq in		A					
A4415	Ost skn barr w/o conv >4 sqi		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4416	Ost pch clsd w barrier/filtr		A					
A4417	Ost pch w bar/bltinconv/fltr		A					
A4418	Ost pch clsd w/o bar w filtr		A					
A4419	Ost pch for bar w flange/flt		A					
A4420	Ost pch clsd for bar w lk fl		A					
A4421	Ostomy supply misc		E					
A4422	Ost pouch absorbent material		A					
A4423	Ost pch for bar w lk fl/fltr		A					
A4424	Ost pch drain w bar & filter		A					
A4425	Ost pch drain for barrier fl		A					
A4426	Ost pch drain 2 piece system		A					
A4427	Ost pch drain/barr lk flng/f		A					
A4428	Urine ost pouch w faucet/tap		A					
A4429	Urine ost pouch w bltinconv		A					
A4430	Ost urine pch w b/bltin conv		A					
A4431	Ost pch urine w barrier/tapv		A					
A4432	Os pch urine w bar/fange/tap		A					
A4433	Urine ost pch bar w lock fln		A					
A4434	Ost pch urine w lock flng/ft		A					
A4450	Non-waterproof tape		A					
A4452	Waterproof tape		A					
A4455	Adhesive remover per ounce		A					
A4456	Adhesive remover, wipes		A					
A4458	Reusable enema bag		E					
A4461	Surgicl dress hold non-reuse		A					
A4463	Surgical dress holder reuse		A					
A4465	Non-elastic extremity binder		N					
A4466	Elastic garment/covering		E					
A4470	Gravlee jet washer		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4480	Vabra aspirator		N					
A4481	Tracheostoma filter		A					
A4483	Moisture exchanger		A					
A4490	Above knee surgical stocking		E					
A4495	Thigh length surg stocking		E					
A4500	Below knee surgical stocking		E					
A4510	Full length surg stocking		E					
A4520	Incontinence garment anytype		E					
A4550	Surgical trays		B					
A4554	Disposable underpads		E					
A4556	Electrodes, pair		Y					
A4557	Lead wires, pair		Y					
A4558	Conductive gel or paste		Y					
A4559	Coupling gel or paste		Y					
A4561	Pessary rubber, any type		N					
A4562	Pessary, non rubber,any type		N					
A4565	Slings		N					
A4570	Splint		E					
A4575	Hyperbaric o2 chamber disps		E					
A4580	Cast supplies (plaster)		E					
A4590	Special casting material		E					
A4595	TENS suppl 2 lead per month		Y					
A4600	Sleeve, inter limb comp dev		Y					
A4601	Lith ion batt, non-pros use		Y					
A4604	Tubing with heating element		Y					
A4605	Trach suction cath close sys		Y					
A4606	Oxygen probe used w oximeter		A					
A4608	Transtracheal oxygen cath		Y					
A4611	Heavy duty battery		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4612	Battery cables		Y					
A4613	Battery charger		Y					
A4614	Hand-held PEFR meter		Y					
A4615	Cannula nasal		Y					
A4616	Tubing (oxygen) per foot		Y					
A4617	Mouth piece		Y					
A4618	Breathing circuits		Y					
A4619	Face tent		Y					
A4620	Variable concentration mask		Y					
A4623	Tracheostomy inner cannula		A					
A4624	Tracheal suction tube		Y					
A4625	Trach care kit for new trach		A					
A4626	Tracheostomy cleaning brush		A					
A4627	Spacer bag/reservoir		E					
A4628	Oropharyngeal suction cath		Y					
A4629	Tracheostomy care kit		A					
A4630	Repl bat t.e.n.s. own by pt		Y					
A4633	Uvl replacement bulb		Y					
A4634	Replacement bulb th lightbox		A					
A4635	Underarm crutch pad		Y					
A4636	Handgrip for cane etc		Y					
A4637	Repl tip cane/crutch/walker		Y					
A4638	Repl batt pulse gen sys		Y					
A4639	Infrared ht sys replcmnt pad		Y					
A4640	Alternating pressure pad		Y					
A4641	Radiopharm dx agent noc		N					
A4642	In111 satumomab		N					
A4648	Implantable tissue marker		N					
A4649	Surgical supplies		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4650	Implant radiation dosimeter		N					
A4651	Calibrated microcap tube		A					
A4652	Microcapillary tube sealant		A					
A4653	PD catheter anchor belt		A					
A4657	Syringe w/wo needle		N					
A4660	Sphyg/bp app w cuff and stet		N					
A4663	Dialysis blood pressure cuff		N					
A4670	Automatic bp monitor, dial		E					
A4671	Disposable cycler set		B					
A4672	Drainage ext line, dialysis		B					
A4673	Ext line w easy lock connect		B					
A4674	Chem/antisept solution, 8oz		B					
A4680	Activated carbon filter, ea		N					
A4690	Dialyzer, each		N					
A4706	Bicarbonate conc sol per gal		N					
A4707	Bicarbonate conc pow per pac		N					
A4708	Acetate conc sol per gallon		N					
A4709	Acid conc sol per gallon		N					
A4714	Treated water per gallon		N					
A4719	"Y set" tubing		N					
A4720	Dialysat sol fld vol > 249cc		N					
A4721	Dialysat sol fld vol > 999cc		N					
A4722	Dialys sol fld vol > 1999cc		N					
A4723	Dialys sol fld vol > 2999cc		N					
A4724	Dialys sol fld vol > 3999cc		N					
A4725	Dialys sol fld vol > 4999cc		N					
A4726	Dialys sol fld vol > 5999cc		N					
A4728	Dialysate solution, non-dex		B					
A4730	Fistula cannulation set, ea		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4736	Topical anesthetic, per gram		N					
A4737	Inj anesthetic per 10 ml		N					
A4740	Shunt accessory		N					
A4750	Art or venous blood tubing		N					
A4755	Comb art/venous blood tubing		N					
A4760	Dialysate sol test kit, each		N					
A4765	Dialysate conc pow per pack		N					
A4766	Dialysate conc sol add 10 ml		N					
A4770	Blood collection tube/vacuum		N					
A4771	Serum clotting time tube		N					
A4772	Blood glucose test strips		N					
A4773	Occult blood test strips		N					
A4774	Ammonia test strips		N					
A4802	Protamine sulfate per 50 mg		N					
A4860	Disposable catheter tips		N					
A4870	Plumb/elec wk hm hemo equip		N					
A4890	Repair/maint cont hemo equip		N					
A4911	Drain bag/bottle		N					
A4913	Misc dialysis supplies noc		N					
A4918	Venous pressure clamp		N					
A4927	Non-sterile gloves		N					
A4928	Surgical mask		N					
A4929	Tourniquet for dialysis, ea		N					
A4930	Sterile, gloves per pair		N					
A4931	Reusable oral thermometer		N					
A4932	Reusable rectal thermometer		E					
A5051	Pouch clsd w barr attached		A					
A5052	Clsd ostomy pouch w/o barr		A					
A5053	Clsd ostomy pouch faceplate		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A5054	Clsd ostomy pouch w/flange		A					
A5055	Stoma cap		A					
A5061	Pouch drainable w barrier at		A					
A5062	Drnble ostomy pouch w/o barr		A					
A5063	Drain ostomy pouch w/flange		A					
A5071	Urinary pouch w/barrier		A					
A5072	Urinary pouch w/o barrier		A					
A5073	Urinary pouch on barr w/flng		A					
A5081	Continent stoma plug		A					
A5082	Continent stoma catheter		A					
A5083	Stoma absorptive cover		A					
A5093	Ostomy accessory convex inse		A					
A5102	Bedside drain btl w/wo tube		A					
A5105	Urinary suspensory		A					
A5112	Urinary leg bag		A					
A5113	Latex leg strap		A					
A5114	Foam/fabric leg strap		A					
A5120	Skin barrier, wipe or swab		A					
A5121	Solid skin barrier 6x6		A					
A5122	Solid skin barrier 8x8		A					
A5126	Disk/foam pad +or- adhesive		A					
A5131	Appliance cleaner		A					
A5200	Percutaneous catheter anchor		A					
A5500	Diab shoe for density insert		Y					
A5501	Diabetic custom molded shoe		Y					
A5503	Diabetic shoe w/roller/rockr		Y					
A5504	Diabetic shoe with wedge		Y					
A5505	Diab shoe w/metatarsal bar		Y					
A5506	Diabetic shoe w/off set heel		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A5507	Modification diabetic shoe		Y					
A5508	Diabetic deluxe shoe		Y					
A5510	Compression form shoe insert		E					
A5512	Multi den insert direct form		Y					
A5513	Multi den insert custom mold		Y					
A6000	Wound warming wound cover		E					
A6010	Collagen based wound filler		A					
A6011	Collagen gel/paste wound fil		A					
A6021	Collagen dressing <=16 sq in		A					
A6022	Collagen drsg>16<=48 sq in		A					
A6023	Collagen dressing >48 sq in		A					
A6024	Collagen dsg wound filler		A					
A6025	Silicone gel sheet, each		E					
A6154	Wound pouch each		A					
A6196	Alginate dressing <=16 sq in		A					
A6197	Alginate drsg >16 <=48 sq in		A					
A6198	alginate dressing > 48 sq in		A					
A6199	Alginate drsg wound filler		A					
A6203	Composite drsg <= 16 sq in		A					
A6204	Composite drsg >16<=48 sq in		A					
A6205	Composite drsg > 48 sq in		A					
A6206	Contact layer <= 16 sq in		A					
A6207	Contact layer >16<= 48 sq in		A					
A6208	Contact layer > 48 sq in		A					
A6209	Foam drsg <=16 sq in w/o bdr		A					
A6210	Foam drg >16<=48 sq in w/o b		A					
A6211	Foam drg > 48 sq in w/o brdr		A					
A6212	Foam drg <=16 sq in w/border		A					
A6213	Foam drg >16<=48 sq in w/bdr		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6214	Foam drg > 48 sq in w/border		A					
A6215	Foam dressing wound filler		A					
A6216	Non-sterile gauze<=16 sq in		A					
A6217	Non-sterile gauze>16<=48 sq		A					
A6218	Non-sterile gauze > 48 sq in		A					
A6219	Gauze <= 16 sq in w/border		A					
A6220	Gauze >16 <=48 sq in w/bordr		A					
A6221	Gauze > 48 sq in w/border		A					
A6222	Gauze <=16 in no w/sal w/o b		A					
A6223	Gauze >16<=48 no w/sal w/o b		A					
A6224	Gauze > 48 in no w/sal w/o b		A					
A6228	Gauze <= 16 sq in water/sal		A					
A6229	Gauze >16<=48 sq in watr/sal		A					
A6230	Gauze > 48 sq in water/salne		A					
A6231	Hydrogel dsg<=16 sq in		A					
A6232	Hydrogel dsg>16<=48 sq in		A					
A6233	Hydrogel dressing >48 sq in		A					
A6234	Hydrocolld drg <=16 w/o bdr		A					
A6235	Hydrocolld drg >16<=48 w/o b		A					
A6236	Hydrocolld drg > 48 in w/o b		A					
A6237	Hydrocolld drg <=16 in w/bdr		A					
A6238	Hydrocolld drg >16<=48 w/bdr		A					
A6239	Hydrocolld drg > 48 in w/bdr		A					
A6240	Hydrocolld drg filler paste		A					
A6241	Hydrocolloid drg filler dry		A					
A6242	Hydrogel drg <=16 in w/o bdr		A					
A6243	Hydrogel drg >16<=48 w/o bdr		A					
A6244	Hydrogel drg >48 in w/o bdr		A					
A6245	Hydrogel drg <= 16 in w/bdr		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6246	Hydrogel drg >16<=48 in w/b		A					
A6247	Hydrogel drg > 48 sq in w/b		A					
A6248	Hydrogel drsg gel filler		A					
A6250	Skin seal protect moisturizr		A					
A6251	Absorpt drg <=16 sq in w/o b		A					
A6252	Absorpt drg >16 <=48 w/o bdr		A					
A6253	Absorpt drg > 48 sq in w/o b		A					
A6254	Absorpt drg <=16 sq in w/bdr		A					
A6255	Absorpt drg >16<=48 in w/bdr		A					
A6256	Absorpt drg > 48 sq in w/bdr		A					
A6257	Transparent film <= 16 sq in		A					
A6258	Transparent film >16<=48 in		A					
A6259	Transparent film > 48 sq in		A					
A6260	Wound cleanser any type/size		A					
A6261	Wound filler gel/paste /oz		A					
A6262	Wound filler dry form / gram		A					
A6266	Impreg gauze no h20/sal/yard		A					
A6402	Sterile gauze <= 16 sq in		A					
A6403	Sterile gauze>16 <= 48 sq in		A					
A6404	Sterile gauze > 48 sq in		A					
A6407	Packing strips, non-impreg		A					
A6410	Sterile eye pad		A					
A6411	Non-sterile eye pad		A					
A6412	Occlusive eye patch		E					
A6413	Adhesive bandage, first-aid		E					
A6441	Pad band w>=3" <5"/yd		A					
A6442	Conform band n/s w<3"/yd		A					
A6443	Conform band n/s w>=3"<5"/yd		A					
A6444	Conform band n/s w>=5"/yd		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6445	Conform band s w <3"/yd		A					
A6446	Conform band s w>=3" <5"/yd		A					
A6447	Conform band s w >=5"/yd		A					
A6448	Lt compres band <3"/yd		A					
A6449	Lt compres band >=3" <5"/yd		A					
A6450	Lt compres band >=5"/yd		A					
A6451	Mod compres band w>=3"<5"/yd		A					
A6452	High compres band w>=3"<5"yd		A					
A6453	Self-adher band w <3"/yd		A					
A6454	Self-adher band w>=3" <5"/yd		A					
A6455	Self-adher band >=5"/yd		A					
A6456	Zinc paste band w >=3"<5"/yd		A					
A6457	Tubular dressing		A					
A6501	Compres burngarment bodysuit		A					
A6502	Compres burngarment chinstrp		A					
A6503	Compres burngarment facehood		A					
A6504	Cmprsburngarment glove-wrist		A					
A6505	Cmprsburngarment glove-elbow		A					
A6506	Cmprsburngrmnt glove-axilla		A					
A6507	Cmprs burngarment foot-knee		A					
A6508	Cmprs burngarment foot-thigh		A					
A6509	Compres burn garment jacket		A					
A6510	Compres burn garment leotard		A					
A6511	Compres burn garment panty		A					
A6512	Compres burn garment, noc		A					
A6513	Compress burn mask face/neck		B					
A6530	Compression stocking BK18-30		E					
A6531	Compression stocking BK30-40		A					
A6532	Compression stocking BK40-50		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6533	Gc stocking thighlngth 18-30		E					
A6534	Gc stocking thighlngth 30-40		E					
A6535	Gc stocking thighlngth 40-50		E					
A6536	Gc stocking full lngth 18-30		E					
A6537	Gc stocking full lngth 30-40		E					
A6538	Gc stocking full lngth 40-50		E					
A6539	Gc stocking waistlngth 18-30		E					
A6540	Gc stocking waistlngth 30-40		E					
A6541	Gc stocking waistlngth 40-50		E					
A6544	Gc stocking garter belt		E					
A6545	Grad comp non-elastic BK		A					
A6549	G compression stocking		E					
A6550	Neg pres wound ther drsg set		Y					
A7000	Disposable canister for pump		Y					
A7001	Nondisposable pump canister		Y					
A7002	Tubing used w suction pump		Y					
A7003	Nebulizer administration set		Y					
A7004	Disposable nebulizer sml vol		Y					
A7005	Nondisposable nebulizer set		Y					
A7006	Filtered nebulizer admin set		Y					
A7007	Lg vol nebulizer disposable		Y					
A7008	Disposable nebulizer prefill		Y					
A7009	Nebulizer reservoir bottle		Y					
A7010	Disposable corrugated tubing		Y					
A7011	Nondispos corrugated tubing		Y					
A7012	Nebulizer water collec devic		Y					
A7013	Disposable compressor filter		Y					
A7014	Compressor nondispos filter		Y					
A7015	Aerosol mask used w nebulize		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A7016	Nebulizer dome & mouthpiece		Y					
A7017	Nebulizer not used w oxygen		Y					
A7018	Water distilled w/nebulizer		Y					
A7025	Replace chest compress vest		Y					
A7026	Replace chst cmprss sys hose		Y					
A7027	Combination oral/nasal mask		Y					
A7028	Repl oral cushion combo mask		Y					
A7029	Repl nasal pillow comb mask		Y					
A7030	CPAP full face mask		Y					
A7031	Replacement facemask interfa		Y					
A7032	Replacement nasal cushion		Y					
A7033	Replacement nasal pillows		Y					
A7034	Nasal application device		Y					
A7035	Pos airway press headgear		Y					
A7036	Pos airway press chinstrap		Y					
A7037	Pos airway pressure tubing		Y					
A7038	Pos airway pressure filter		Y					
A7039	Filter, non disposable w pap		Y					
A7040	One way chest drain valve		A					
A7041	Water seal drain container		A					
A7042	Implanted pleural catheter		N					
A7043	Vacuum drainagebottle/tubing		A					
A7044	PAP oral interface		Y					
A7045	Repl exhalation port for PAP		Y					
A7046	Repl water chamber, PAP dev		Y					
A7501	Tracheostoma valve w diaphra		A					
A7502	Replacement diaphragm/fplate		A					
A7503	HMES filter holder or cap		A					
A7504	Tracheostoma HMES filter		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A7505	HMES or trach valve housing		A					
A7506	HMES/trachvalve adhesivedisk		A					
A7507	Integrated filter & holder		A					
A7508	Housing & Integrated Adhesiv		A					
A7509	Heat & moisture exchange sys		A					
A7520	Trach/laryn tube non-cuffed		A					
A7521	Trach/laryn tube cuffed		A					
A7522	Trach/laryn tube stainless		A					
A7523	Tracheostomy shower protect		A					
A7524	Tracheostoma stent/stud/bttn		A					
A7525	Tracheostomy mask		A					
A7526	Tracheostomy tube collar		A					
A7527	Trach/laryn tube plug/stop		A					
A8000	Soft protect helmet prefab		Y					
A8001	Hard protect helmet prefab		Y					
A8002	Soft protect helmet custom		Y					
A8003	Hard protect helmet custom		Y					
A8004	Repl soft interface, helmet		Y					
A9150	Misc/exper non-prescript dru		B					
A9152	Single vitamin nos		E					
A9153	Multi-vitamin nos		E					
A9155	Artificial saliva		B					
A9180	Lice treatment, topical		E					
A9270	Non-covered item or service		E					
A9274	Ext amb insulin delivery sys		E					
A9275	Disp home glucose monitor		E					
A9276	Disposable sensor, CGM sys		E					
A9277	External transmitter, CGM		E					
A9278	External receiver, CGM sys		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A9279	Monitoring feature/deviceNOC		E					
A9280	Alert device, noc		E					
A9281	Reaching/grabbing device		E					
A9282	Wig any type		E					
A9283	Foot press off load supp dev		E					
A9284	Non-electronic spirometer		N					
A9300	Exercise equipment		E					
A9500	Tc99m sestamibi		N					
A9501	Technetium TC-99m teboroxime		N					
A9502	Tc99m tetrofosmin		N					
A9503	Tc99m medronate		N					
A9504	Tc99m apcitide		N					
A9505	TL201 thallium		N					
A9507	In111 capromab		N					
A9508	I131 iodobenguate, dx		N					
A9509	Iodine I-123 sod iodide mil		N					
A9510	Tc99m disofenin		N					
A9512	Tc99m pertechnetate		N					
A9516	Iodine I-123 sod iodide mic		N					
A9517	I131 iodide cap, rx		K	1064		$18.20	.	$3.64
A9521	Tc99m exametazime		N					
A9524	I131 serum albumin, dx		N					
A9526	Nitrogen N-13 ammonia		N					
A9527	Iodine I-125 sodium iodide		U	2632	0.3077	$21.01	.	$4.21
A9528	Iodine I-131 iodide cap, dx		N					
A9529	I131 iodide sol, dx		N					
A9530	I131 iodide sol, rx		K	1150		$13.72	.	$2.75
A9531	I131 max 100uCi		N					
A9532	I125 serum albumin, dx		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A9536	Tc99m depreotide		N					
A9537	Tc99m mebrofenin		N					
A9538	Tc99m pyrophosphate		N					
A9539	Tc99m pentetate		N					
A9540	Tc99m MAA		N					
A9541	Tc99m sulfur colloid		N					
A9542	In111 ibritumomab, dx		N					
A9543	Y90 ibritumomab, rx		K	1643		$31,434.63	.	$6,286.93
A9544	I131 tositumomab, dx		N					
A9545	I131 tositumomab, rx		K	1645		$23,132.09	.	$4,626.42
A9546	Co57/58		N					
A9547	In111 oxyquinoline		N					
A9548	In111 pentetate		N					
A9550	Tc99m gluceptate		N					
A9551	Tc99m succimer		N					
A9552	F18 fdg		N					
A9553	Cr51 chromate		N					
A9554	I125 iothalamate, dx		N					
A9555	Rb82 rubidium		N					
A9556	Ga67 gallium		N					
A9557	Tc99m bicisate		N					
A9558	Xe133 xenon 10mci		N					
A9559	Co57 cyano		N					
A9560	Tc99m labeled rbc		N					
A9561	Tc99m oxidronate		N					
A9562	Tc99m mertiatide		N					
A9563	P32 Na phosphate		K	1675		$196.49	.	$39.30
A9564	P32 chromic phosphate		K	1676		$113.44	.	$22.69
A9566	Tc99m fanolesomab		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A9567	Technetium TC-99m aerosol		N					
A9568	Technetium tc99m arcitumomab		N					
A9569	Technetium TC-99m auto WBC		N					
A9570	Indium In-111 auto WBC		N					
A9571	Indium IN-111 auto platelet		N					
A9572	Indium In-111 pentetreotide		N					
A9576	Inj prohance multipack		N					
A9577	Inj multihance		N					
A9578	Inj multihance multipack		N					
A9579	Gad-base MR contrast NOS,1ml		N					
A9580	Sodium fluoride F-18		N					
A9581	Gadoxetate disodium inj	CH	N					
A9582	Iodine I-123 iobenguane		G	9247		$2,282.67		
A9583	Gadofosveset trisodium inj		G	1299		$12.89		
A9600	Sr89 strontium		K	0701		$805.83	.	$161.17
A9604	Sm 153 lexidronam		K	1295		$5,613.99	.	$1,122.80
A9698	Non-rad contrast materialNOC		N					
A9699	Radiopharm rx agent noc		N					
A9700	Echocardiography Contrast		B					
A9900	Supply/accessory/service		Y					
A9901	Delivery/set up/dispensing		A					
A9999	DME supply or accessory, nos		Y					
B4034	Enter feed supkit syr by day		Y					
B4035	Enteral feed supp pump per d		Y					
B4036	Enteral feed sup kit grav by		Y					
B4081	Enteral ng tubing w/ stylet		Y					
B4082	Enteral ng tubing w/o stylet		Y					
B4083	Enteral stomach tube levine		Y					
B4087	Gastro/jejuno tube, std		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
B4088	Gastro/jejuno tube, low-pro		A					
B4100	Food thickener oral		E					
B4102	EF adult fluids and electro		Y					
B4103	EF ped fluid and electrolyte		Y					
B4104	Additive for enteral formula		E					
B4149	EF blenderized foods		Y					
B4150	EF complet w/intact nutrient		Y					
B4152	EF calorie dense>/=1.5Kcal		Y					
B4153	EF hydrolyzed/amino acids		Y					
B4154	EF spec metabolic noninherit		Y					
B4155	EF incomplete/modular		Y					
B4157	EF special metabolic inherit		Y					
B4158	EF ped complete intact nut		Y					
B4159	EF ped complete soy based		Y					
B4160	EF ped caloric dense>/=0.7kc		Y					
B4161	EF ped hydrolyzed/amino acid		Y					
B4162	EF ped specmetabolic inherit		Y					
B4164	Parenteral 50% dextrose solu		Y					
B4168	Parenteral sol amino acid 3.		Y					
B4172	Parenteral sol amino acid 5.		Y					
B4176	Parenteral sol amino acid 7-		Y					
B4178	Parenteral sol amino acid >		Y					
B4180	Parenteral sol carb > 50%		Y					
B4185	Parenteral sol 10 gm lipids		B					
B4189	Parenteral sol amino acid &		Y					
B4193	Parenteral sol 52-73 gm prot		Y					
B4197	Parenteral sol 74-100 gm pro		Y					
B4199	Parenteral sol > 100gm prote		Y					
B4216	Parenteral nutrition additiv		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
B4220	Parenteral supply kit premix		Y					
B4222	Parenteral supply kit homemi		Y					
B4224	Parenteral administration ki		Y					
B5000	Parenteral sol renal-amirosy		Y					
B5100	Parenteral sol hepatic-fream		Y					
B5200	Parenteral sol stres-brnch c		Y					
B9000	Enter infusion pump w/o alrm		Y					
B9002	Enteral infusion pump w/ ala		Y					
B9004	Parenteral infus pump portab		Y					
B9006	Parenteral infus pump statio		Y					
B9998	Enteral supp not otherwise c		Y					
B9999	Parenteral supp not othrws c		Y					
C1300	HYPERBARIC Oxygen		S	0659	1.565	$106.84	.	$21.37
C1713	Anchor/screw bn/bn,tis/bn		N					
C1714	Cath, trans atherectomy, dir		N					
C1715	Brachytherapy needle		N					
C1716	Brachytx, non-str, Gold-198		U	1716	2.7019	$184.45	.	$36.89
C1717	Brachytx, non-str,HDR Ir-192		U	1717	3.2259	$220.22	.	$44.05
C1719	Brachytx, NS, Non-HDRIr-192		U	1719	0.3366	$22.98	.	$4.60
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1732	Cath, EP, diag/abl, 3D/vect		N					
C1733	Cath, EP, othr than cool-tip		N					
C1750	Cath, hemodialysis,long-term		N					
C1751	Cath, inf, per/cent/midline		N					
C1752	Cath,hemodialysis,short-term		N					
C1753	Cath, intravas ultrasound		N					
C1754	Catheter, intradiscal		N					
C1755	Catheter, intraspinal		N					
C1756	Cath, pacing, transesoph		N					
C1757	Cath, thrombectomy/embolect		N					
C1758	Catheter, ureteral		N					
C1759	Cath, intra echocardiography		N					
C1760	Closure dev, vasc		N					
C1762	Conn tiss, human(inc fascia)		N					
C1763	Conn tiss, non-human		N					
C1764	Event recorder, cardiac		N					
C1765	Adhesion barrier		N					
C1766	Intro/sheath,strble,non-peel		N					
C1767	Generator, neuro non-recharg		N					
C1768	Graft, vascular		N					
C1769	Guide wire		N					
C1770	Imaging coil, MR, insertable		N					
C1771	Rep dev, urinary, w/sling		N					
C1772	Infusion pump, programmable		N					
C1773	Ret dev, insertable		N					
C1776	Joint device (implantable)		N					
C1777	Lead, AICD, endo single coil		N					
C1778	Lead, neurostimulator		N					
C1779	Lead, pmkr, transvenous VDD		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		N					
C1821	Interspinous implant		N					
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					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1884	Embolization Protect syst		N					
C1885	Cath, translumin angio laser		N					
C1887	Catheter, guiding		N					
C1888	Endovas non-cardiac abl cath		N					
C1891	Infusion pump,non-prog, perm		N					
C1892	Intro/sheath,fixed,peel-away		N					
C1893	Intro/sheath, fixed,non-peel		N					
C1894	Intro/sheath, non-laser		N					
C1895	Lead, AICD, endo dual coil		N					
C1896	Lead, AICD, non sing/dual		N					
C1897	Lead, neurostim test kit		N					
C1898	Lead, pmkr, other than trans		N					
C1899	Lead, pmkr/AICD combination		N					
C1900	Lead, coronary venous		N					
C2614	Probe, perc lumb disc		N					
C2615	Sealant, pulmonary, liquid		N					
C2616	Brachytx, non-str,Yttrium-90		U	2616	245.7374	$16,775.76	.	$3,355.16
C2617	Stent, non-cor, tem w/o del		N					
C2618	Probe, cryoablation		N					
C2619	Pmkr, dual, non rate-resp		N					
C2620	Pmkr, single, non rate-resp		N					
C2621	Pmkr, other than sing/dual		N					
C2622	Prosthesis, penile, non-inf		N					
C2625	Stent, non-cor, tem w/del sy		N					
C2626	Infusion pump, non-prog,temp		N					
C2627	Cath, suprapubic/cystoscopic		N					
C2628	Catheter, occlusion		N					
C2629	Intro/sheath, laser		N					
C2630	Cath, EP, cool-tip		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C2631	Rep dev, urinary, w/o sling		N					
C2634	Brachytx, non-str, HA, I-125		U	2634	0.7596	$51.86	.	$10.38
C2635	Brachytx, non-str, HA, P-103		U	2635	0.4337	$29.61	.	$5.93
C2636	Brachy linear, non-str,P-103		U	2636	0.528	$36.04	.	$7.21
C2637	Brachy,non-str,Ytterbium-169		B					
C2638	Brachytx, stranded, I-125		U	2638	0.5662	$38.65	.	$7.73
C2639	Brachytx, non-stranded,I-125		U	2639	0.5292	$36.13	.	$7.23
C2640	Brachytx, stranded, P-103		U	2640	0.9334	$63.72	.	$12.75
C2641	Brachytx, non-stranded,P-103		U	2641	0.9135	$62.36	.	$12.48
C2642	Brachytx, stranded, C-131		U	2642	1.6774	$114.51	.	$22.91
C2643	Brachytx, non-stranded,C-131		U	2643	0.9143	$62.42	.	$12.49
C2698	Brachytx, stranded, NOS		U	2698	0.5662	$38.65	.	$7.73
C2699	Brachytx, non-stranded, NOS		U	2699	0.3366	$22.98	.	$4.60
C8900	MRA w/cont, abd		Q3	0284	6.4555	$440.70	$146.85	$88.14
C8901	MRA w/o cont, abd		Q3	0336	5.1052	$348.52	$137.34	$69.71
C8902	MRA w/o fol w/cont, abd		Q3	0337	7.9271	$541.16	$197.83	$108.24
C8903	MRI w/cont, breast, uni		Q3	0284	6.4555	$440.70	$146.85	$88.14
C8904	MRI w/o cont, breast, uni		Q3	0336	5.1052	$348.52	$137.34	$69.71
C8905	MRI w/o fol w/cont, brst, un		Q3	0337	7.9271	$541.16	$197.83	$108.24
C8906	MRI w/cont, breast, bi		Q3	0284	6.4555	$440.70	$146.85	$88.14
C8907	MRI w/o cont, breast, bi		Q3	0336	5.1052	$348.52	$137.34	$69.71
C8908	MRI w/o fol w/cont, breast,		Q3	0337	7.9271	$541.16	$197.83	$108.24
C8909	MRA w/cont, chest		Q3	0284	6.4555	$440.70	$146.85	$88.14
C8910	MRA w/o cont, chest		Q3	0336	5.1052	$348.52	$137.34	$69.71
C8911	MRA w/o fol w/cont, chest		Q3	0337	7.9271	$541.16	$197.83	$108.24
C8912	MRA w/cont, lwr ext		Q3	0284	6.4555	$440.70	$146.85	$88.14
C8913	MRA w/o cont, lwr ext		Q3	0336	5.1052	$348.52	$137.34	$69.71
C8914	MRA w/o fol w/cont, lwr ext		Q3	0337	7.9271	$541.16	$197.83	$108.24
C8918	MRA w/cont, pelvis		Q3	0284	6.4555	$440.70	$146.85	$88.14

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C8919	MRA w/o cont, pelvis		Q3	0336	5.1052	$348.52	$137.34	$69.71
C8920	MRA w/o fol w/cont, pelvis		Q3	0337	7.9271	$541.16	$197.83	$108.24
C8921	TTE w or w/o fol w/cont, com		S	0128	7.1663	$489.22	$162.90	$97.85
C8922	TTE w or w/o fol w/cont, f/u		S	0128	7.1663	$489.22	$162.90	$97.85
C8923	2D TTE w or w/o fol w/con,co		S	0128	7.1663	$489.22	$162.90	$97.85
C8924	2D TTE w or w/o fol w/con,fu		S	0128	7.1663	$489.22	$162.90	$97.85
C8925	2D TEE w or w/o fol w/con,in		S	0128	7.1663	$489.22	$162.90	$97.85
C8926	TEE w or w/o fol w/cont,cong		S	0128	7.1663	$489.22	$162.90	$97.85
C8927	TEE w or w/o fol w/cont, mon		S	0128	7.1663	$489.22	$162.90	$97.85
C8928	TTE w or w/o fol w/con,stres		S	0128	7.1663	$489.22	$162.90	$97.85
C8929	TTE w or wo fol wcon,Doppler		S	0128	7.1663	$489.22	$162.90	$97.85
C8930	TTE w or w/o contr, cont ECG		S	0128	7.1663	$489.22	$162.90	$97.85
C8957	Prolonged IV inf, req pump		S	0440	2.9855	$203.81	.	$40.77
C9113	Inj pantoprazole sodium, via		N					
C9121	Injection, argatroban		K	9121		$18.39	.	$3.68
C9248	Inj, clevidipine butyrate	CH	K	9248		$2.98	.	$0.60
C9250	Artiss fibrin sealant		G	9250		$136.64	.	$27.33
C9254	Injection, lacosamide		K	9254		$0.18	.	$0.04
C9255	Paliperidone palmitate inj		G	9255		$6.54	.	$1.31
C9256	Dexamethasone intravitreal		G	9256		$196.10	.	$39.22
C9257	Bevacizumab injection		K	1281		$1.44	.	$0.29
C9258	Telavancin injection		G	9258		$0.21	.	$0.05
C9259	Pralatrexate injection		G	9259		$165.63	.	$33.13
C9260	Ofatumumab injection		G	9260		$46.64	.	$9.33
C9261	Ustekinumab injection		G	9261		$107.43	.	$21.49
C9262	Fludarabine phosphate, oral		G	9262		$81.77	.	$16.36
C9263	Ecallantide injection		G	9263		$280.90	.	$56.18
C9352	Neuragen nerve guide, per cm		N					
C9353	Neurawrap nerve protector,cm		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C9354	Veritas collagen matrix, cm2		N					
C9355	Neuromatrix nerve cuff, cm		N					
C9356	TenoGlide tendon prot, cm2	CH	N					
C9358	SurgiMend, fetal	CH	K	9358		$10.67	.	$2.14
C9359	Implnt,bon void filler-putty	CH	N					
C9360	SurgiMend, neonatal		G	9360		$11.24	.	$2.25
C9361	NeuroMend nerve wrap		G	9361		$265.18		
C9362	Implnt,bon void filler-strip		G	9362		$50.88		
C9363	Integra Meshed Bil Wound Mat		G	9363		$17.88	.	$3.58
C9364	Porcine implant, Permacol		G	9364		$17.67		
C9399	Unclassified drugs or biolog		A					
C9716	Radiofrequency energy to anu		T	0150	32.6184	$2,226.76	.	$445.36
C9724	EPS gast cardia plic		T	0422	16.3107	$1,113.48	$271.47	$222.70
C9725	Place endorectal app		T	0148	6.2678	$427.88	.	$85.58
C9726	Rxt breast appl place/remov		T	0028	25.7651	$1,758.91	.	$351.79
C9727	Insert palate implants		T	0252	7.8743	$537.55	$109.16	$107.51
C9728	Place device/marker, non pro		X	0310	13.5651	$926.05	$325.27	$185.21
C9898	Inpnt stay radiolabeled item		N					
C9899	Inpt implant pros dev,no cov		A					
D0120	Periodic oral evaluation		E					
D0140	Limit oral eval problm focus		E					
D0145	Oral evaluation, pt < 3yrs		E					
D0150	Comprehensve oral evaluation		S	0330	9.9085	$676.42	.	$135.29
D0160	Extensv oral eval prob focus		E					
D0170	Re-eval,est pt,problem focus		E					
D0180	Comp periodontal evaluation		E					
D0210	Intraor complete film series		E					
D0220	Intraoral periapical first f		E					
D0230	Intraoral periapical ea add		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D0240	Intraoral occlusal film		S	0330	9.9085	$676.42	.	$135.29
D0250	Extraoral first film		S	0330	9.9085	$676.42	.	$135.29
D0260	Extraoral ea additional film		S	0330	9.9085	$676.42	.	$135.29
D0270	Dental bitewing single film		S	0330	9.9085	$676.42	.	$135.29
D0272	Dental bitewings two films		S	0330	9.9085	$676.42	.	$135.29
D0273	Bitewings - three films		E					
D0274	Dental bitewings four films		S	0330	9.9085	$676.42	.	$135.29
D0277	Vert bitewings-sev to eight		S	0330	9.9085	$676.42	.	$135.29
D0290	Dental film skull/facial bon		E					
D0310	Dental saliography		E					
D0320	Dental tmj arthrogram incl i		E					
D0321	Dental other tmj films		E					
D0322	Dental tomographic survey		E					
D0330	Dental panoramic film		E					
D0340	Dental cephalometric film		E					
D0350	Oral/facial photo images		E					
D0360	Cone beam ct		E					
D0362	Cone beam, two dimensional		E					
D0363	Cone beam, three dimensional		E					
D0415	Collection of microorganisms		E					
D0416	Viral culture		B					
D0417	Collect & prep saliva sample		E					
D0418	Analysis of saliva sample		E					
D0421	Gen tst suscept oral disease		B					
D0425	Caries susceptibility test		E					
D0431	Diag tst detect mucos abnorm		B					
D0460	Pulp vitality test		S	0330	9.9085	$676.42	.	$135.29
D0470	Diagnostic casts		E					
D0472	Gross exam, prep & report		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D0473	Micro exam, prep & report		B					
D0474	Micro w exam of surg margins		B					
D0475	Decalcification procedure		B					
D0476	Spec stains for microorganis		B					
D0477	Spec stains not for microorg		B					
D0478	Immunohistochemical stains		B					
D0479	Tissue in-situ hybridization		B					
D0480	Cytopath smear prep & report		B					
D0481	Electron microscopy diagnost		B					
D0482	Direct immunofluorescence		B					
D0483	Indirect immunofluorescence		B					
D0484	Consult slides prep elsewher		B					
D0485	Consult inc prep of slides		B					
D0486	Accession of brush biopsy		E					
D0502	Other oral pathology procedu		B					
D0999	Unspecified diagnostic proce		B					
D1110	Dental prophylaxis adult		E					
D1120	Dental prophylaxis child		E					
D1203	Topical app fluoride child		E					
D1204	Topical app fluoride adult		E					
D1206	Topical fluoride varnish		E					
D1310	Nutri counsel-control caries		E					
D1320	Tobacco counseling		E					
D1330	Oral hygiene instruction		E					
D1351	Dental sealant per tooth		E					
D1510	Space maintainer fxd unilat		S	0330	9.9085	$676.42	.	$135.29
D1515	Fixed bilat space maintainer		S	0330	9.9085	$676.42	.	$135.29
D1520	Remove unilat space maintain		S	0330	9.9085	$676.42	.	$135.29
D1525	Remove bilat space maintain		S	0330	9.9085	$676.42	.	$135.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D1550	Recement space maintainer		S	0330	9.9085	$676.42	.	$135.29
D1555	Remove fix space maintainer		E					
D2140	Amalgam one surface permanen		E					
D2150	Amalgam two surfaces permane		E					
D2160	Amalgam three surfaces perma		E					
D2161	Amalgam 4 or > surfaces perm		E					
D2330	Resin one surface-anterior		E					
D2331	Resin two surfaces-anterior		E					
D2332	Resin three surfaces-anterio		E					
D2335	Resin 4/> surf or w incis an		E					
D2390	Ant resin-based cmpst crown		E					
D2391	Post 1 srfc resinbased cmpst		E					
D2392	Post 2 srfc resinbased cmpst		E					
D2393	Post 3 srfc resinbased cmpst		E					
D2394	Post >=4srfc resinbase cmpst		E					
D2410	Dental gold foil one surface		E					
D2420	Dental gold foil two surface		E					
D2430	Dental gold foil three surfa		E					
D2510	Dental inlay metalic 1 surf		E					
D2520	Dental inlay metallic 2 surf		E					
D2530	Dental inlay metl 3/more sur		E					
D2542	Dental onlay metallic 2 surf		E					
D2543	Dental onlay metallic 3 surf		E					
D2544	Dental onlay metl 4/more sur		E					
D2610	Inlay porcelain/ceramic 1 su		E					
D2620	Inlay porcelain/ceramic 2 su		E					
D2630	Dental onlay porc 3/more sur		E					
D2642	Dental onlay porcelin 2 surf		E					
D2643	Dental onlay porcelin 3 surf		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D2644	Dental onlay porc 4/more sur		E					
D2650	Inlay composite/resin one su		E					
D2651	Inlay composite/resin two su		E					
D2652	Dental inlay resin 3/mre sur		E					
D2662	Dental onlay resin 2 surface		E					
D2663	Dental onlay resin 3 surface		E					
D2664	Dental onlay resin 4/mre sur		E					
D2710	Crown resin-based indirect		E					
D2712	Crown 3/4 resin-based compos		E					
D2720	Crown resin w/ high noble me		E					
D2721	Crown resin w/ base metal		E					
D2722	Crown resin w/ noble metal		E					
D2740	Crown porcelain/ceramic subs		E					
D2750	Crown porcelain w/ h noble m		E					
D2751	Crown porcelain fused base m		E					
D2752	Crown porcelain w/ noble met		E					
D2780	Crown 3/4 cast hi noble met		E					
D2781	Crown 3/4 cast base metal		E					
D2782	Crown 3/4 cast noble metal		E					
D2783	Crown 3/4 porcelain/ceramic		E					
D2790	Crown full cast high noble m		E					
D2791	Crown full cast base metal		E					
D2792	Crown full cast noble metal		E					
D2794	Crown-titanium		E					
D2799	Provisional crown		E					
D2910	Recement inlay onlay or part		E					
D2915	Recement cast or prefab post		E					
D2920	Dental recement crown		E					
D2930	Prefab stnlss steel crwn pri		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D2931	Prefab stnlss steel crown pe		E					
D2932	Prefabricated resin crown		E					
D2933	Prefab stainless steel crown		E					
D2934	Prefab steel crown primary		E					
D2940	Dental sedative filling		E					
D2950	Core build-up incl any pins		E					
D2951	Tooth pin retention		E					
D2952	Post and core cast + crown		E					
D2953	Each addtnl cast post		E					
D2954	Prefab post/core + crown		E					
D2955	Post removal		E					
D2957	Each addtnl prefab post		E					
D2960	Laminate labial veneer		E					
D2961	Lab labial veneer resin		E					
D2962	Lab labial veneer porcelain		E					
D2970	Temp crown (fractured tooth)		E					
D2971	Add proc construct new crown		E					
D2975	Coping		E					
D2980	Crown repair		E					
D2999	Dental unspec restorative pr		S	0330	9.9085	$676.42	.	$135.29
D3110	Pulp cap direct		E					
D3120	Pulp cap indirect		E					
D3220	Therapeutic pulpotomy		E					
D3221	Gross pulpal debridement		E					
D3222	Part pulp for apexogenesis		E					
D3230	Pulpal therapy anterior prim		E					
D3240	Pulpal therapy posterior pri		E					
D3310	End thxpy, anterior tooth		E					
D3320	End thxpy, bicuspid tooth		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D3330	End thxpy, molar		E					
D3331	Non-surg tx root canal obs		E					
D3332	Incomplete endodontic tx		E					
D3333	Internal root repair		E					
D3346	Retreat root canal anterior		E					
D3347	Retreat root canal bicuspid		E					
D3348	Retreat root canal molar		E					
D3351	Apexification/recalc initial		E					
D3352	Apexification/recalc interim		E					
D3353	Apexification/recalc final		E					
D3410	Apicoect/perirad surg anter		E					
D3421	Root surgery bicuspid		E					
D3425	Root surgery molar		E					
D3426	Root surgery ea add root		E					
D3430	Retrograde filling		E					
D3450	Root amputation		E					
D3460	Endodontic endosseous implan		S	0330	9.9085	$676.42	.	$135.29
D3470	Intentional replantation		E					
D3910	Isolation- tooth w rubb dam		E					
D3920	Tooth splitting		E					
D3950	Canal prep/fitting of dowel		E					
D3999	Endodontic procedure		S	0330	9.9085	$676.42	.	$135.29
D4210	Gingivectomy/plasty per quad		E					
D4211	Gingivectomy/plasty per toot		E					
D4230	Ana crown exp 4 or> per quad		E					
D4231	Ana crown exp 1-3 per quad		E					
D4240	Gingival flap proc w/ planin		E					
D4241	Gngvl flap w rootplan 1-3 th		E					
D4245	Apically positioned flap		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D4249	Crown lengthen hard tissue		E					
D4260	Osseous surgery per quadrant		S	0330	9.9085	$676.42	.	$135.29
D4261	Osseous surgl-3teethperquad		E					
D4263	Bone replce graft first site		S	0330	9.9085	$676.42	.	$135.29
D4264	Bone replce graft each add		S	0330	9.9085	$676.42	.	$135.29
D4265	Bio mtrls to aid soft/os reg		E					
D4266	Guided tiss regen resorble		E					
D4267	Guided tiss regen nonresorb		E					
D4268	Surgical revision procedure		S	0330	9.9085	$676.42	.	$135.29
D4270	Pedicle soft tissue graft pr		S	0330	9.9085	$676.42	.	$135.29
D4271	Free soft tissue graft proc		S	0330	9.9085	$676.42	.	$135.29
D4273	Subepithelial tissue graft		S	0330	9.9085	$676.42	.	$135.29
D4274	Distal/proximal wedge proc		E					
D4275	Soft tissue allograft		E					
D4276	Con tissue w dble ped graft		E					
D4320	Provision splnt intracoronal		E					
D4321	Provisional splint extracoro		E					
D4341	Periodontal scaling & root		E					
D4342	Periodontal scaling 1-3teeth		E					
D4355	Full mouth debridement		S	0330	9.9085	$676.42	.	$135.29
D4381	Localized delivery antimicro		S	0330	9.9085	$676.42	.	$135.29
D4910	Periodontal maint procedures		E					
D4920	Unscheduled dressing change		E					
D4999	Unspecified periodontal proc		E					
D5110	Dentures complete maxillary		E					
D5120	Dentures complete mandible		E					
D5130	Dentures immediat maxillary		E					
D5140	Dentures immediat mandible		E					
D5211	Dentures maxill part resin		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5212	Dentures mand part resin		E					
D5213	Dentures maxill part metal		E					
D5214	Dentures mandibl part metal		E					
D5225	Maxillary part denture flex		E					
D5226	Mandibular part denture flex		E					
D5281	Removable partial denture		E					
D5410	Dentures adjust cmplt maxil		E					
D5411	Dentures adjust cmplt mand		E					
D5421	Dentures adjust part maxill		E					
D5422	Dentures adjust part mandbl		E					
D5510	Dentur repr broken compl bas		E					
D5520	Replace denture teeth complt		E					
D5610	Dentures repair resin base		E					
D5620	Rep part denture cast frame		E					
D5630	Rep partial denture clasp		E					
D5640	Replace part denture teeth		E					
D5650	Add tooth to partial denture		E					
D5660	Add clasp to partial denture		E					
D5670	Replc tth&acrlc on mtl frmwk		E					
D5671	Replc tth&acrlc mandibular		E					
D5710	Dentures rebase cmplt maxil		E					
D5711	Dentures rebase cmplt mand		E					
D5720	Dentures rebase part maxill		E					
D5721	Dentures rebase part mandbl		E					
D5730	Denture reln cmplt maxil ch		E					
D5731	Denture reln cmplt mand chr		E					
D5740	Denture reln part maxil chr		E					
D5741	Denture reln part mand chr		E					
D5750	Denture reln cmplt max lab		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5751	Denture reln cmplt mand lab		E					
D5760	Denture reln part maxil lab		E					
D5761	Denture reln part mand lab		E					
D5810	Denture interm cmplt maxill		E					
D5811	Denture interm cmplt mandbl		E					
D5820	Denture interm part maxill		E					
D5821	Denture interm part mandbl		E					
D5850	Denture tiss conditn maxill		E					
D5851	Denture tiss condtin mandbl		E					
D5860	Overdenture complete		E					
D5861	Overdenture partial		E					
D5862	Precision attachment		E					
D5867	Replacement of precision att		E					
D5875	Prosthesis modification		E					
D5899	Removable prosthodontic proc		E					
D5911	Facial moulage sectional		S	0330	9.9085	$676.42	.	$135.29
D5912	Facial moulage complete		S	0330	9.9085	$676.42	.	$135.29
D5913	Nasal prosthesis		E					
D5914	Auricular prosthesis		E					
D5915	Orbital prosthesis		E					
D5916	Ocular prosthesis		E					
D5919	Facial prosthesis		E					
D5922	Nasal septal prosthesis		E					
D5923	Ocular prosthesis interim		E					
D5924	Cranial prosthesis		E					
D5925	Facial augmentation implant		E					
D5926	Replacement nasal prosthesis		E					
D5927	Auricular replacement		E					
D5928	Orbital replacement		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5929	Facial replacement		E					
D5931	Surgical obturator		E					
D5932	Postsurgical obturator		E					
D5933	Refitting of obturator		E					
D5934	Mandibular flange prosthesis		E					
D5935	Mandibular denture prosth		E					
D5936	Temp obturator prosthesis		E					
D5937	Trismus appliance		E					
D5951	Feeding aid		E					
D5952	Pediatric speech aid		E					
D5953	Adult speech aid		E					
D5954	Superimposed prosthesis		E					
D5955	Palatal lift prosthesis		E					
D5958	Intraoral con def inter plt		E					
D5959	Intraoral con def mod palat		E					
D5960	Modify speech aid prosthesis		E					
D5982	Surgical stent		E					
D5983	Radiation applicator		S	0330	9.9085	$676.42	.	$135.29
D5984	Radiation shield		S	0330	9.9085	$676.42	.	$135.29
D5985	Radiation cone locator		S	0330	9.9085	$676.42	.	$135.29
D5986	Fluoride applicator		E					
D5987	Commissure splint		S	0330	9.9085	$676.42	.	$135.29
D5988	Surgical splint		E					
D5991	Topical medicament carrier		E					
D5999	Maxillofacial prosthesis		E					
D6010	Odontics endosteal implant		E					
D6012	Endosteal implant		E					
D6040	Odontics eposteal implant		E					
D6050	Odontics transosteal implnt		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6053	Implnt/abtmnt spprt remv dnt		E					
D6054	Implnt/abtmnt spprt remvprtl		E					
D6055	Implant connecting bar		E					
D6056	Prefabricated abutment		E					
D6057	Custom abutment		E					
D6058	Abutment supported crown		E					
D6059	Abutment supported mtl crown		E					
D6060	Abutment supported mtl crown		E					
D6061	Abutment supported mtl crown		E					
D6062	Abutment supported mtl crown		E					
D6063	Abutment supported mtl crown		E					
D6064	Abutment supported mtl crown		E					
D6065	Implant supported crown		E					
D6066	Implant supported mtl crown		E					
D6067	Implant supported mtl crown		E					
D6068	Abutment supported retainer		E					
D6069	Abutment supported retainer		E					
D6070	Abutment supported retainer		E					
D6071	Abutment supported retainer		E					
D6072	Abutment supported retainer		E					
D6073	Abutment supported retainer		E					
D6074	Abutment supported retainer		E					
D6075	Implant supported retainer		E					
D6076	Implant supported retainer		E					
D6077	Implant supported retainer		E					
D6078	Implnt/abut suprtd fixd dent		E					
D6079	Implnt/abut suprtd fixd dent		E					
D6080	Implant maintenance		E					
D6090	Repair implant		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6091	Repl semi/precision attach		E					
D6092	Recement supp crown		E					
D6093	Recement supp part denture		E					
D6094	Abut support crown titanium		E					
D6095	Odontics repr abutment		E					
D6100	Removal of implant		E					
D6190	Radio/surgical implant index		E					
D6194	Abut support retainer titani		E					
D6199	Implant procedure		E					
D6205	Pontic-indirect resin based		E					
D6210	Prosthodont high noble metal		E					
D6211	Bridge base metal cast		E					
D6212	Bridge noble metal cast		E					
D6214	Pontic titanium		E					
D6240	Bridge porcelain high noble		E					
D6241	Bridge porcelain base metal		E					
D6242	Bridge porcelain nobel metal		E					
D6245	Bridge porcelain/ceramic		E					
D6250	Bridge resin w/high noble		E					
D6251	Bridge resin base metal		E					
D6252	Bridge resin w/noble metal		E					
D6253	Provisional pontic		E					
D6545	Dental retainr cast metl		E					
D6548	Porcelain/ceramic retainer		E					
D6600	Porcelain/ceramic inlay 2srf		E					
D6601	Porc/ceram inlay >= 3 surfac		E					
D6602	Cst hgh nble mtl inlay 2 srf		E					
D6603	Cst hgh nble mtl inlay >=3sr		E					
D6604	Cst bse mtl inlay 2 surfaces		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6605	Cst bse mtl inlay >= 3 surfa		E					
D6606	Cast noble metal inlay 2 sur		E					
D6607	Cst noble mtl inlay >=3 surf		E					
D6608	Onlay porc/crmc 2 surfaces		E					
D6609	Onlay porc/crmc >=3 surfaces		E					
D6610	Onlay cst hgh nbl mtl 2 srfc		E					
D6611	Onlay cst hgh nbl mtl >=3srf		E					
D6612	Onlay cst base mtl 2 surface		E					
D6613	Onlay cst base mtl >=3 surfa		E					
D6614	Onlay cst nbl mtl 2 surfaces		E					
D6615	Onlay cst nbl mtl >=3 surfac		E					
D6624	Inlay titanium		E					
D6634	Onlay titanium		E					
D6710	Crown-indirect resin based		E					
D6720	Retain crown resin w hi nble		E					
D6721	Crown resin w/base metal		E					
D6722	Crown resin w/noble metal		E					
D6740	Crown porcelain/ceramic		E					
D6750	Crown porcelain high noble		E					
D6751	Crown porcelain base metal		E					
D6752	Crown porcelain noble metal		E					
D6780	Crown 3/4 high noble metal		E					
D6781	Crown 3/4 cast based metal		E					
D6782	Crown 3/4 cast noble metal		E					
D6783	Crown 3/4 porcelain/ceramic		E					
D6790	Crown full high noble metal		E					
D6791	Crown full base metal cast		E					
D6792	Crown full noble metal cast		E					
D6793	Provisional retainer crown		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6794	Crown titanium		E					
D6920	Dental connector bar		S	0330	9.9085	$676.42	.	$135.29
D6930	Dental recement bridge		E					
D6940	Stress breaker		E					
D6950	Precision attachment		E					
D6970	Post & core plus retainer		E					
D6972	Prefab post & core plus reta		E					
D6973	Core build up for retainer		E					
D6975	Coping metal		E					
D6976	Each addtnl cast post		E					
D6977	Each addtl prefab post		E					
D6980	Bridge repair		E					
D6985	Pediatric partial denture fx		E					
D6999	Fixed prosthodontic proc		E					
D7111	Extraction coronal remnants		S	0330	9.9085	$676.42	.	$135.29
D7140	Extraction erupted tooth/exr		S	0330	9.9085	$676.42	.	$135.29
D7210	Rem imp tooth w mucoper flp		S	0330	9.9085	$676.42	.	$135.29
D7220	Impact tooth remov soft tiss		S	0330	9.9085	$676.42	.	$135.29
D7230	Impact tooth remov part bony		S	0330	9.9085	$676.42	.	$135.29
D7240	Impact tooth remov comp bony		S	0330	9.9085	$676.42	.	$135.29
D7241	Impact tooth rem bony w/comp		S	0330	9.9085	$676.42	.	$135.29
D7250	Tooth root removal		S	0330	9.9085	$676.42	.	$135.29
D7260	Oral antral fistula closure		S	0330	9.9085	$676.42	.	$135.29
D7261	Primary closure sinus perf		S	0330	9.9085	$676.42	.	$135.29
D7270	Tooth reimplantation		E					
D7272	Tooth transplantation		E					
D7280	Exposure impact tooth orthod		E					
D7282	Mobilize erupted/malpos toot		E					
D7283	Place device impacted tooth		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7285	Biopsy of oral tissue hard		E					
D7286	Biopsy of oral tissue soft		E					
D7287	Exfoliative cytolog collect		E					
D7288	Brush biopsy		B					
D7290	Repositioning of teeth		E					
D7291	Transseptal fiberotomy		S	0330	9.9085	$676.42	.	$135.29
D7292	Screw retained plate		E					
D7293	Temp anchorage dev w flap		E					
D7294	Temp anchorage dev w/o flap		E					
D7310	Alveoplasty w/ extraction		E					
D7311	Alveoloplasty w/extract 1-3		E					
D7320	Alveoplasty w/o extraction		E					
D7321	Alveoloplasty not w/extracts		B					
D7340	Vestibuloplasty ridge extens		E					
D7350	Vestibuloplasty exten graft		E					
D7410	Rad exc lesion up to 1.25 cm		E					
D7411	Excision benign lesion>1.25c		E					
D7412	Excision benign lesion compl		E					
D7413	Excision malig lesion<=1.25c		E					
D7414	Excision malig lesion>1.25cm		E					
D7415	Excision malig les complicat		E					
D7440	Malig tumor exc to 1.25 cm		E					
D7441	Malig tumor > 1.25 cm		E					
D7450	Rem odontogen cyst to 1.25cm		E					
D7451	Rem odontogen cyst > 1.25 cm		E					
D7460	Rem nonodonto cyst to 1.25cm		E					
D7461	Rem nonodonto cyst > 1.25 cm		E					
D7465	Lesion destruction		E					
D7471	Rem exostosis any site		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7472	Removal of torus palatinus		E					
D7473	Remove torus mandibularis		E					
D7485	Surg reduct osseoustuberosit		E					
D7490	Maxilla or mandible resectio		E					
D7510	I&d absc intraoral soft tiss		E					
D7511	Incision/drain abscess intra		B					
D7520	I&d abscess extraoral		E					
D7521	Incision/drain abscess extra		B					
D7530	Removal fb skin/areolar tiss		E					
D7540	Removal of fb reaction		E					
D7550	Removal of sloughed off bone		E					
D7560	Maxillary sinusotomy		E					
D7610	Maxilla open reduct simple		E					
D7620	Clsd reduct simpl maxilla fx		E					
D7630	Open red simpl mandible fx		E					
D7640	Clsd red simpl mandible fx		E					
D7650	Open red simp malar/zygom fx		E					
D7660	Clsd red simp malar/zygom fx		E					
D7670	Closd rductn splint alveolus		E					
D7671	Alveolus open reduction		E					
D7680	Reduct simple facial bone fx		E					
D7710	Maxilla open reduct compound		E					
D7720	Clsd reduct compd maxilla fx		E					
D7730	Open reduct compd mandble fx		E					
D7740	Clsd reduct compd mandble fx		E					
D7750	Open red comp malar/zygma fx		E					
D7760	Clsd red comp malar/zygma fx		E					
D7770	Open reduc compd alveolus fx		E					
D7771	Alveolus clsd reduc stblz te		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7780	Reduct compnd facial bone fx		E					
D7810	Tmj open reduct-dislocation		E					
D7820	Closed tmp manipulation		E					
D7830	Tmj manipulation under anest		E					
D7840	Removal of tmj condyle		E					
D7850	Tmj meniscectomy		E					
D7852	Tmj repair of joint disc		E					
D7854	Tmj excisn of joint membrane		E					
D7856	Tmj cutting of a muscle		E					
D7858	Tmj reconstruction		E					
D7860	Tmj cutting into joint		E					
D7865	Tmj reshaping components		E					
D7870	Tmj aspiration joint fluid		E					
D7871	Lysis + lavage w catheters		E					
D7872	Tmj diagnostic arthroscopy		E					
D7873	Tmj arthroscopy lysis adhesn		E					
D7874	Tmj arthroscopy disc reposit		E					
D7875	Tmj arthroscopy synovectomy		E					
D7876	Tmj arthroscopy discectomy		E					
D7877	Tmj arthroscopy debridement		E					
D7880	Occlusal orthotic appliance		E					
D7899	Tmj unspecified therapy		E					
D7910	Dent sutur recent wnd to 5cm		E					
D7911	Dental suture wound to 5 cm		E					
D7912	Suture complicate wnd > 5 cm		E					
D7920	Dental skin graft		E					
D7940	Reshaping bone orthognathic		S	0330	9.9085	$676.42	.	$135.29
D7941	Bone cutting ramus closed		E					
D7943	Cutting ramus open w/graft		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7944	Bone cutting segmented		E					
D7945	Bone cutting body mandible		E					
D7946	Reconstruction maxilla total		E					
D7947	Reconstruct maxilla segment		E					
D7948	Reconstruct midface no graft		E					
D7949	Reconstruct midface w/graft		E					
D7950	Mandible graft		E					
D7951	Sinus aug w bone/bone sup		E					
D7953	Bone replacement graft		E					
D7955	Repair maxillofacial defects		E					
D7960	Frenulectomy/frenulotomy		E					
D7963	Frenuloplasty		E					
D7970	Excision hyperplastic tissue		E					
D7971	Excision pericoronal gingiva		E					
D7972	Surg redct fibrous tuberosit		E					
D7980	Sialolithotomy		E					
D7981	Excision of salivary gland		E					
D7982	Sialodochoplasty		E					
D7983	Closure of salivary fistula		E					
D7990	Emergency tracheotomy		E					
D7991	Dental coronoidectomy		E					
D7995	Synthetic graft facial bones		E					
D7996	Implant mandible for augment		E					
D7997	Appliance removal		E					
D7998	Intraoral place of fix dev		E					
D7999	Oral surgery procedure		E					
D8010	Limited dental tx primary		E					
D8020	Limited dental tx transition		E					
D8030	Limited dental tx adolescent		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D8040	Limited dental tx adult		E					
D8050	Intercep dental tx primary		E					
D8060	Intercep dental tx transitn		E					
D8070	Compre dental tx transition		E					
D8080	Compre dental tx adolescent		E					
D8090	Compre dental tx adult		E					
D8210	Orthodontic rem appliance tx		E					
D8220	Fixed appliance therapy habt		E					
D8660	Preorthodontic tx visit		E					
D8670	Periodic orthodontc tx visit		E					
D8680	Orthodontic retention		E					
D8690	Orthodontic treatment		E					
D8691	Repair ortho appliance		E					
D8692	Replacement retainer		E					
D8693	Rebond/cement/repair retain		E					
D8999	Orthodontic procedure		E					
D9110	Tx dental pain minor proc		N					
D9120	Fix partial denture section		E					
D9210	Dent anesthesia w/o surgery		E					
D9211	Regional block anesthesia		E					
D9212	Trigeminal block anesthesia		E					
D9215	Local anesthesia		E					
D9220	General anesthesia		E					
D9221	General anesthesia ea ad 15m		E					
D9230	Analgesia		N					
D9241	Intravenous sedation		E					
D9242	IV sedation ea ad 30 m		E					
D9248	Sedation (non-iv)		N					
D9310	Dental consultation		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D9410	Dental house call		E					
D9420	Hospital call		E					
D9430	Office visit during hours		E					
D9440	Office visit after hours		E					
D9450	Case presentation tx plan		E					
D9610	Dent therapeutic drug inject		E					
D9612	Thera par drugs 2 or > admin		E					
D9630	Other drugs/medicaments		S	0330	9.9085	$676.42	.	$135.29
D9910	Dent appl desensitizing med		E					
D9911	Appl desensitizing resin		E					
D9920	Behavior management		E					
D9930	Treatment of complications		S	0330	9.9085	$676.42	.	$135.29
D9940	Dental occlusal guard		S	0330	9.9085	$676.42	.	$135.29
D9941	Fabrication athletic guard		E					
D9942	Repair/reline occlusal guard		E					
D9950	Occlusion analysis		S	0330	9.9085	$676.42	.	$135.29
D9951	Limited occlusal adjustment		S	0330	9.9085	$676.42	.	$135.29
D9952	Complete occlusal adjustment		S	0330	9.9085	$676.42	.	$135.29
D9970	Enamel microabrasion		E					
D9971	Odontoplasty 1-2 teeth		E					
D9972	Extrnl bleaching per arch		E					
D9973	Extrnl bleaching per tooth		E					
D9974	Intrnl bleaching per tooth		E					
D9999	Adjunctive procedure		E					
E0100	Cane adjust/fixed with tip		Y					
E0105	Cane adjust/fixed quad/3 pro		Y					
E0110	Crutch forearm pair		Y					
E0111	Crutch forearm each		Y					
E0112	Crutch underarm pair wood		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0113	Crutch underarm each wood		Y					
E0114	Crutch underarm pair no wood		Y					
E0116	Crutch underarm each no wood		Y					
E0117	Underarm springassist crutch		Y					
E0118	Crutch substitute		E					
E0130	Walker rigid adjust/fixed ht		Y					
E0135	Walker folding adjust/fixed		Y					
E0140	Walker w trunk support		Y					
E0141	Rigid wheeled walker adj/fix		Y					
E0143	Walker folding wheeled w/o s		Y					
E0144	Enclosed walker w rear seat		Y					
E0147	Walker variable wheel resist		Y					
E0148	Heavyduty walker no wheels		Y					
E0149	Heavy duty wheeled walker		Y					
E0153	Forearm crutch platform atta		Y					
E0154	Walker platform attachment		Y					
E0155	Walker wheel attachment,pair		Y					
E0156	Walker seat attachment		Y					
E0157	Walker crutch attachment		Y					
E0158	Walker leg extenders set of4		Y					
E0159	Brake for wheeled walker		Y					
E0160	Sitz type bath or equipment		Y					
E0161	Sitz bath/equipment w/faucet		Y					
E0162	Sitz bath chair		Y					
E0163	Commode chair with fixed arm		Y					
E0165	Commode chair with detacharm		Y					
E0167	Commode chair pail or pan		Y					
E0168	Heavyduty/wide commode chair		Y					
E0170	Commode chair electric		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0171	Commode chair non-electric		Y					
E0172	Seat lift mechanism toilet		E					
E0175	Commode chair foot rest		Y					
E0181	Press pad alternating w/ pum		Y					
E0182	Replace pump, alt press pad		Y					
E0184	Dry pressure mattress		Y					
E0185	Gel pressure mattress pad		Y					
E0186	Air pressure mattress		Y					
E0187	Water pressure mattress		Y					
E0188	Synthetic sheepskin pad		Y					
E0189	Lambswool sheepskin pad		Y					
E0190	Positioning cushion		E					
E0191	Protector heel or elbow		Y					
E0193	Powered air flotation bed		Y					
E0194	Air fluidized bed		Y					
E0196	Gel pressure mattress		Y					
E0197	Air pressure pad for mattres		Y					
E0198	Water pressure pad for mattr		Y					
E0199	Dry pressure pad for mattres		Y					
E0200	Heat lamp without stand		Y					
E0202	Phototherapy light w/ photom		Y					
E0203	Therapeutic lightbox tabletp		E					
E0205	Heat lamp with stand		Y					
E0210	Electric heat pad standard		Y					
E0215	Electric heat pad moist		Y					
E0217	Water circ heat pad w pump		Y					
E0218	Water circ cold pad w pump		Y					
E0220	Hot water bottle		Y					
E0221	Infrared heating pad system		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0225	Hydrocollator unit		Y					
E0230	Ice cap or collar		Y					
E0231	Wound warming device		E					
E0232	Warming card for NWT		E					
E0235	Paraffin bath unit portable		Y					
E0236	Pump for water circulating p		Y					
E0238	Heat pad non-electric moist		Y					
E0239	Hydrocollator unit portable		Y					
E0240	Bath/shower chair		E					
E0241	Bath tub wall rail		E					
E0242	Bath tub rail floor		E					
E0243	Toilet rail		E					
E0244	Toilet seat raised		E					
E0245	Tub stool or bench		E					
E0246	Transfer tub rail attachment		E					
E0247	Trans bench w/wo comm open		E					
E0248	HDtrans bench w/wo comm open		E					
E0249	Pad water circulating heat u		Y					
E0250	Hosp bed fixed ht w/ mattres		Y					
E0251	Hosp bed fixd ht w/o mattres		Y					
E0255	Hospital bed var ht w/ mattr		Y					
E0256	Hospital bed var ht w/o matt		Y					
E0260	Hosp bed semi-electr w/ matt		Y					
E0261	Hosp bed semi-electr w/o mat		Y					
E0265	Hosp bed total electr w/ mat		Y					
E0266	Hosp bed total elec w/o matt		Y					
E0270	Hospital bed institutional t		E					
E0271	Mattress innerspring		Y					
E0272	Mattress foam rubber		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0273	Bed board		E					
E0274	Over-bed table		E					
E0275	Bed pan standard		Y					
E0276	Bed pan fracture		Y					
E0277	Powered pres-redu air mattrs		Y					
E0280	Bed cradle		Y					
E0290	Hosp bed fx ht w/o rails w/m		Y					
E0291	Hosp bed fx ht w/o rail w/o		Y					
E0292	Hosp bed var ht w/o rail w/o		Y					
E0293	Hosp bed var ht w/o rail w/		Y					
E0294	Hosp bed semi-elect w/ mattr		Y					
E0295	Hosp bed semi-elect w/o matt		Y					
E0296	Hosp bed total elect w/ matt		Y					
E0297	Hosp bed total elect w/o mat		Y					
E0300	Enclosed ped crib hosp grade		Y					
E0301	HD hosp bed, 350-600 lbs		Y					
E0302	Ex hd hosp bed > 600 lbs		Y					
E0303	Hosp bed hvy dty xtra wide		Y					
E0304	Hosp bed xtra hvy dty x wide		Y					
E0305	Rails bed side half length		Y					
E0310	Rails bed side full length		Y					
E0315	Bed accessory brd/tbl/supprt		E					
E0316	Bed safety enclosure		Y					
E0325	Urinal male jug-type		Y					
E0326	Urinal female jug-type		Y					
E0328	Ped hospital bed, manual		Y					
E0329	Ped hospital bed semi/elect		Y					
E0350	Control unit bowel system		E					
E0352	Disposable pack w/bowel syst		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0370	Air elevator for heel		E					
E0371	Nonpower mattress overlay		Y					
E0372	Powered air mattress overlay		Y					
E0373	Nonpowered pressure mattress		Y					
E0424	Stationary compressed gas 02		Y					
E0425	Gas system stationary compre		E					
E0430	Oxygen system gas portable		E					
E0431	Portable gaseous 02		Y					
E0433	Portable liquid oxygen sys		Y					
E0434	Portable liquid 02		Y					
E0435	Oxygen system liquid portabl		E					
E0439	Stationary liquid 02		Y					
E0440	Oxygen system liquid station		E					
E0441	Stationary O2 contents, gas		Y					
E0442	Stationary O2 contents, liq		Y					
E0443	Portable 02 contents, gas		Y					
E0444	Portable 02 contents, liquid		Y					
E0445	Oximeter non-invasive		N					
E0450	Vol control vent invasiv int		Y					
E0455	Oxygen tent excl croup/ped t		Y					
E0457	Chest shell		Y					
E0459	Chest wrap		Y					
E0460	Neg press vent portabl/statn		Y					
E0461	Vol control vent noninv int		Y					
E0462	Rocking bed w/ or w/o side r		Y					
E0463	Press supp vent invasive int		Y					
E0464	Press supp vent noninv int		Y					
E0470	RAD w/o backup non-inv intfc		Y					
E0471	RAD w/backup non inv intrfc		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0472	RAD w backup invasive intrfc		Y					
E0480	Percussor elect/pneum home m		Y					
E0481	Intrpulmnry percuss vent sys		E					
E0482	Cough stimulating device		Y					
E0483	Chest compression gen system		Y					
E0484	Non-elec oscillatory pep dvc		Y					
E0485	Oral device/appliance prefab		Y					
E0486	Oral device/appliance cusfab		Y					
E0487	Electronic spirometer		N					
E0500	Ippb all types		Y					
E0550	Humidif extens supple w ippb		Y					
E0555	Humidifier for use w/ regula		Y					
E0560	Humidifier supplemental w/ i		Y					
E0561	Humidifier nonheated w PAP		Y					
E0562	Humidifier heated used w PAP		Y					
E0565	Compressor air power source		Y					
E0570	Nebulizer with compression		Y					
E0571	Aerosol compressor for svneb		Y					
E0572	Aerosol compressor adjust pr		Y					
E0574	Ultrasonic generator w svneb		Y					
E0575	Nebulizer ultrasonic		Y					
E0580	Nebulizer for use w/ regulat		Y					
E0585	Nebulizer w/ compressor & he		Y					
E0600	Suction pump portab hom modl		Y					
E0601	Cont airway pressure device		Y					
E0602	Manual breast pump		Y					
E0603	Electric breast pump		N					
E0604	Hosp grade elec breast pump		A					
E0605	Vaporizer room type		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0606	Drainage board postural		Y					
E0607	Blood glucose monitor home		Y					
E0610	Pacemaker monitr audible/vis		Y					
E0615	Pacemaker monitr digital/vis		Y					
E0616	Cardiac event recorder		N					
E0617	Automatic ext defibrillator		Y					
E0618	Apnea monitor		Y					
E0619	Apnea monitor w recorder		Y					
E0620	Cap bld skin piercing laser		Y					
E0621	Patient lift sling or seat		Y					
E0625	Patient lift bathroom or toi		E					
E0627	Seat lift incorp lift-chair		Y					
E0628	Seat lift for pt furn-electr		Y					
E0629	Seat lift for pt furn-non-el		Y					
E0630	Patient lift hydraulic		Y					
E0635	Patient lift electric		Y					
E0636	PT support & positioning sys		Y					
E0637	Combination sit to stand sys		E					
E0638	Standing frame sys		E					
E0639	Moveable patient lift system		E					
E0640	Fixed patient lift system		E					
E0641	Multi-position stnd fram sys		E					
E0642	Dynamic standing frame		E					
E0650	Pneuma compresor non-segment		Y					
E0651	Pneum compressor segmental		Y					
E0652	Pneum compres w/cal pressure		Y					
E0655	Pneumatic appliance half arm		Y					
E0656	Segmental pneumatic trunk		Y					
E0657	Segmental pneumatic chest		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0660	Pneumatic appliance full leg		Y					
E0665	Pneumatic appliance full arm		Y					
E0666	Pneumatic appliance half leg		Y					
E0667	Seg pneumatic appl full leg		Y					
E0668	Seg pneumatic appl full arm		Y					
E0669	Seg pneumatic appli half leg		Y					
E0671	Pressure pneum appl full leg		Y					
E0672	Pressure pneum appl full arm		Y					
E0673	Pressure pneum appl half leg		Y					
E0675	Pneumatic compression device		Y					
E0676	Inter limb compress dev NOS		Y					
E0691	Uvl pnl 2 sq ft or less		Y					
E0692	Uvl sys panel 4 ft		Y					
E0693	Uvl sys panel 6 ft		Y					
E0694	Uvl md cabinet sys 6 ft		Y					
E0700	Safety equipment		E					
E0705	Transfer device		B					
E0710	Restraints any type		E					
E0720	Tens two lead		Y					
E0730	Tens four lead		Y					
E0731	Conductive garment for tens/		Y					
E0740	Incontinence treatment systm		Y					
E0744	Neuromuscular stim for scoli		Y					
E0745	Neuromuscular stim for shock		Y					
E0746	Electromyograph biofeedback		N					
E0747	Elec osteogen stim not spine		Y					
E0748	Elec osteogen stim spinal		Y					
E0749	Elec osteogen stim implanted		N					
E0755	Electronic salivary reflex s		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0760	Osteogen ultrasound stimltor		Y					
E0761	Nontherm electromgntc device		E					
E0762	Trans elec jt stim dev sys		B					
E0764	Functional neuromuscularstim		Y					
E0765	Nerve stimulator for tx n&v		Y					
E0769	Electric wound treatment dev		B					
E0770	Functional electric stim NOS		Y					
E0776	Iv pole		Y					
E0779	Amb infusion pump mechanical		Y					
E0780	Mech amb infusion pump <8hrs		Y					
E0781	External ambulatory infus pu		Y					
E0782	Non-programble infusion pump		N					
E0783	Programmable infusion pump		N					
E0784	Ext amb infusn pump insulin		Y					
E0785	Replacement impl pump cathet		N					
E0786	Implantable pump replacement		N					
E0791	Parenteral infusion pump sta		Y					
E0830	Ambulatory traction device		N					
E0840	Tract frame attach headboard		Y					
E0849	Cervical pneum trac equip		Y					
E0850	Traction stand free standing		Y					
E0855	Cervical traction equipment		Y					
E0856	Cervic collar w air bladder		Y					
E0860	Tract equip cervical tract		Y					
E0870	Tract frame attach footboard		Y					
E0880	Trac stand free stand extrem		Y					
E0890	Traction frame attach pelvic		Y					
E0900	Trac stand free stand pelvic		Y					
E0910	Trapeze bar attached to bed		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0911	HD trapeze bar attach to bed		Y					
E0912	HD trapeze bar free standing		Y					
E0920	Fracture frame attached to b		Y					
E0930	Fracture frame free standing		Y					
E0935	Cont pas motion exercise dev		Y					
E0936	CPM device, other than knee		E					
E0940	Trapeze bar free standing		Y					
E0941	Gravity assisted traction de		Y					
E0942	Cervical head harness/halter		Y					
E0944	Pelvic belt/harness/boot		Y					
E0945	Belt/harness extremity		Y					
E0946	Fracture frame dual w cross		Y					
E0947	Fracture frame attachmnts pe		Y					
E0948	Fracture frame attachmnts ce		Y					
E0950	Tray		Y					
E0951	Loop heel		Y					
E0952	Toe loop/holder, each		Y					
E0955	Cushioned headrest		Y					
E0956	W/c lateral trunk/hip suppor		Y					
E0957	W/c medial thigh support		Y					
E0958	Whlchr att- conv 1 arm drive		Y					
E0959	Amputee adapter		B					
E0960	W/c shoulder harness/straps		Y					
E0961	Wheelchair brake extension		B					
E0966	Wheelchair head rest extensi		B					
E0967	Manual wc hand rim w project		Y					
E0968	Wheelchair commode seat		Y					
E0969	Wheelchair narrowing device		Y					
E0970	Wheelchair no. 2 footplates		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0971	Wheelchair anti-tipping devi		B					
E0973	W/Ch access det adj armrest		B					
E0974	W/Ch access anti-rollback		B					
E0978	W/C acc,saf belt pelv strap		B					
E0980	Wheelchair safety vest		Y					
E0981	Seat upholstery, replacement		Y					
E0982	Back upholstery, replacement		Y					
E0983	Add pwr joystick		Y					
E0984	Add pwr tiller		Y					
E0985	W/c seat lift mechanism		Y					
E0986	Man w/c push-rim pow assist		Y					
E0990	Wheelchair elevating leg res		B					
E0992	Wheelchair solid seat insert		B					
E0994	Wheelchair arm rest		Y					
E0995	Wheelchair calf rest		B					
E1002	Pwr seat tilt		Y					
E1003	Pwr seat recline		Y					
E1004	Pwr seat recline mech		Y					
E1005	Pwr seat recline pwr		Y					
E1006	Pwr seat combo w/o shear		Y					
E1007	Pwr seat combo w/shear		Y					
E1008	Pwr seat combo pwr shear		Y					
E1009	Add mech leg elevation		Y					
E1010	Add pwr leg elevation		Y					
E1011	Ped wc modify width adjustm		Y					
E1014	Reclining back add ped w/c		Y					
E1015	Shock absorber for man w/c		Y					
E1016	Shock absorber for power w/c		Y					
E1017	HD shck absrbr for hd man wc		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1018	HD shck absrber for hd powwc		Y					
E1020	Residual limb support system		Y					
E1028	W/c manual swingaway		Y					
E1029	W/c vent tray fixed		Y					
E1030	W/c vent tray gimbaled		Y					
E1031	Rollabout chair with casters		Y					
E1035	Patient transfer system <300		Y					
E1036	Patient transfer system >300		Y					
E1037	Transport chair, ped size		Y					
E1038	Transport chair pt wt<=300lb		Y					
E1039	Transport chair pt wt >300lb		Y					
E1050	Whelchr fxd full length arms		Y					
E1060	Wheelchair detachable arms		Y					
E1070	Wheelchair detachable foot r		Y					
E1083	Hemi-wheelchair fixed arms		Y					
E1084	Hemi-wheelchair detachable a		Y					
E1085	Hemi-wheelchair fixed arms		E					
E1086	Hemi-wheelchair detachable a		E					
E1087	Wheelchair lightwt fixed arm		Y					
E1088	Wheelchair lightweight det a		Y					
E1089	Wheelchair lightwt fixed arm		E					
E1090	Wheelchair lightweight det a		E					
E1092	Wheelchair wide w/ leg rests		Y					
E1093	Wheelchair wide w/ foot rest		Y					
E1100	Whchr s-recl fxd arm leg res		Y					
E1110	Wheelchair semi-recl detach		Y					
E1130	Whlchr stand fxd arm ft rest		E					
E1140	Wheelchair standard detach a		E					
E1150	Wheelchair standard w/ leg r		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1160	Wheelchair fixed arms		Y					
E1161	Manual adult wc w tiltinspac		Y					
E1170	Whlchr ampu fxd arm leg rest		Y					
E1171	Wheelchair amputee w/o leg r		Y					
E1172	Wheelchair amputee detach ar		Y					
E1180	Wheelchair amputee w/ foot r		Y					
E1190	Wheelchair amputee w/ leg re		Y					
E1195	Wheelchair amputee heavy dut		Y					
E1200	Wheelchair amputee fixed arm		Y					
E1220	Whlchr special size/constrc		Y					
E1221	Wheelchair spec size w foot		Y					
E1222	Wheelchair spec size w/ leg		Y					
E1223	Wheelchair spec size w foot		Y					
E1224	Wheelchair spec size w/ leg		Y					
E1225	Manual semi-reclining back		Y					
E1226	Manual fully reclining back		B					
E1227	Wheelchair spec sz spec ht a		Y					
E1228	Wheelchair spec sz spec ht b		Y					
E1229	Pediatric wheelchair NOS		Y					
E1230	Power operated vehicle		Y					
E1231	Rigid ped w/c tilt-in-space		Y					
E1232	Folding ped wc tilt-in-space		Y					
E1233	Rig ped wc tltnspc w/o seat		Y					
E1234	Fld ped wc tltnspc w/o seat		Y					
E1235	Rigid ped wc adjustable		Y					
E1236	Folding ped wc adjustable		Y					
E1237	Rgd ped wc adjstabl w/o seat		Y					
E1238	Fld ped wc adjstabl w/o seat		Y					
E1239	Ped power wheelchair NOS		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1240	Whchr litwt det arm leg rest		Y					
E1250	Wheelchair lightwt fixed arm		E					
E1260	Wheelchair lightwt foot rest		E					
E1270	Wheelchair lightweight leg r		Y					
E1280	Whchr h-duty det arm leg res		Y					
E1285	Wheelchair heavy duty fixed		E					
E1290	Wheelchair hvy duty detach a		E					
E1295	Wheelchair heavy duty fixed		Y					
E1296	Wheelchair special seat heig		Y					
E1297	Wheelchair special seat dept		Y					
E1298	Wheelchair spec seat depth/w		Y					
E1300	Whirlpool portable		E					
E1310	Whirlpool non-portable		Y					
E1353	Oxygen supplies regulator		Y					
E1354	Wheeled cart, port cyl/conc		Y					
E1355	Oxygen supplies stand/rack		Y					
E1356	Batt pack/cart, port conc		Y					
E1357	Battery charger, port conc		Y					
E1358	DC power adapter, port conc		Y					
E1372	Oxy suppl heater for nebuliz		Y					
E1390	Oxygen concentrator		Y					
E1391	Oxygen concentrator, dual		Y					
E1392	Portable oxygen concentrator		Y					
E1399	Durable medical equipment mi		Y					
E1405	O2/water vapor enrich w/heat		Y					
E1406	O2/water vapor enrich w/o he		Y					
E1500	Centrifuge		A					
E1510	Kidney dialysate delivry sys		A					
E1520	Heparin infusion pump		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1530	Replacement air bubble detec		A					
E1540	Replacement pressure alarm		A					
E1550	Bath conductivity meter		A					
E1560	Replace blood leak detector		A					
E1570	Adjustable chair for esrd pt		A					
E1575	Transducer protect/fld bar		A					
E1580	Unipuncture control system		A					
E1590	Hemodialysis machine		A					
E1592	Auto interm peritoneal dialy		A					
E1594	Cycler dialysis machine		A					
E1600	Deli/install chrg hemo equip		A					
E1610	Reverse osmosis h2o puri sys		A					
E1615	Deionizer H2O puri system		A					
E1620	Replacement blood pump		A					
E1625	Water softening system		A					
E1630	Reciprocating peritoneal dia		A					
E1632	Wearable artificial kidney		A					
E1634	Peritoneal dialysis clamp		B					
E1635	Compact travel hemodialyzer		A					
E1636	Sorbent cartridges per 10		A					
E1637	Hemostats for dialysis, each		A					
E1639	Dialysis scale		A					
E1699	Dialysis equipment noc		A					
E1700	Jaw motion rehab system		Y					
E1701	Repl cushions for jaw motion		Y					
E1702	Repl measr scales jaw motion		Y					
E1800	Adjust elbow ext/flex device		Y					
E1801	SPS elbow device		Y					
E1802	Adjst forearm pro/sup device		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1805	Adjust wrist ext/flex device		Y					
E1806	SPS wrist device		Y					
E1810	Adjust knee ext/flex device		Y					
E1811	SPS knee device		Y					
E1812	Knee ext/flex w act res ctrl		Y					
E1815	Adjust ankle ext/flex device		Y					
E1816	SPS ankle device		Y					
E1818	SPS forearm device		Y					
E1820	Soft interface material		Y					
E1821	Replacement interface SPSD		Y					
E1825	Adjust finger ext/flex devc		Y					
E1830	Adjust toe ext/flex device		Y					
E1840	Adj shoulder ext/flex device		Y					
E1841	Static str shldr dev rom adj		Y					
E1902	AAC non-electronic board		Y					
E2000	Gastric suction pump hme mdl		Y					
E2100	Bld glucose monitor w voice		Y					
E2101	Bld glucose monitor w lance		Y					
E2120	Pulse gen sys tx endolymp fl		Y					
E2201	Man w/ch acc seat w>=20"<24"		Y					
E2202	Seat width 24-27 in		Y					
E2203	Frame depth less than 22 in		Y					
E2204	Frame depth 22 to 25 in		Y					
E2205	Manual wc accessory, handrim		Y					
E2206	Complete wheel lock assembly		Y					
E2207	Crutch and cane holder		Y					
E2208	Cylinder tank carrier		Y					
E2209	Arm trough each		Y					
E2210	Wheelchair bearings		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2211	Pneumatic propulsion tire		Y					
E2212	Pneumatic prop tire tube		Y					
E2213	Pneumatic prop tire insert		Y					
E2214	Pneumatic caster tire each		Y					
E2215	Pneumatic caster tire tube		Y					
E2216	Foam filled propulsion tire		Y					
E2217	Foam filled caster tire each		Y					
E2218	Foam propulsion tire each		Y					
E2219	Foam caster tire any size ea		Y					
E2220	Solid propulsion tire each		Y					
E2221	Solid caster tire each		Y					
E2222	Solid caster integrated whl		Y					
E2224	Propulsion whl excludes tire		Y					
E2225	Caster wheel excludes tire		Y					
E2226	Caster fork replacement only		Y					
E2227	Gear reduction drive wheel		Y					
E2228	Mwc acc, wheelchair brake		Y					
E2230	Manual standing system		E					
E2231	Solid seat support base		Y					
E2291	Planar back for ped size wc		Y					
E2292	Planar seat for ped size wc		Y					
E2293	Contour back for ped size wc		Y					
E2294	Contour seat for ped size wc		Y					
E2295	Ped dynamic seating frame		Y					
E2300	Pwr seat elevation sys		Y					
E2301	Pwr standing		Y					
E2310	Electro connect btw control		Y					
E2311	Electro connect btw 2 sys		Y					
E2312	Mini-prop remote joystick		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2313	PWC harness, expand control		Y					
E2321	Hand interface joystick		Y					
E2322	Mult mech switches		Y					
E2323	Special joystick handle		Y					
E2324	Chin cup interface		Y					
E2325	Sip and puff interface		Y					
E2326	Breath tube kit		Y					
E2327	Head control interface mech		Y					
E2328	Head/extremity control inter		Y					
E2329	Head control nonproportional		Y					
E2330	Head control proximity switc		Y					
E2331	Attendant control		Y					
E2340	W/c wdth 20-23 in seat frame		Y					
E2341	W/c wdth 24-27 in seat frame		Y					
E2342	W/c dpth 20-21 in seat frame		Y					
E2343	W/c dpth 22-25 in seat frame		Y					
E2351	Electronic SGD interface		Y					
E2360	22nf nonsealed leadacid		Y					
E2361	22nf sealed leadacid battery		Y					
E2362	Gr24 nonsealed leadacid		Y					
E2363	Gr24 sealed leadacid battery		Y					
E2364	U1nonsealed leadacid battery		Y					
E2365	U1 sealed leadacid battery		Y					
E2366	Battery charger, single mode		Y					
E2367	Battery charger, dual mode		Y					
E2368	Power wc motor replacement		Y					
E2369	Pwr wc gear box replacement		Y					
E2370	Pwr wc motor/gear box combo		Y					
E2371	Gr27 sealed leadacid battery		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2372	Gr27 non-sealed leadacid		Y					
E2373	Hand/chin ctrl spec joystick		Y					
E2374	Hand/chin ctrl std joystick		Y					
E2375	Non-expandable controller		Y					
E2376	Expandable controller, repl		Y					
E2377	Expandable controller, initl		Y					
E2381	Pneum drive wheel tire		Y					
E2382	Tube, pneum wheel drive tire		Y					
E2383	Insert, pneum wheel drive		Y					
E2384	Pneumatic caster tire		Y					
E2385	Tube, pneumatic caster tire		Y					
E2386	Foam filled drive wheel tire		Y					
E2387	Foam filled caster tire		Y					
E2388	Foam drive wheel tire		Y					
E2389	Foam caster tire		Y					
E2390	Solid drive wheel tire		Y					
E2391	Solid caster tire		Y					
E2392	Solid caster tire, integrate		Y					
E2394	Drive wheel excludes tire		Y					
E2395	Caster wheel excludes tire		Y					
E2396	Caster fork		Y					
E2397	Pwc acc, lith-based battery		Y					
E2402	Neg press wound therapy pump		Y					
E2500	SGD digitized pre-rec <=8min		Y					
E2502	SGD prerec msg >8min <=20min		Y					
E2504	SGD prerec msg>20min <=40min		Y					
E2506	SGD prerec msg > 40 min		Y					
E2508	SGD spelling phys contact		Y					
E2510	SGD w multi methods msg/accs		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2511	SGD sftwre prgrm for PC/PDA		Y					
E2512	SGD accessory, mounting sys		Y					
E2599	SGD accessory noc		Y					
E2601	Gen w/c cushion wdth < 22 in		Y					
E2602	Gen w/c cushion wdth >=22 in		Y					
E2603	Skin protect wc cus wd <22in		Y					
E2604	Skin protect wc cus wd>=22in		Y					
E2605	Position wc cush wdth <22 in		Y					
E2606	Position wc cush wdth>=22 in		Y					
E2607	Skin pro/pos wc cus wd <22in		Y					
E2608	Skin pro/pos wc cus wd>=22in		Y					
E2609	Custom fabricate w/c cushion		Y					
E2610	Powered w/c cushion		B					
E2611	Gen use back cush wdth <22in		Y					
E2612	Gen use back cush wdth>=22in		Y					
E2613	Position back cush wd <22in		Y					
E2614	Position back cush wd>=22in		Y					
E2615	Pos back post/lat wdth <22in		Y					
E2616	Pos back post/lat wdth>=22in		Y					
E2617	Custom fab w/c back cushion		Y					
E2619	Replace cover w/c seat cush		Y					
E2620	WC planar back cush wd <22in		Y					
E2621	WC planar back cush wd>=22in		Y					
E8000	Posterior gait trainer		E					
E8001	Upright gait trainer		E					
E8002	Anterior gait trainer		E					
G0008	Admin influenza virus vac		S	0350	0.3853	$26.30		
G0009	Admin pneumococcal vaccine		S	0350	0.3853	$26.30		
G0010	Admin hepatitis b vaccine		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0027	Semen analysis		A					
G0101	CA screen;pelvic/breast exam		V	0604	0.7431	$50.73		
G0102	Prostate ca screening; dre		N					
G0103	PSA screening		A					
G0104	CA screen;flexi sigmoidscope		S	0159	5.1653	$352.62		
G0105	Colorectal scrn; hi risk ind		T	0158	8.2505	$563.24		
G0106	Colon CA screen;barium enema		S	0157	1.322	$90.25	.	$18.05
G0108	Diab manage trn per indiv		A					
G0109	Diab manage trn ind/group		A					
G0117	Glaucoma scrn hgh risk direc		S	0698	0.9316	$63.60	.	$12.72
G0118	Glaucoma scrn hgh risk direc		S	0230	0.5913	$40.37	.	$8.08
G0120	Colon ca scrn; barium enema		S	0157	1.322	$90.25	.	$18.05
G0121	Colon ca scrn not hi rsk ind		T	0158	8.2505	$563.24		
G0122	Colon ca scrn; barium enema		E					
G0123	Screen cerv/vag thin layer		A					
G0124	Screen c/v thin layer by MD		B					
G0127	Trim nail(s)		T	0012	0.4253	$29.03	.	$5.81
G0128	CORF skilled nursing service		B					
G0129	Partial hosp prog service		P					
G0130	Single energy x-ray study		X	0260	0.6683	$45.62		
G0141	Scr c/v cyto,autosys and md		B					
G0143	Scr c/v cyto,thinlayer,rescr		A					
G0144	Scr c/v cyto,thinlayer,rescr		A					
G0145	Scr c/v cyto,thinlayer,rescr		A					
G0147	Scr c/v cyto, automated sys		A					
G0148	Scr c/v cyto, autosys, rescr		A					
G0151	HHCP-serv of pt,ea 15 min		B					
G0152	HHCP-serv of ot,ea 15 min		B					
G0153	HHCP-svs of s/l path,ea 15mn		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0154	HHCP-svs of rn,ea 15 min		B					
G0155	HHCP-svs of csw,ea 15 min		B					
G0156	HHCP-svs of aide,ea 15 min		B					
G0166	Extrnl counterpulse, per tx		T	0678	1.4509	$99.05	.	$19.81
G0168	Wound closure by adhesive		B					
G0173	Linear acc stereo radsur com		S	0067	50.0116	$3,414.14	.	$682.83
G0175	OPPS Service,sched team conf		V	0607	1.7939	$122.46	.	$24.50
G0176	OPPS/PHP;activity therapy		P					
G0177	OPPS/PHP; train & educ serv		N					
G0179	MD recertification HHA PT		M					
G0180	MD certification HHA patient		M					
G0181	Home health care supervision		M					
G0182	Hospice care supervision		M					
G0186	Dstry eye lesn,fdr vssl tech		T	0235	5.2921	$361.28	.	$72.26
G0202	Screeningmammographydigital		A					
G0204	Diagnosticmammographydigital		A					
G0206	Diagnosticmammographydigital		A					
G0219	PET img wholbod melano nonco		E					
G0235	PET not otherwise specified		E					
G0237	Therapeutic procd strg endur		S	0077	0.418	$28.54	$7.74	$5.71
G0238	Oth resp proc, indiv		S	0077	0.418	$28.54	$7.74	$5.71
G0239	Oth resp proc, group		S	0077	0.418	$28.54	$7.74	$5.71
G0245	Initial foot exam pt lops		V	0604	0.7431	$50.73	.	$10.15
G0246	Followup eval of foot pt lop		V	0605	1.0573	$72.18	.	$14.44
G0247	Routine footcare pt w lops		T	0013	0.8782	$59.95	.	$11.99
G0248	Demonstrate use home inr mon		V	0607	1.7939	$122.46	.	$24.50
G0249	Provide INR test mater/equip		V	0607	1.7939	$122.46	.	$24.50
G0250	MD INR test revie inter mgmt		M					
G0251	Linear acc based stero radio		S	0065	13.7821	$940.86	.	$188.18

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0252	PET imaging initial dx		E					
G0255	Current percep threshold tst		E					
G0257	Unsched dialysis ESRD pt hos		S	0170	7.0059	$478.27	.	$95.66
G0259	Inject for sacroiliac joint		N					
G0260	Inj for sacroiliac jt anesth		T	0207	7.7204	$527.05	.	$105.41
G0268	Removal of impacted wax md		N					
G0269	Occlusive device in vein art		N					
G0270	MNT subs tx for change dx		A					
G0271	Group MNT 2 or more 30 mins		A					
G0275	Renal angio, cardiac cath		N					
G0278	Iliac art angio,cardiac cath		N					
G0281	Elec stim unattend for press		A					
G0282	Elect stim wound care not pd		E					
G0283	Elec stim other than wound		A					
G0288	Recon, CTA for surg plan		N					
G0289	Arthro, loose body + chondro		N					
G0290	Drug-eluting stents, single		T	0656	104.6619	$7,144.95	.	$1,428.99
G0291	Drug-eluting stents,each add		T	0656	104.6619	$7,144.95	.	$1,428.99
G0293	Non-cov surg proc,clin trial		X	0340	0.6899	$47.10	.	$9.42
G0294	Non-cov proc, clinical trial		X	0340	0.6899	$47.10	.	$9.42
G0295	Electromagnetic therapy onc		E					
G0302	Pre-op service LVRS complete		S	0209	11.462	$782.48	$268.73	$156.50
G0303	Pre-op service LVRS 10-15dos		S	0209	11.462	$782.48	$268.73	$156.50
G0304	Pre-op service LVRS 1-9 dos		S	0213	2.4455	$166.95	$53.58	$33.39
G0305	Post op service LVRS min 6		S	0213	2.4455	$166.95	$53.58	$33.39
G0306	CBC/diffwbc w/o platelet		A					
G0307	CBC without platelet		A					
G0328	Fecal blood scrn immunoassay		A					
G0329	Electromagntic tx for ulcers		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0333	Dispense fee initial 30 day		M					
G0337	Hospice evaluation preelecti		B					
G0339	Robot lin-radsurg com, first		S	0067	50.0116	$3,414.14	.	$682.83
G0340	Robt lin-radsurg fractx 2-5		S	0066	36.858	$2,516.19	.	$503.24
G0341	Percutaneous islet celltrans		C					
G0342	Laparoscopy islet cell trans		C					
G0343	Laparotomy islet cell transp		C					
G0364	Bone marrow aspirate &biopsy		X	0340	0.6899	$47.10	.	$9.42
G0365	Vessel mapping hemo access		S	0267	2.2748	$155.29	$60.50	$31.06
G0372	MD service required for PMD		M					
G0378	Hospital observation per hr		N					
G0379	Direct refer hospital observ		Q3	0604	0.7431	$50.73	.	$10.15
G0380	Lev 1 hosp type B ED visit		V	0626	0.625	$42.67	.	$8.54
G0381	Lev 2 hosp type B ED visit		V	0627	0.9279	$63.34	.	$12.67
G0382	Lev 3 hosp type B ED visit		V	0628	1.4941	$102.00	.	$20.40
G0383	Lev 4 hosp type B ED visit		V	0629	2.4251	$165.55	.	$33.11
G0384	Lev 5 hosp type B ED visit		Q3	0630	3.8788	$264.79	.	$52.96
G0389	Ultrasound exam AAA screen		S	0266	1.4262	$97.36		
G0390	Trauma Respons w/hosp criti		S	0618	13.999	$955.67	.	$191.14
G0396	Alcohol/subs interv 15-30mn		S	0432	0.4597	$31.38	.	$6.28
G0397	Alcohol/subs interv >30 min		S	0432	0.4597	$31.38	.	$6.28
G0398	Home sleep test/type 2 Porta		S	0213	2.4455	$166.95	$53.58	$33.39
G0399	Home sleep test/type 3 Porta		S	0213	2.4455	$166.95	$53.58	$33.39
G0400	Home sleep test/type 4 Porta		S	0213	2.4455	$166.95	$53.58	$33.39
G0402	Initial preventive exam		V	0606	1.365	$93.18		
G0403	EKG for initial prevent exam		M					
G0404	EKG tracing for initial prev		S	0099	0.3998	$27.29	.	$5.46
G0405	EKG interpret & report preve		B					
G0406	Telhealth inpt consult 15min		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0407	Telheath inpt consult 25min		C					
G0408	Telhealth inpt consult 35min		C					
G0409	CORF related serv 15 mins ea		M					
G0410	Grp psych partial hosp 45-50		P					
G0411	Inter active grp psych parti		P					
G0412	Open tx iliac spine uni/bil		C					
G0413	Pelvic ring fracture uni/bil		T	0050	32.4253	$2,213.58	.	$442.72
G0414	Pelvic ring fx treat int fix		C					
G0415	Open tx post pelvic fxcture		C					
G0416	Sat biopsy prostate 1-20 spc	CH	X	0661	2.3687	$161.70	.	$32.34
G0417	Sat biopsy prostate 21-40	CH	S	1506		$450.00	.	$90.00
G0418	Sat biopsy prostate 41-60		S	1511		$950.00	.	$190.00
G0419	Sat biopsy prostate: >60		S	1513		$1,150.00	.	$230.00
G0420	Ed svc CKD ind per session		A					
G0421	Ed svc CKD grp per session		A					
G0422	Intens cardiac rehab w/exerc		S	0095	0.5678	$38.76	$13.86	$7.76
G0423	Intens cardiac rehab no exer		S	0095	0.5678	$38.76	$13.86	$7.76
G0424	Pulmonary rehab w exer		S	0102	0.9754	$66.59	.	$13.32
G0425	Inpt telehealth consult 30m		C					
G0426	Inpt telehealth consult 50m		C					
G0427	Inpt telehealth con 70/>m		C					
G0430	Drug screen multi class		A					
G0431	Drug screen single class		A					
G0432	EIA HIV-1/HIV-2 screen		A					
G0433	ELISA HIV-1/HIV-2 screen		A					
G0435	Oral HIV-1/HIV-2 screen		A					
G3001	Admin + supply, tositumomab		S	0442	31.989	$2,183.79	.	$436.76
G8006	AMI pt recd aspirin at arriv		M					
G8007	AMI pt did not receiv aspiri		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8008	AMI pt ineligible for aspiri		M					
G8009	AMI pt recd Bblock at arr		M					
G8010	AMI pt did not rec bblock		M					
G8011	AMI pt inelig Bbloc at arriv		M					
G8012	Pneum pt recv antibiotic 4 h		M					
G8013	Pneum pt w/o antibiotic 4 hr		M					
G8014	Pneum pt not elig antibiotic		M					
G8015	Diabetic pt w/ HBA1c>9%		M					
G8016	Diabetic pt w/ HBA1c<or=9%		M					
G8017	DM pt inelig for HBA1c measu		M					
G8018	Care not provided for HbA1c		M					
G8019	Diabetic pt w/LDL>= 100mg/dl		M					
G8020	Diab pt w/LDL< 100mg/dl		M					
G8021	Diab pt inelig for LDL meas		M					
G8022	Care not provided for LDL		M					
G8023	DM pt w BP>=140/80		M					
G8024	Diabetic pt wBP<140/80		M					
G8025	Diabetic pt inelig for BP me		M					
G8026	Diabet pt w no care re BP me		M					
G8027	HF p w/LVSD on ACE-I/ARB		M					
G8028	HF pt w/LVSD not on ACE-I/AR		M					
G8029	HF pt not elig for ACE-I/ARB		M					
G8030	HF pt w/LVSD on Bblocker		M					
G8031	HF pt w/LVSD not on Bblocker		M					
G8032	HF pt not elig for Bblocker		M					
G8033	PMI-CAD pt on Bblocker		M					
G8034	PMI-CAD pt not on Bblocker		M					
G8035	PMI-CAD pt inelig Bblocker		M					
G8036	AMI-CAD pt doc on antiplatel		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8037	AMI-CAD pt not docu on antip		M					
G8038	AMI-CAD inelig antiplate mea		M					
G8039	CAD pt w/LDL>100mg/dl		M					
G8040	CAD pt w/LDL<or=100mg/dl		M					
G8041	CAD pt not eligible for LDL		M					
G8051	Osteoporosis assess		M					
G8052	Osteopor pt not assess		M					
G8053	Pt inelig for osteopor meas		M					
G8054	Falls assess not docum 12 mo		M					
G8055	Falls assess w/ 12 mon		M					
G8056	Not elig for falls assessmen		M					
G8057	Hearing assess receive		M					
G8058	Pt w/o hearing assess		M					
G8059	Pt inelig for hearing assess		M					
G8060	Urinary incont pt assess		M					
G8061	Pt not assess for urinary in		M					
G8062	Pt not elig for urinary inco		M					
G8075	ESRD pt w/ dialy of URR>=65%		M					
G8076	ESRD pt w/ dialy of URR<65%		M					
G8077	ESRD pt not elig for URR/KtV		M					
G8078	ESRD pt w/Hct>or=33		M					
G8079	ESRD pt w/Hct<33		M					
G8080	ESRD pt inelig for HCT/Hgb		M					
G8081	ESRD pt w/ auto AV fistula		M					
G8082	ESRD pt w other fistula		M					
G8085	ESRD PT inelig auto AV FISTU		M					
G8093	COPD pt rec smoking cessat		M					
G8094	COPD pt w/o smoke cessat int		M					
G8099	Osteopo pt given Ca+VitD sup		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8100	Osteop pt inelig for Ca+VitD		M					
G8103	New dx osteo pt w/antiresorp		M					
G8104	Osteo pt inelig for antireso		M					
G8106	Bone dens meas test perf		M					
G8107	Bone dens meas test inelig		M					
G8108	Pt receiv influenza vacc		M					
G8109	Pt w/o influenza vacc		M					
G8110	Pt inelig for influenza vacc		M					
G8111	Pt receiv mammogram		M					
G8112	Pt not doc mammogram		M					
G8113	Pt ineligible mammography		M					
G8114	Care not provided for mamogr		M					
G8115	Pt receiv pneumo vacc		M					
G8116	Pt did not rec pneumo vacc		M					
G8117	Pt was inelig for pneumo vac		M					
G8126	Pt treat w/antidepress12wks		M					
G8127	Pt not treat w/antidepres12w		M					
G8128	Pt inelig for antidepres med		M					
G8129	Pt treat w/antidepres for 6m		M					
G8130	Pt not treat w/antidepres 6m		M					
G8131	Pt inelig for antidepres med		M					
G8152	Pt w/AB 1 hr prior to incisi		M					
G8153	Pt not doc for AB 1 hr prior		M					
G8154	Pt ineligi for AB therapy		M					
G8155	Pt recd thromboemb prophylax		M					
G8156	Pt did not rec thromboembo		M					
G8157	Pt ineligi for thrombolism		M					
G8159	Pt w/CABG w/o IMA		M					
G8162	Iso CABG pt w/o preop Bblock		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8164	Iso CABG pt w/prolng intub		M					
G8165	Iso CABG pt w/o prolng intub		M					
G8166	Iso CABG req surg rexpo		M					
G8167	Iso CABG w/o surg explo		M					
G8170	CEA/ext bypass pt on aspirin		M					
G8171	Pt w/carot endarct/ext bypas		M					
G8172	CEA/ext bypass pt not on asp		M					
G8182	CAD pt care not prov LDL		M					
G8183	HF/atrial fib pt on warfarin		M					
G8184	HF/atrial fib pt inelig warf		M					
G8185	Osteoarth pt w/ assess pain		M					
G8186	Osteoarth pt inelig assess		M					
G8193	Antibio not doc prior surg		M					
G8196	Antibio not docum prior surg		M					
G8200	Cefazolin not docum prophy		M					
G8204	MD not doc order to d/c anti		M					
G8209	Clinician did not doc		M					
G8214	Clini not doc order VTE		M					
G8217	Pt not received DVT proph		M					
G8219	Received DVT proph day 2		M					
G8220	Pt not rec DVT proph day 2		M					
G8221	Pt inelig for DVT proph		M					
G8223	Pt not doc for presc antipla		M					
G8226	Pt no prescr anticoa at D/C		M					
G8231	Pt not doc for admin t-PA		M					
G8234	Pt not doc dysphagia screen		M					
G8238	Pt not doc to rec rehab serv		M					
G8240	Inter carotid stenosis30-99%		M					
G8243	Pt not doc MRI/CT w/o lesion		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8246	Pt inelig hx w new/chg mole		M					
G8248	Pt w/one alarm symp not doc		M					
G8251	Pt not doc w/Barretts, endo		M					
G8254	Pt w/no doc order for barium		M					
G8257	Pt not doc rev meds D/C		M					
G8260	Pt not doc to have dec maker		M					
G8263	Pt not doc assess urinary in		M					
G8266	Pt not doc charc urin incon		M					
G8268	Pt not doc rec care urin inc		M					
G8271	Pt no doc screen fall		M					
G8274	Clini not doc pres/abs alarm		M					
G8276	Pt not doc mole change		M					
G8279	Pt not doc rec PE		M					
G8282	Pt not doc to rec couns		M					
G8285	Pt did not rec pres osteo		M					
G8289	Pt not doc rec Ca/Vit D		M					
G8293	COPD pt w/o spir results		M					
G8296	COPD pt not doc bronch ther		M					
G8298	Pt doc optic nerve eval		M					
G8299	Pt not doc optic nerv eval		M					
G8302	Pt doc w/ target IOP		M					
G8303	Pt not doc w/ IOP		M					
G8304	Clin doc pt inelig IOP		M					
G8305	Clin not prov care POAG		M					
G8306	POAG w/ IOP rec care plan		M					
G8307	POAG w/ IOP no care plan		M					
G8308	POAG w/ IOP not doc plan		M					
G8310	Pt not doc rec antiox		M					
G8314	Pt not doc to rec mac exam		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8318	Pt doc not have visual func		M					
G8322	Pt not doc pre axial leng		M					
G8326	Pt not doc rec fundus exam		M					
G8330	Pt not doc rec dilated mac		M					
G8334	Doc of macular not giv MD		M					
G8338	Clin not doc pt test osteo		M					
G8341	Pt not doc for DEXA		M					
G8345	Pt not doc have DEXA		M					
G8351	Pt not doc ECG		M					
G8354	Pt not rec aspirin prior ER		M					
G8357	Pt not doc to have ECG		M					
G8360	Pt not doc vital signs recor		M					
G8362	Pt not doc 02 SAT assess		M					
G8365	Pt not doc mental status		M					
G8367	Pt not doc have empiric AB		M					
G8370	Asthma pt w survey not docum		M					
G8371	Chemother not rec stg3 colon		M					
G8372	Chemother rec stg3 colon ca		M					
G8373	Chemo plan documen prior che		M					
G8374	Chemo plan not doc prior che		M					
G8375	CLL pt w/o doc flow cytometr		M					
G8376	Brst ca pt inelig tamoxifen		M					
G8377	MD doc colon ca pt inelig ch		M					
G8378	MD doc pt inelig radiation		M					
G8379	Doc radiat tx recom 12mo ov		M					
G8380	Pt w stgIC-3Brst ca not rec		M					
G8381	Pt w stgIC-3Brst ca rec tam		M					
G8382	MM pt w/o doc IV bisphophon		M					
G8383	No doc radiation rec 12mo ov		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8384	Base cytogen test MDS notper		M					
G8385	Diabet pt no do Hgb A1c 12m		M					
G8386	Diabet pt nodoc LDLiprotei		M					
G8387	ESRD pt w Hct/Hgb not docume		M					
G8388	ESRD pt w URR/Ktv notdoc eli		M					
G8389	MDS pt no doc FE st prio EPO		M					
G8390	Diabetic w/o document BP 12m		M					
G8391	Pt w asthma no doc med or tx		M					
G8395	LVEF>=40% doc normal or mild		M					
G8396	LVEF not performed		M					
G8397	Dil macula/fundus exam/w doc		M					
G8398	Dil macular/fundus not perfo		M					
G8399	Pt w/DXA document or order		M					
G8400	Pt w/DXA no document or orde		M					
G8401	Pt inelig osteo screen measu		M					
G8402	Smoke preven interven counse		M					
G8403	Smoke preven nocounsel		M					
G8404	Low extemity neur exam docum		M					
G8405	Low extemity neur not perfor		M					
G8406	Pt inelig lower extrem neuro		M					
G8407	ABI documented		M					
G8408	ABI not documented		M					
G8409	Pt inelig for ABI measure		M					
G8410	Eval on foot documented		M					
G8415	Eval on foot not performed		M					
G8416	Pt inelig footwear evaluatio		M					
G8417	Calc BMI abv up param f/u		M					
G8418	Calc BMI blw low param f/u		M					
G8419	Calc BMI out nrm param nof/u		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8420	Calc BMI norm parameters		M					
G8421	BMI not calculated		M					
G8422	Pt inelig BMI calculation		M					
G8423	Pt screen flu vac & counsel		M					
G8424	Flu vaccine not screen		M					
G8425	Flu vaccine screen not curre		M					
G8426	Pt not approp screen & counc		M					
G8427	Doc meds verified w/pt or re		M					
G8428	Meds document w/o verifica		M					
G8429	Incomplete doc pt on meds		M					
G8430	Pt inelig med check		M					
G8431	Pos clin depres scrn f/u doc		M					
G8432	Clin depression screen not d		M					
G8433	Pt inelig; scrn clin dep		M					
G8434	Cognitive impairment screen		M					
G8435	Cognitive screen not documen		M					
G8436	Pt inelig for cognitive impa		M					
G8437	Care plan develop & document		M					
G8438	Pt inelig for devlp care pln		M					
G8439	Care plan develp & not docum		M					
G8440	Pain assess f/u pln document		M					
G8441	No document of pain assess		M					
G8442	Pt inelig pain assessment		M					
G8443	Prescription by E-Prescrib s		M					
G8445	Prescrip not gen at encounte		M					
G8446	Some prescrib print or call		M					
G8447	Pt vis doc use CCHIT cer EHR		M					
G8448	Pt vis doc w/non-CCHIT EHR		M					
G8449	Pt not doc w/EMR due to syst		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8450	Beta-bloc rx pt w/abn lvef		M					
G8451	Pt w/abn lvef inelig b-bloc		M					
G8452	Pt w/abn lvef b-bloc no rx		M					
G8453	Tob use cess int counsel		M					
G8454	Tob use cess int no counsel		M					
G8455	Current tobacco smoker		M					
G8456	Current smkless tobacco user		M					
G8457	Cur tobacco non-user		M					
G8458	Pt inelig geno no antvir tx		M					
G8459	Doc pt rec antivir treat		M					
G8460	Pt inelig RNA no antvir tx		M					
G8461	Pt rec antivir treat hep c		M					
G8462	Pt inelig couns no antvir tx		M					
G8463	Pt rec antiviral treat doc		M					
G8464	Pt inelig; lo to no dter rsk		M					
G8465	High risk recurrence pro ca		M					
G8466	Pt inelig suic; MDD remis		M					
G8467	New dx init/rec episode MDD		M					
G8468	ACE/ARB rx pt w/abn lvef		M					
G8469	Pt w/abn lvef inelig ACE/ARB		M					
G8470	Pt w/ normal lvef		M					
G8471	LVEF not performed/doc		M					
G8472	ACE/ARB no rx pt w/abn lvef		M					
G8473	ACE/ARB thxpy rx'd		M					
G8474	ACE/ARB not rx'd; doc reas		M					
G8475	ACE/ARB thxpy not rx'd		M					
G8476	BP sys <130 and dias <80		M					
G8477	BP sys>=130 and/or dias >=80		M					
G8478	BP not performed/doc		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8479	MD rx'd ACE/ARB thxpy		M					
G8480	Pt inelig ACE/ARB thxpy		M					
G8481	MD not rx'd ACE/ARB thxpy		M					
G8482	Flu immunize order/admin		M					
G8483	Flu imm no ord/admin doc rea		M					
G8484	Flu immunize no order/admin		M					
G8485	Report, Diabetes measures		M					
G8486	Report, Prev Care Measures		M					
G8487	Report CKD Measures		M					
G8488	Report ESRD Measures		M					
G8489	CAD measures grp		M					
G8490	RA measures grp		M					
G8491	HIV/AIDS measures grp		M					
G8492	Periop Care measures grp		M					
G8493	Back pain measures grp		M					
G8494	DM meas qual act perform		M					
G8495	CKD meas qual act perform		M					
G8496	Prev Care MG qual act perfrm		M					
G8497	CABG meas qual act perform		M					
G8498	CAD meas qual act perform		M					
G8499	RA meas qual act perform		M					
G8500	HIV meas qual act perform		M					
G8501	Perio meas qual act perform		M					
G8502	Back Pain MG qual act perfrm		M					
G8506	Pt rec ACE/ARB		M					
G8507	Pt inelig pt verif meds		M					
G8508	Pt inelig; pain asses no f/u		M					
G8509	Pain assess no f/u pln doc		M					
G8510	Pt inelig neg scrn depres		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8511	Clin depres scrn no f/u doc		M					
G8518	Clin stg b/f lun/eso ca surg		M					
G8519	Pt in; clin ca stg b/f surg		M					
G8520	Clin stg b/f surg not doc		M					
G8524	Patch closure conv CEA		M					
G8525	No patch closure CEA		M					
G8526	No patch closure conv CEA		M					
G8530	Auto AV fistula recd		M					
G8531	Pt inelig; auto AV fistula		M					
G8532	No auto AV fistula; no reas		M					
G8534	Doc elder mal scrn f/u plan		M					
G8535	Pt inelig no eld mal scrn		M					
G8536	No doc elder mal scrn		M					
G8537	Pt inelig eldmal scrn no f/u		M					
G8538	Eld mal scrn no f/u pln		M					
G8539	Cur funct assess & care pln		M					
G8540	Pt inelig funct assess		M					
G8541	No doc cur funct assess		M					
G8542	Pt inelig func asses no pln		M					
G8543	Cur funct asses; no care pln		M					
G8544	CABG measures grp		M					
G8545	HepC measures grp		M					
G8546	CAP measures grp		M					
G8547	IVD measures grp		M					
G8548	HF measures grp		M					
G8549	HepC MG qual act perform		M					
G8550	CAP MG qual act perform		M					
G8551	HF MG qual act perform		M					
G8552	IVD MG qual act perform		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8553	1 Rx via qualified eRx sys		M					
G8556	Ref to doc otolog eval		M					
G8557	Pt inelig ref otolog eval		M					
G8558	No ref to doc otolog eval		M					
G8559	Pt ref doc oto eval		M					
G8560	Pt hx act drain prev 90 days		M					
G8561	Pt inelig for ref oto eval		M					
G8562	Pt no hx act drain 90 d		M					
G8563	Pt no ref oto reas no spec		M					
G8564	Pt ref oto eval		M					
G8565	Ver doc hear loss		M					
G8566	Pt inelig ref oto eval		M					
G8567	Pt no doc hear loss		M					
G8568	Pt no ref otolo no spec		M					
G8569	Prol intubation req		M					
G8570	No prol intub req		M					
G8571	Ster wd ifx 30 d postop		M					
G8572	No ster wd ifx		M					
G8573	Stk/CVA CABG		M					
G8574	No strk/CVA CABG		M					
G8575	Postop ren insuf		M					
G8576	No postop ren insuf		M					
G8577	Reop req bld grft oth		M					
G8578	No reop req bld grft oth		M					
G8579	Antplt med disch		M					
G8580	Antplt med contraind		M					
G8581	no antplt med disch		M					
G8582	Bblock disch		M					
G8583	Bblock contraind		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8584	No bblock disch		M					
G8585	Antilipid treat disch		M					
G8586	Antlip disch contra		M					
G8587	No antlipid treat disch		M					
G8588	Sys BP <140		M					
G8589	Sys BP >= 140		M					
G8590	Dia BP < 90		M					
G8591	Dia BP >= 90		M					
G8592	No BP measure		M					
G8593	Lipid pn results		M					
G8594	No lipid prof perf		M					
G8595	Ldl < 100		M					
G8596	No LDL perf		M					
G8597	Ldl >= 100		M					
G8598	Asp therp used		M					
G8599	No asp therp used		M					
G8600	tPA initi w/in 3 hrs		M					
G8601	No elig tPA init w/in 3 hrs		M					
G8602	No tPA init w/in 3 hrs		M					
G8603	Spok lang comp score		M					
G8604	No high score spok lang		M					
G8605	No spok lang comp score		M					
G8606	Attention score		M					
G8607	No high score attention		M					
G8608	No attention score		M					
G8609	Memory score		M					
G8610	No high score memory		M					
G8611	No memory score		M					
G8612	Moto speech score		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8613	No high score moto speech		M					
G8614	No moto speech score		M					
G8615	Reading score		M					
G8616	No high score reading		M					
G8617	No reading score		M					
G8618	Spok lang exp score		M					
G8619	No high score spok lang exp		M					
G8620	No spok lang exp score		M					
G8621	Writing score		M					
G8622	No high score writing		M					
G8623	No writing score		M					
G8624	Swallowing score		M					
G8625	No high score swallowing		M					
G8626	No swallowing score		M					
G8627	Surg proc w/in 30 days		M					
G8628	No surg proc w/in 30 days		M					
G9001	MCCD, initial rate		B					
G9002	MCCD,maintenance rate		B					
G9003	MCCD, risk adj hi, initial		B					
G9004	MCCD, risk adj lo, initial		B					
G9005	MCCD, risk adj, maintenance		B					
G9006	MCCD, Home monitoring		B					
G9007	MCCD, sch team conf		B					
G9008	Mccd,phys coor-care ovrsght		B					
G9009	MCCD, risk adj, level 3		B					
G9010	MCCD, risk adj, level 4		B					
G9011	MCCD, risk adj, level 5		B					
G9012	Other Specified Case Mgmt		B					
G9013	ESRD demo bundle level I		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9014	ESRD demo bundle-level II		E					
G9016	Demo-smoking cessation coun		E					
G9017	Amantadine HCL 100mg oral		A					
G9018	Zanamivir,inhalation pwd 10m		A					
G9019	Oseltamivir phosphate 75mg		A					
G9020	Rimantadine HCL 100mg oral		A					
G9033	Amantadine HCL oral brand		A					
G9034	Zanamivir, inh pwdr, brand		A					
G9035	Oseltamivir phosp, brand		A					
G9036	Rimantadine HCL, brand		A					
G9041	Low vision rehab occupationa		A					
G9042	Low vision rehab orient/mobi		A					
G9043	Low vision lowvision therapi		A					
G9044	Low vision rehabilate teache		A					
G9050	Oncology work-up evaluation		E					
G9051	Oncology tx decision-mgmt		E					
G9052	Onc surveillance for disease		E					
G9053	Onc expectant management pt		E					
G9054	Onc supervision palliative		E					
G9055	Onc visit unspecified NOS		E					
G9056	Onc prac mgmt adheres guide		E					
G9057	Onc pract mgmt differs trial		E					
G9058	Onc prac mgmt disagree w/gui		E					
G9059	Onc prac mgmt pt opt alterna		E					
G9060	Onc prac mgmt dif pt comorb		E					
G9061	Onc prac cond noadd by guide		E					
G9062	Onc prac guide differs nos		E					
G9063	Onc dx nsclc stgI no progres		M					
G9064	Onc dx nsclc stg2 no progres		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9065	Onc dx nsclc stg3A no progre		M					
G9066	Onc dx nsclc stg3B-4 metasta		M					
G9067	Onc dx nsclc dx unknown nos		M					
G9068	Onc dx sclc/nsclc limited		M					
G9069	Onc dx sclc/nsclc ext at dx		M					
G9070	Onc dx sclc/nsclc ext unknwn		M					
G9071	Onc dx brst stg1-2B HR,nopro		M					
G9072	Onc dx brst stg1-2 noprogres		M					
G9073	Onc dx brst stg3-HR, no pro		M					
G9074	Onc dx brst stg3-noprogress		M					
G9075	Onc dx brst metastic/ recur		M					
G9077	Onc dx prostate T1no progres		M					
G9078	Onc dx prostate T2no progres		M					
G9079	Onc dx prostate T3b-T4noprog		M					
G9080	Onc dx prostate w/rise PSA		M					
G9083	Onc dx prostate unknwn nos		M					
G9084	Onc dx colon t1-3,n1-2,no pr		M					
G9085	Onc dx colon T4, N0 w/o prog		M					
G9086	Onc dx colon T1-4 no dx prog		M					
G9087	Onc dx colon metas evid dx		M					
G9088	Onc dx colon metas noevid dx		M					
G9089	Onc dx colon extent unknown		M					
G9090	Onc dx rectal T1-2 no progr		M					
G9091	Onc dx rectal T3 N0 no prog		M					
G9092	Onc dx rectal T1-3,N1-2noprg		M					
G9093	Onc dx rectal T4,N,M0 no prg		M					
G9094	Onc dx rectal M1 w/mets prog		M					
G9095	Onc dx rectal extent unknwn		M					
G9096	Onc dx esophag T1-T3 noprog		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9097	Onc dx esophageal T4 no prog		M					
G9098	Onc dx esophageal mets recur		M					
G9099	Onc dx esophageal unknown		M					
G9100	Onc dx gastric no recurrence		M					
G9101	Onc dx gastric p R1-R2noprog		M					
G9102	Onc dx gastric unresectable		M					
G9103	Onc dx gastric recurrent		M					
G9104	Onc dx gastric unknown NOS		M					
G9105	Onc dx pancreatc p R0 res no		M					
G9106	Onc dx pancreatc p R1/R2 no		M					
G9107	Onc dx pancreatic unresectab		M					
G9108	Onc dx pancreatic unknwn NOS		M					
G9109	Onc dx head/neck T1-T2no prg		M					
G9110	Onc dx head/neck T3-4 noprog		M					
G9111	Onc dx head/neck M1 mets rec		M					
G9112	Onc dx head/neck ext unknown		M					
G9113	Onc dx ovarian stg1A-B no pr		M					
G9114	Onc dx ovarian stg1A-B or 2		M					
G9115	Onc dx ovarian stg3/4 noprog		M					
G9116	Onc dx ovarian recurrence		M					
G9117	Onc dx ovarian unknown NOS		M					
G9123	Onc dx CML chronic phase		M					
G9124	Onc dx CML acceler phase		M					
G9125	Onc dx CML blast phase		M					
G9126	Onc dx CML remission		M					
G9128	Onc dx multi myeloma stage I		M					
G9129	Onc dx mult myeloma stg2 hig		M					
G9130	Onc dx multi myeloma unknown		M					
G9131	Onc dx brst unknown NOS		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9132	Onc dx prostate mets no cast		M					
G9133	Onc dx prostate clinical met		M					
G9134	Onc NHLstg 1-2 no relap no		M					
G9135	Onc dx NHL stg 3-4 not relap		M					
G9136	Onc dx NHL trans to lg Bcell		M					
G9137	Onc dx NHL relapse/refractor		M					
G9138	Onc dx NHL stg unknown		M					
G9139	Onc dx CML dx status unknown		M					
G9140	Frontier extended stay demo		A					
G9141	Influenza A H1N1,admin w cou		S	0350	0.3853	$26.30		
G9142	Influenza A H1N1, vaccine		E					
G9143	Warfarin respon genetic test		A					
G9147	Outpt IV insulin tx any mea		E					
J0120	Tetracyclin injection		N					
J0128	Abarelix injection		E					
J0129	Abatacept injection		K	9230		$19.96	.	$4.00
J0130	Abciximab injection		K	1605		$462.83	.	$92.57
J0132	Acetylcysteine injection		K	1272		$2.45	.	$0.49
J0133	Acyclovir injection		N					
J0135	Adalimumab injection		K	1083		$374.48	.	$74.90
J0150	Injection adenosine 6 MG	CH	N					
J0152	Adenosine injection		K	0917		$82.72	.	$16.55
J0170	Adrenalin epinephrin inject		N					
J0180	Agalsidase beta injection		K	9208		$136.24	.	$27.25
J0190	Inj biperiden lactate/5 mg	CH	E					
J0200	Alatrofloxacin mesylate		N					
J0205	Alglucerase injection		K	0900		$41.98	.	$8.40
J0207	Amifostine		K	7000		$327.97	.	$65.60
J0210	Methyldopate hcl injection		K	2210		$36.34	.	$7.27

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0215	Alefacept		K	1633		$30.63	.	$6.13
J0220	Alglucosidase alfa injection		K	9234		$127.08	.	$25.42
J0256	Alpha 1 proteinase inhibitor		K	0901		$3.77	.	$0.76
J0270	Alprostadil for injection		B					
J0275	Alprostadil urethral suppos		B					
J0278	Amikacin sulfate injection		N					
J0280	Aminophyllin 250 MG inj		N					
J0282	Amiodarone HCl		N					
J0285	Amphotericin B		N					
J0287	Amphotericin b lipid complex		K	9024		$9.84	.	$1.97
J0288	Ampho b cholesteryl sulfate		K	0735		$14.00	.	$2.80
J0289	Amphotericin b liposome inj		K	0736		$15.78	.	$3.16
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	Anidulafungin injection	CH	N					
J0350	Injection anistreplase 30 u		E					
J0360	Hydralazine hcl injection		N					
J0364	Apomorphine hydrochloride		N					
J0365	Aprotonin, 10,000 kiu	CH	N					
J0380	Inj metaraminol bitartrate		N					
J0390	Chloroquine injection		N					
J0395	Arbutamine hcl injection		E					
J0400	Aripiprazole injection		N					
J0456	Azithromycin		N					
J0461	Atropine sulfate injection		N					
J0470	Dimecaprol injection	CH	N					
J0475	Baclofen 10 MG injection		K	9032		$203.89	.	$40.78

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0476	Baclofen intrathecal trial		K	1631		$73.50	.	$14.70
J0480	Basiliximab		K	1683		$1,755.73	.	$351.15
J0500	Dicyclomine injection		N					
J0515	Inj benztropine mesylate	CH	K	1302		$42.16	.	$8.44
J0520	Bethanechol chloride inject		N					
J0559	PenG benzathine/procaine inj		N					
J0560	Penicillin g benzathine inj		N					
J0570	Penicillin g benzathine inj		N					
J0580	Penicillin g benzathine inj		N					
J0583	Bivalirudin		K	3041		$2.41	.	$0.49
J0585	Injection,onabotulinumtoxinA		K	0902		$5.49	.	$1.10
J0586	AbobotulinumtoxinA		K	1289		$7.71	.	$1.55
J0587	Inj, rimabotulinumtoxinB		K	9018		$10.58	.	$2.12
J0592	Buprenorphine hydrochloride		N					
J0594	Busulfan injection		K	1178		$14.45	.	$2.89
J0595	Butorphanol tartrate 1 mg		N					
J0598	C1 esterase inhibitor inj		G	9251		$42.75	.	$8.55
J0600	Edetate calcium disodium inj		K	1274		$197.37	.	$39.48
J0610	Calcium gluconate injection		N					
J0620	Calcium glycer & lact/10 ML		N					
J0630	Calcitonin salmon injection		K	1220		$49.26	.	$9.86
J0636	Inj calcitriol per 0.1 mcg		N					
J0637	Caspofungin acetate		K	9019		$11.59	.	$2.32
J0640	Leucovorin calcium injection		N					
J0641	Levoleucovorin injection		G	1236		$0.78	.	$0.16
J0670	Inj mepivacaine HCL/10 ml		N					
J0690	Cefazolin sodium injection		N					
J0692	Cefepime HCl for injection		N					
J0694	Cefoxitin sodium injection		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		N					
J0710	Cephapirin sodium injection		N					
J0713	Inj ceftazidime per 500 mg		N					
J0715	Ceftizoxime sodium / 500 MG		N					
J0718	Certolizumab pegol inj		G	9249		$3.78	.	$0.76
J0720	Chloramphenicol sodium injec		N					
J0725	Chorionic gonadotropin/1000u		N					
J0735	Clonidine hydrochloride		K	0935		$98.64	.	$19.73
J0740	Cidofovir injection		K	9033		$761.10	.	$152.22
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		$4.48	.	$0.90
J0800	Corticotropin injection		K	1280		$2,441.70	.	$488.34
J0833	Cosyntropin injection NOS		K	0835		$73.19	.	$14.64
J0834	Cosyntropin cortrosyn inj		K	1298		$90.95	.	$18.19
J0850	Cytomegalovirus imm IV /vial		K	0903		$878.82	.	$175.77
J0878	Daptomycin injection		K	9124		$0.43	.	$0.09
J0881	Darbepoetin alfa, non-esrd		K	1685		$2.88	.	$0.58
J0882	Darbepoetin alfa, esrd use		A					
J0885	Epoetin alfa, non-esrd		K	1686		$9.44	.	$1.89

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0886	Epoetin alfa 1000 units ESRD		A					
J0894	Decitabine injection		K	9231		$29.65	.	$5.93
J0895	Deferoxamine mesylate inj		N					
J0900	Testosterone enanthate inj		N					
J0945	Brompheniramine maleate inj		K	1256		$9.24	.	$1.85
J0970	Estradiol valerate injection		N					
J1000	Depo-estradiol cypionate inj		N					
J1020	Methylprednisolone 20 MG inj		N					
J1030	Methylprednisolone 40 MG inj		N					
J1040	Methylprednisolone 80 MG inj		N					
J1051	Medroxyprogesterone inj		N					
J1055	Medrxyprogester acetate inj		E					
J1056	MA/EC contraceptiveinjection		E					
J1060	Testosterone cypionate 1 ML		N					
J1070	Testosterone cypionat 100 MG		N					
J1080	Testosterone cypionat 200 MG		N					
J1094	Inj dexamethasone acetate		N					
J1100	Dexamethasone sodium phos		N					
J1110	Inj dihydroergotamine mesylt		N					
J1120	Acetazolamid sodium injectio		N					
J1160	Digoxin injection		N					
J1162	Digoxin immune fab (ovine)		K	1687		$487.78	.	$97.56
J1165	Phenytoin sodium injection		N					
J1170	Hydromorphone injection		N					
J1180	Dyphylline injection		N					
J1190	Dexrazoxane HCl injection		K	0726		$261.24	.	$52.25
J1200	Diphenhydramine hcl injectio		N					
J1205	Chlorothiazide sodium inj		K	0747		$352.37	.	$70.48
J1212	Dimethyl sulfoxide 50% 50 ML		K	1221		$69.98	.	$14.00

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1230	Methadone injection		N					
J1240	Dimenhydrinate injection		N					
J1245	Dipyridamole injection		N					
J1250	Inj dobutamine HCL/250 mg		N					
J1260	Dolasetron mesylate		N					
J1265	Dopamine injection		N					
J1267	Doripenem injection	CH	N					
J1270	Injection, doxercalciferol		N					
J1300	Eculizumab injection		K	9236		$182.61	.	$36.53
J1320	Amitriptyline injection		N					
J1324	Enfuvirtide injection	CH	N					
J1325	Epoprostenol injection		N					
J1327	Eptifibatide injection		K	1607		$19.00	.	$3.80
J1330	Ergonovine maleate injection		N					
J1335	Ertapenem injection		N					
J1364	Erythro lactobionate /500 MG		N					
J1380	Estradiol valerate 10 MG inj		N					
J1390	Estradiol valerate 20 MG inj		N					
J1410	Inj estrogen conjugate 25 MG		K	9038		$88.68	.	$17.74
J1430	Ethanolamine oleate 100 mg		K	1688		$149.97	.	$30.00
J1435	Injection estrone per 1 MG	CH	E					
J1436	Etidronate disodium inj	CH	N					
J1438	Etanercept injection		K	1608		$191.55	.	$38.31
J1440	Filgrastim 300 mcg injection		K	0728		$223.05	.	$44.61
J1441	Filgrastim 480 mcg injection		K	7049		$348.68	.	$69.74
J1450	Fluconazole		N					
J1451	Fomepizole, 15 mg		K	1689		$7.64	.	$1.53
J1452	Intraocular Fomivirsen na		E					
J1453	Fosaprepitant injection	CH	K	9242		$1.62	.	$0.33

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1455	Foscarnet sodium injection		N					
J1457	Gallium nitrate injection		K	0878		$2.03	.	$0.41
J1458	Galsulfase injection		K	9224		$339.90	.	$67.98
J1459	Inj IVIG privigen 500 mg	CH	K	1214		35.10	.	$7.02
J1460	Gamma globulin 1 CC inj		K	3043		$16.03	.	$3.21
J1470	Gamma globulin 2 CC inj		K	1282		$32.07	.	$6.42
J1480	Gamma globulin 3 CC inj		K	1283		$48.10	.	$9.62
J1490	Gamma globulin 4 CC inj		K	0904		$64.13	.	$12.83
J1500	Gamma globulin 5 CC inj		K	1284		$80.16	.	$16.04
J1510	Gamma globulin 6 CC inj		K	0920		$96.23	.	$19.25
J1520	Gamma globulin 7 CC inj		K	0921		$112.17	.	$22.44
J1530	Gamma globulin 8 CC inj		K	0922		$128.27	.	$25.66
J1540	Gamma globulin 9 CC inj		K	0923		$160.34	.	$32.07
J1550	Gamma globulin 10 CC inj		K	0924		$160.34	.	$32.07
J1560	Gamma globulin > 10 CC inj		K	0933		$160.34	.	$32.07
J1561	Gamunex injection		K	0948		$37.63	.	$7.53
J1562	Vivaglobin, inj		K	1275		$7.20	.	$1.44
J1566	Immune globulin, powder		K	2731		$30.86	.	$6.18
J1568	Octagam injection		K	0943		$37.69	.	$7.54
J1569	Gammagard liquid injection		K	0944		$38.53	.	$7.71
J1570	Ganciclovir sodium injection		N					
J1571	Hepagam b im injection	CH	K	0946		$50.63	.	$10.13
J1572	Flebogamma injection		K	0947		$37.01	.	$7.41
J1573	Hepagam b intravenous, inj	CH	K	1138		$50.63	.	$10.13
J1580	Garamycin gentamicin inj		N					
J1590	Gatifloxacin injection		N					
J1595	Injection glatiramer acetate		K	1015		$82.34	.	$16.47
J1600	Gold sodium thiomaleate inj		N					
J1610	Glucagon hydrochloride/1 MG		K	9042		$81.41	.	$16.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1620	Gonadorelin hydroch/ 100 mcg	CH	N					
J1626	Granisetron hcl injection		N					
J1630	Haloperidol injection		N					
J1631	Haloperidol decanoate inj		N					
J1640	Hemin, 1 mg		K	1690		$8.18	.	$1.64
J1642	Inj heparin sodium per 10 u		N					
J1644	Inj heparin sodium per 1000u		N					
J1645	Dalteparin sodium		N					
J1650	Inj enoxaparin sodium		N					
J1652	Fondaparinux sodium	CH	N					
J1655	Tinzaparin sodium injection		N					
J1670	Tetanus immune globulin inj		K	1670		$136.81	.	$27.37
J1675	Histrelin acetate		B					
J1680	Human fibrinogen conc inj		G	1290		$72.89	.	$14.58
J1700	Hydrocortisone acetate inj		N					
J1710	Hydrocortisone sodium ph inj		N					
J1720	Hydrocortisone sodium succ i		N					
J1730	Diazoxide injection		K	1740		$114.32	.	$22.87
J1740	Ibandronate sodium injection		K	9229		$141.39	.	$28.28
J1742	Ibutilide fumarate injection		K	9044		$416.61	.	$83.33
J1743	Idursulfase injection		K	9232		$455.03	.	$91.01
J1745	Infliximab injection		K	7043		$58.74	.	$11.75
J1750	Inj iron dextran		K	1237		$12.63	.	$2.53
J1756	Iron sucrose injection		K	9046		$0.37	.	$0.08
J1785	Injection imiglucerase /unit		K	0916		$4.20	.	$0.84
J1790	Droperidol injection		N					
J1800	Propranolol injection		N					
J1810	Droperidol/fentanyl inj		E					
J1815	Insulin injection		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1817	Insulin for insulin pump use	CH	N					
J1825	Interferon beta-1a		E					
J1830	Interferon beta-1b / .25 MG		K	0910		$176.67	.	$35.34
J1835	Itraconazole injection	CH	K	1303		$42.28	.	$8.46
J1840	Kanamycin sulfate 500 MG inj		N					
J1850	Kanamycin sulfate 75 MG inj		N					
J1885	Ketorolac tromethamine inj		N					
J1890	Cephalothin sodium injection		N					
J1930	Lanreotide injection		K	9237		$29.30	.	$5.86
J1931	Laronidase injection		K	9209		$25.56	.	$5.12
J1940	Furosemide injection		N					
J1945	Lepirudin		K	1693		$234.37	.	$46.88
J1950	Leuprolide acetate /3.75 MG		K	0800		$516.09	.	$103.22
J1953	Levetiracetam injection	CH	N					
J1955	Inj levocarnitine per 1 gm		B					
J1956	Levofloxacin injection		N					
J1960	Levorphanol tartrate inj		N					
J1980	Hyoscyamine sulfate inj		N					
J1990	Chlordiazepoxide injection		N					
J2001	Lidocaine injection		N					
J2010	Lincomycin injection		N					
J2020	Linezolid injection		K	9001		$32.57	.	$6.52
J2060	Lorazepam injection		N					
J2150	Mannitol injection		N					
J2170	Mecasermin injection	CH	K	1308		$125.21	.	$25.05
J2175	Meperidine hydrochl /100 MG		N					
J2180	Meperidine/promethazine inj		N					
J2185	Meropenem		N					
J2210	Methylergonovin maleate inj		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2248	Micafungin sodium injection		K	9227		$1.10	.	$0.22
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		K	1694		$6.50	.	$1.30
J2280	Inj, moxifloxacin 100 mg		N					
J2300	Inj nalbuphine hydrochloride		N					
J2310	Inj naloxone hydrochloride		N					
J2315	Naltrexone, depot form		K	0759		$2.43	.	$0.49
J2320	Nandrolone decanoate 50 MG		K	1285		$7.08	.	$1.42
J2321	Nandrolone decanoate 100 MG		K	1260		$71.34	.	$14.27
J2322	Nandrolone decanoate 200 MG		K	1286		$43.59	.	$8.72
J2323	Natalizumab injection		K	9126		$7.97	.	$1.60
J2325	Nesiritide injection		K	1695		$38.37	.	$7.68
J2353	Octreotide injection, depot		K	1207		$109.01	.	$21.81
J2354	Octreotide inj, non-depot		N					
J2355	Oprelvekin injection		K	7011		$245.08	.	$49.02
J2357	Omalizumab injection		K	9300		$19.77	.	$3.96
J2360	Orphenadrine injection		N					
J2370	Phenylephrine hcl injection		N					
J2400	Chloroprocaine hcl injection		N					
J2405	Ondansetron hcl injection		N					
J2410	Oxymorphone hcl injection		N					
J2425	Palifermin injection		K	1696		$11.34	.	$2.27
J2430	Pamidronate disodium /30 MG	CH	N					
J2440	Papaverin hcl injection		N					
J2460	Oxytetracycline injection		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2469	Palonosetron hcl		K	9210		$17.62	.	$3.53
J2501	Paricalcitol		N					
J2503	Pegaptanib sodium injection		K	1697		$1,030.34	.	$206.07
J2504	Pegademase bovine, 25 iu		K	1739		$247.34	.	$49.47
J2505	Injection, pegfilgrastim 6mg		K	9119		$2,432.50	.	$486.50
J2510	Penicillin g procaine inj		N					
J2513	Pentastarch 10% solution		K	1222		$161.82	.	$32.37
J2515	Pentobarbital sodium inj		N					
J2540	Penicillin g potassium inj		N					
J2543	Piperacillin/tazobactam		N					
J2545	Pentamidine non-comp unit		B					
J2550	Promethazine hcl injection		N					
J2560	Phenobarbital sodium inj		N					
J2562	Plerixafor injection		G	9252		$268.58	.	$53.72
J2590	Oxytocin injection		N					
J2597	Inj desmopressin acetate		N					
J2650	Prednisolone acetate inj		N					
J2670	Totazoline hcl injection		N					
J2675	Inj progesterone per 50 MG		N					
J2680	Fluphenazine decanoate 25 MG		N					
J2690	Procainamide hcl injection		N					
J2700	Oxacillin sodium injeciton		N					
J2710	Neostigmine methylslfte inj		N					
J2720	Inj protamine sulfate/10 MG		N					
J2724	Protein c concentrate		K	1139		$12.19	.	$2.44
J2725	Inj protirelin per 250 mcg		N					
J2730	Pralidoxime chloride inj		K	1023		$90.79	.	$18.16
J2760	Phentolaine mesylate inj		N					
J2765	Metoclopramide hcl injection		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2770	Quinupristin/dalfopristin		K	2770		$147.06	.	$29.42
J2778	Ranibizumab injection		K	9233		$404.70	.	$80.94
J2780	Ranitidine hydrochloride inj		N					
J2783	Rasburicase		K	0738		$172.53	.	$34.51
J2785	Regadenoson injection	CH	K	9244		$50.73	.	$10.15
J2788	Rho d immune globulin 50 mcg		K	9023		$25.14	.	$5.03
J2790	Rho d immune globulin inj		K	0884		$77.47	.	$15.50
J2791	Rhophylac injection		K	0945		$5.21	.	$1.05
J2792	Rho(D) immune globulin h, sd		K	1609		$18.55	.	$3.71
J2793	Rilonacept injection		K	1291		$24.09	.	$4.82
J2794	Risperidone, long acting		K	9125		$5.06	.	$1.02
J2795	Ropivacaine HCl injection		N					
J2796	Romiplostim injection	CH	K	9245		$44.18	.	$8.84
J2800	Methocarbamol injection		N					
J2805	Sincalide injection		N					
J2810	Inj theophylline per 40 MG		N					
J2820	Sargramostim injection		K	0731		$25.25	.	$5.05
J2850	Inj secretin synthetic human		K	1700		$20.31	.	$4.07
J2910	Aurothioglucose injeciton		N					
J2916	Na ferric gluconate complex		N					
J2920	Methylprednisolone injection		N					
J2930	Methylprednisolone injection		N					
J2940	Somatrem injection	CH	N					
J2941	Somatropin injection		K	7034		$55.46	.	$11.10
J2950	Promazine hcl injection		N					
J2993	Reteplase injection		K	9005		$1,555.98	.	$311.20
J2995	Inj streptokinase /250000 IU		K	1226		$32.12	.	$6.43
J2997	Alteplase recombinant		K	7048		$37.35	.	$7.47
J3000	Streptomycin injection		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J3010	Fentanyl citrate injeciton		N					
J3030	Sumatriptan succinate / 6 MG	CH	N					
J3070	Pentazocine injection		N					
J3101	Tenecteplase injection		K	9002		$46.74	.	$9.35
J3105	Terbutaline sulfate inj		N					
J3110	Teriparatide injection		B					
J3120	Testosterone enanthate inj		N					
J3130	Testosterone enanthate inj		N					
J3140	Testosterone suspension inj		N					
J3150	Testosteron propionate inj		N					
J3230	Chlorpromazine hcl injection		N					
J3240	Thyrotropin injection		K	9108		$1,053.42	.	$210.69
J3243	Tigecycline injection		K	9228		$1.16	.	$0.24
J3246	Tirofiban HCl		K	7041		$7.39	.	$1.48
J3250	Trimethobenzamide hcl inj		N					
J3260	Tobramycin sulfate injection		N					
J3265	Injection torsemide 10 mg/ml		N					
J3280	Thiethylperazine maleate inj		N					
J3285	Treprostinil injection		K	1701		$55.88	.	$11.18
J3300	Triamcinolone A inj PRS-free		K	1253		$3.21	.	$0.65
J3301	Triamcinolone acet inj NOS		N					
J3302	Triamcinolone diacetate inj		N					
J3303	Triamcinolone hexacetonl inj		N					
J3305	Inj trimetrexate glucoronate	CH	N					
J3310	Perphenazine injeciton	CH	K	1304		$29.11	.	$5.83
J3315	Triptorelin pamoate		K	9122		$164.10	.	$32.82
J3320	Spectinomycn di-hcl inj	CH	E					
J3350	Urea injection	CH	K	1306		$83.87	.	$16.78
J3355	Urofollitropin, 75 iu		K	1741		$60.01	.	$12.01

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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		$9.50	.	$1.90
J3400	Triflupromazine hcl inj	CH	E					
J3410	Hydroxyzine hcl injection		N					
J3411	Thiamine hcl 100 mg		N					
J3415	Pyridoxine hcl 100 mg		N					
J3420	Vitamin b12 injection		N					
J3430	Vitamin k phytonadione inj		N					
J3465	Injection, voriconazole		K	1052		$5.82	.	$1.17
J3470	Hyaluronidase injection		N					
J3471	Ovine, up to 999 USP units		N					
J3472	Ovine, 1000 USP units		N					
J3473	Hyaluronidase recombinant		N					
J3475	Inj magnesium sulfate		N					
J3480	Inj potassium chloride		N					
J3485	Zidovudine		N					
J3486	Ziprasidone mesylate		N					
J3487	Zoledronic acid		K	9115		$221.12	.	$44.23
J3488	Reclast injection		K	0951		$222.92	.	$44.59
J3490	Drugs unclassified injection		N					
J3520	Edetate disodium per 150 mg		E					
J3530	Nasal vaccine inhalation		N					
J3535	Metered dose inhaler drug		E					
J3570	Laetrile amygdalin vit B17		E					
J3590	Unclassified biologics		N					
J7030	Normal saline solution infus		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
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					
J7185	Xyntha inj		K	1268		$1.08	.	$0.22
J7186	Antihemophilic viii/vwf comp		K	1213		$0.92	.	$0.19
J7187	Humate-P, inj		K	1704		$0.88	.	$0.18
J7189	Factor viia		K	1705		$1.36	.	$0.28
J7190	Factor viii		K	0925		$0.87	.	$0.18
J7191	Factor VIII (porcine)		K	1279		$8.21	.	$1.65
J7192	Factor viii recombinant NOS		K	0927		$1.09	.	$0.22
J7193	Factor IX non-recombinant		K	0931		$0.91	.	$0.19
J7194	Factor ix complex		K	0928		$0.88	.	$0.18
J7195	Factor IX recombinant		K	0932		$1.11	.	$0.23
J7197	Antithrombin iii injection		K	1263		$2.31	.	$0.47
J7198	Anti-inhibitor		K	0929		$1.55	.	$0.31
J7199	Hemophilia clot factor noc		B					
J7300	Intraut copper contraceptive		E					
J7302	Levonorgestrel iu contracept		E					
J7303	Contraceptive vaginal ring		E					
J7304	Contraceptive hormone patch		E					
J7306	Levonorgestrel implant sys		E					
J7307	Etonogestrel implant system		E					
J7308	Aminolevulinic acid hcl top		K	7308		$134.54	.	$26.91

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7310	Ganciclovir long act implant		K	0913		$16,960.00	.	$3,392.00
J7311	Fluocinolone acetonide implt		K	9225		$19,345.00	.	$3,869.00
J7321	Hyalgan/supartz inj per dose		K	0873		$91.96	.	$18.40
J7323	Euflexxa inj per dose		K	0875		$113.79	.	$22.76
J7324	Orthovisc inj per dose		K	0877		$176.70	.	$35.34
J7325	Synvisc or Synvisc-One		K	0874		$11.78	.	$2.36
J7330	Cultured chondrocytes implnt		B					
J7500	Azathioprine oral 50mg		N					
J7501	Azathioprine parenteral		K	0887		$96.29	.	$19.26
J7502	Cyclosporine oral 100 mg	CH	N					
J7504	Lymphocyte immune globulin		K	0890		$487.88	.	$97.58
J7505	Monoclonal antibodies		K	7038		$1,133.50	.	$226.70
J7506	Prednisone oral		N					
J7507	Tacrolimus oral per 1 MG	CH	N					
J7509	Methylprednisolone oral		N					
J7510	Prednisolone oral per 5 mg		N					
J7511	Antithymocyte globuln rabbit		K	9104		$386.48	.	$77.30
J7513	Daclizumab, parenteral		K	1612		$351.10	.	$70.22
J7515	Cyclosporine oral 25 mg	CH	N					
J7516	Cyclosporin parenteral 250mg	CH	N					
J7517	Mycophenolate mofetil oral	CH	N					
J7518	Mycophenolic acid		N					
J7520	Sirolimus, oral	CH	N					
J7525	Tacrolimus injection		K	9006		$139.41	.	$27.89
J7599	Immunosuppressive drug noc		N					
J7604	Acetylcysteine comp unit		M					
J7605	Arformoterol non-comp unit		M					
J7606	Formoterol fumarate, inh		M					
J7607	Levalbuterol comp con		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7608	Acetylcysteine non-comp unit		M					
J7609	Albuterol comp unit		M					
J7610	Albuterol comp con		M					
J7611	Albuterol non-comp con		M					
J7612	Levalbuterol non-comp con		M					
J7613	Albuterol non-comp unit		M					
J7614	Levalbuterol non-comp unit		M					
J7615	Levalbuterol comp unit		M					
J7620	Albuterol ipratrop non-comp		M					
J7622	Beclomethasone comp unit		M					
J7624	Betamethasone comp unit		M					
J7626	Budesonide non-comp unit		M					
J7627	Budesonide comp unit		M					
J7628	Bitolterol mesylate comp con		M					
J7629	Bitolterol mesylate comp unt		M					
J7631	Cromolyn sodium noncomp unit		M					
J7632	Cromolyn sodium comp unit		M					
J7633	Budesonide non-comp con		M					
J7634	Budesonide comp con		M					
J7635	Atropine comp con		M					
J7636	Atropine comp unit		M					
J7637	Dexamethasone comp con		M					
J7638	Dexamethasone comp unit		M					
J7639	Dornase alfa non-comp unit		M					
J7640	Formoterol comp unit		E					
J7641	Flunisolide comp unit		M					
J7642	Glycopyrrolate comp con		M					
J7643	Glycopyrrolate comp unit		M					
J7644	Ipratropium bromide non-comp		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7645	Ipratropium bromide comp		M					
J7647	Isoetharine comp con		M					
J7648	Isoetharine non-comp con		M					
J7649	Isoetharine non-comp unit		M					
J7650	Isoetharine comp unit		M					
J7657	Isoproterenol comp con		M					
J7658	Isoproterenol non-comp con		M					
J7659	Isoproterenol non-comp unit		M					
J7660	Isoproterenol comp unit		M					
J7667	Metaproterenol comp con		M					
J7668	Metaproterenol non-comp con		M					
J7669	Metaproterenol non-comp unit		M					
J7670	Metaproterenol comp unit		M					
J7674	Methacholine chloride, neb		N					
J7676	Pentamidine comp unit dose		M					
J7680	Terbutaline sulf comp con		M					
J7681	Terbutaline sulf comp unit		M					
J7682	Tobramycin non-comp unit		M					
J7683	Triamcinolone comp con		M					
J7684	Triamcinolone comp unit		M					
J7685	Tobramycin comp unit		M					
J7699	Inhalation solution for DME		M					
J7799	Non-inhalation drug for DME		N					
J8498	Antiemetic rectal/supp NOS		B					
J8499	Oral prescrip drug non chemo		E					
J8501	Oral aprepitant		K	0868		$5.67	.	$1.14
J8510	Oral busulfan	CH	K	1307		$3.65	.	$0.73
J8515	Cabergoline, oral 0.25mg		E					
J8520	Capecitabine, oral, 150 mg		K	7042		$6.28	.	$1.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J8521	Capecitabine, oral, 500 mg		K	0934		$20.66	.	$4.14
J8530	Cyclophosphamide oral 25 MG		N					
J8540	Oral dexamethasone		N					
J8560	Etoposide oral 50 MG		K	0802		$28.26	.	$5.66
J8565	Gefitinib oral		E					
J8597	Antiemetic drug oral NOS		N					
J8600	Melphalan oral 2 MG		N					
J8610	Methotrexate oral 2.5 MG		N					
J8650	Nabilone oral		N					
J8700	Temozolomide		K	1086		$8.83	.	$1.77
J8705	Topotecan oral		G	1238		$74.66	.	$14.94
J8999	Oral prescription drug chemo		B					
J9000	Doxorubicin hcl injection		N					
J9001	Doxorubicin hcl liposome inj		K	7046		$472.01	.	$94.41
J9010	Alemtuzumab injection		K	9110		$578.02	.	$115.61
J9015	Aldesleukin injection		K	0807		$844.43	.	$168.89
J9017	Arsenic trioxide injection		K	9012		$37.43	.	$7.49
J9020	Asparaginase injection		K	0814		$60.94	.	$12.19
J9025	Azacitidine injection		K	1709		$4.99	.	$1.00
J9027	Clofarabine injection		K	1710		$116.49	.	$23.30
J9031	Bcg live intravesical vac		K	0809		$121.25	.	$24.25
J9033	Bendamustine injection	CH	K	9243		$18.47	.	$3.70
J9035	Bevacizumab injection		K	9214		$57.57	.	$11.52
J9040	Bleomycin sulfate injection		N					
J9041	Bortezomib injection		K	9207		$38.24	.	$7.65
J9045	Carboplatin injection		N					
J9050	Carmustine injection		K	0812		$176.41	.	$35.29
J9055	Cetuximab injection		K	9215		$49.73	.	$9.95
J9060	Cisplatin 10 MG injection		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9062	Cisplatin 50 MG injection		N					
J9065	Inj cladribine per 1 MG		K	0858		$28.22	.	$5.65
J9070	Cyclophosphamide 100 MG inj		N					
J9080	Cyclophosphamide 200 MG inj		N					
J9090	Cyclophosphamide 500 MG inj		N					
J9091	Cyclophosphamide 1.0 grm inj		N					
J9092	Cyclophosphamide 2.0 grm inj		N					
J9093	Cyclophosphamide lyophilized		N					
J9094	Cyclophosphamide lyophilized		N					
J9095	Cyclophosphamide lyophilized		N					
J9096	Cyclophosphamide lyophilized		N					
J9097	Cyclophosphamide lyophilized		N					
J9098	Cytarabine liposome inj		K	1166		$488.90	.	$97.78
J9100	Cytarabine hcl 100 MG inj		N					
J9110	Cytarabine hcl 500 MG inj		N					
J9120	Dactinomycin injection		K	0752		$570.53	.	$114.11
J9130	Dacarbazine 100 mg inj		N					
J9140	Dacarbazine 200 MG inj		N					
J9150	Daunorubicin injection		K	0820		$19.46	.	$3.90
J9151	Daunorubicin citrate inj		K	0821		$56.31	.	$11.27
J9155	Degarelix injection		G	1296		$2.60	.	$0.52
J9160	Denileukin diftitox inj		K	1084		$1,494.82	.	$298.97
J9165	Diethylstilbestrol injection	CH	N					
J9171	Docetaxel injection		K	0823		$17.86	.	$3.58
J9175	Elliotts b solution per ml		N					
J9178	Inj, epirubicin hcl, 2 mg		K	1167		$2.48	.	$0.50
J9181	Etoposide injection		N					
J9185	Fludarabine phosphate inj		K	0842		$205.81	.	$41.17
J9190	Fluorouracil injection		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9200	Floxuridine injection		K	0827		$42.99	.	$8.60
J9201	Gemcitabine hcl injection		K	0828		$145.10	.	$29.02
J9202	Goserelin acetate implant		K	0810		$195.23	.	$39.05
J9206	Irinotecan injection		K	0830		$9.15	.	$1.83
J9207	Ixabepilone injection	CH	K	9240		$63.74	.	$12.75
J9208	Ifosfomide injection		K	0831		$30.76	.	$6.16
J9209	Mesna injection	CH	N					
J9211	Idarubicin hcl injection		K	0832		$63.57	.	$12.72
J9212	Interferon alfacon-1 inj		K	1266		$4.80	.	$0.96
J9213	Interferon alfa-2a inj	CH	N					
J9214	Interferon alfa-2b inj		K	0836		$15.84	.	$3.17
J9215	Interferon alfa-n3 inj		K	0865		$18.23	.	$3.65
J9216	Interferon gamma 1-b inj		K	0838		$430.93	.	$86.19
J9217	Leuprolide acetate suspnsion		K	9217		$220.41	.	$44.09
J9218	Leuprolide acetate injeciton		K	0861		$4.27	.	$0.86
J9219	Leuprolide acetate implant		K	7051		$4,819.82	.	$963.97
J9225	Vantas implant	CH	K	1711		$1,515.25	.	$303.05
J9226	Supprelin LA implant	CH	K	1142		$14,990.44	.	$2,998.09
J9230	Mechlorethamine hcl inj		K	0751		$154.50	.	$30.90
J9245	Inj melphalan hydrochl 50 MG		K	0840		$1,500.32	.	$300.07
J9250	Methotrexate sodium inj		N					
J9260	Methotrexate sodium inj		N					
J9261	Nelarabine injection		K	0825		$105.91	.	$21.19
J9263	Oxaliplatin		K	1738		$6.83	.	$1.37
J9264	Paclitaxel protein bound		K	1712		$9.43	.	$1.89
J9265	Paclitaxel injection	CH	K	1309		$11.46	.	$2.30
J9266	Pegaspargase injection		K	0843		$2,747.44	.	$549.49
J9268	Pentostatin injection		K	0844		$1,246.38	.	$249.28
J9270	Plicamycin (mithramycin) inj		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9280	Mitomycin 5 MG inj		K	1232		$20.35	.	$4.07
J9290	Mitomycin 20 MG inj		K	1233		$81.44	.	$16.29
J9291	Mitomycin 40 MG inj		K	1234		$162.86	.	$32.58
J9293	Mitoxantrone hydrochl / 5 MG		K	0864		$45.26	.	$9.06
J9300	Gemtuzumab ozogamicin inj		K	9004		$2,687.21	.	$537.45
J9303	Panitumumab injection		K	9235		$87.24	.	$17.45
J9305	Pemetrexed injection		K	9213		$50.63	.	$10.13
J9310	Rituximab injection		K	0849		$578.40	.	$115.68
J9320	Streptozocin injection		K	0850		$282.86	.	$56.58
J9328	Temozolomide injection		G	9253		$4.90	.	$0.98
J9330	Temsirolimus injection		K	1168		$49.83	.	$9.97
J9340	Thiotepa injection		K	0851		$113.52	.	$22.71
J9350	Topotecan injection		K	0852		$1,058.90	.	$211.78
J9355	Trastuzumab injection		K	1613		$66.41	.	$13.29
J9357	Valrubicin injection		K	1235		$960.22	.	$192.05
J9360	Vinblastine sulfate inj		N					
J9370	Vincristine sulfate 1 MG inj		N					
J9375	Vincristine sulfate 2 MG inj		N					
J9380	Vincristine sulfate 5 MG inj		N					
J9390	Vinorelbine tartrate inj		N					
J9395	Injection, Fulvestrant		K	9120		$82.22	.	$16.45
J9600	Porfimer sodium injection		K	0856		$2,934.28	.	$586.86
J9999	Chemotherapy drug		N					
K0001	Standard wheelchair		Y					
K0002	Stnd hemi (low seat) whlchr		Y					
K0003	Lightweight wheelchair		Y					
K0004	High strength ltwt whlchr		Y					
K0005	Ultralightweight wheelchair		Y					
K0006	Heavy duty wheelchair		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0007	Extra heavy duty wheelchair		Y					
K0009	Other manual wheelchair/base		Y					
K0010	Stnd wt frame power whlchr		Y					
K0011	Stnd wt pwr whlchr w control		Y					
K0012	Ltwt portbl power whlchr		Y					
K0014	Other power whlchr base		Y					
K0015	Detach non-adjus hght armrst		Y					
K0017	Detach adjust armrest base		Y					
K0018	Detach adjust armrst upper		Y					
K0019	Arm pad each		Y					
K0020	Fixed adjust armrest pair		Y					
K0037	High mount flip-up footrest		Y					
K0038	Leg strap each		Y					
K0039	Leg strap h style each		Y					
K0040	Adjustable angle footplate		Y					
K0041	Large size footplate each		Y					
K0042	Standard size footplate each		Y					
K0043	Ftrst lower extension tube		Y					
K0044	Ftrst upper hanger bracket		Y					
K0045	Footrest complete assembly		Y					
K0046	Elevat legrst low extension		Y					
K0047	Elevat legrst up hangr brack		Y					
K0050	Ratchet assembly		Y					
K0051	Cam relese assem ftrst/lgrst		Y					
K0052	Swingaway detach footrest		Y					
K0053	Elevate footrest articulate		Y					
K0056	Seat ht <17 or >=21 ltwt wc		Y					
K0065	Spoke protectors		Y					
K0069	Rear whl complete solid tire		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0070	Rear whl compl pneum tire		Y					
K0071	Front castr compl pneum tire		Y					
K0072	Frnt cstr cmpl sem-pneum tir		Y					
K0073	Caster pin lock each		Y					
K0077	Front caster assem complete		Y					
K0098	Drive belt power wheelchair		Y					
K0105	Iv hanger		Y					
K0108	W/c component-accessory NOS		Y					
K0195	Elevating whlchair leg rests		Y					
K0455	Pump uninterrupted infusion		Y					
K0462	Temporary replacement eqpmnt		Y					
K0552	Supply/ext inf pump syr type		Y					
K0601	Repl batt silver oxide 1.5 v		Y					
K0602	Repl batt silver oxide 3 v		Y					
K0603	Repl batt alkaline 1.5 v		Y					
K0604	Repl batt lithium 3.6 v		Y					
K0605	Repl batt lithium 4.5 v		Y					
K0606	AED garment w elec analysis		Y					
K0607	Repl batt for AED		Y					
K0608	Repl garment for AED		Y					
K0609	Repl electrode for AED		Y					
K0669	Seat/back cus no sadmerc ver		Y					
K0672	Removable soft interface LE		A					
K0730	Ctrl dose inh drug deliv sys		Y					
K0733	12-24hr sealed lead acid		Y					
K0734	Adj skin pro w/c cus wd<22in		Y					
K0735	Adj skin pro wc cus wd>=22in		Y					
K0736	Adj skin pro/pos wc cus<22in		Y					
K0737	Adj skin pro/pos wc cus>=22"		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0738	Portable gas oxygen system		Y					
K0739	Repair/svc DME non-oxygen eq		Y					
K0740	Repair/svc oxygen equipment		E					
K0800	POV group 1 std up to 300lbs		Y					
K0801	POV group 1 hd 301-450 lbs		Y					
K0802	POV group 1 vhd 451-600 lbs		Y					
K0806	POV group 2 std up to 300lbs		Y					
K0807	POV group 2 hd 301-450 lbs		Y					
K0808	POV group 2 vhd 451-600 lbs		Y					
K0812	Power operated vehicle NOC		Y					
K0813	PWC gp 1 std port seat/back		Y					
K0814	PWC gp 1 std port cap chair		Y					
K0815	PWC gp 1 std seat/back		Y					
K0816	PWC gp 1 std cap chair		Y					
K0820	PWC gp 2 std port seat/back		Y					
K0821	PWC gp 2 std port cap chair		Y					
K0822	PWC gp 2 std seat/back		Y					
K0823	PWC gp 2 std cap chair		Y					
K0824	PWC gp 2 hd seat/back		Y					
K0825	PWC gp 2 hd cap chair		Y					
K0826	PWC gp 2 vhd seat/back		Y					
K0827	PWC gp vhd cap chair		Y					
K0828	PWC gp 2 xtra hd seat/back		Y					
K0829	PWC gp 2 xtra hd cap chair		Y					
K0830	PWC gp2 std seat elevate s/b		Y					
K0831	PWC gp2 std seat elevate cap		Y					
K0835	PWC gp2 std sing pow opt s/b		Y					
K0836	PWC gp2 std sing pow opt cap		Y					
K0837	PWC gp 2 hd sing pow opt s/b		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0838	PWC gp 2 hd sing pow opt cap		Y					
K0839	PWC gp2 vhd sing pow opt s/b		Y					
K0840	PWC gp2 xhd sing pow opt s/b		Y					
K0841	PWC gp2 std mult pow opt s/b		Y					
K0842	PWC gp2 std mult pow opt cap		Y					
K0843	PWC gp2 hd mult pow opt s/b		Y					
K0848	PWC gp 3 std seat/back		Y					
K0849	PWC gp 3 std cap chair		Y					
K0850	PWC gp 3 hd seat/back		Y					
K0851	PWC gp 3 hd cap chair		Y					
K0852	PWC gp 3 vhd seat/back		Y					
K0853	PWC gp 3 vhd cap chair		Y					
K0854	PWC gp 3 xhd seat/back		Y					
K0855	PWC gp 3 xhd cap chair		Y					
K0856	PWC gp3 std sing pow opt s/b		Y					
K0857	PWC gp3 std sing pow opt cap		Y					
K0858	PWC gp3 hd sing pow opt s/b		Y					
K0859	PWC gp3 hd sing pow opt cap		Y					
K0860	PWC gp3 vhd sing pow opt s/b		Y					
K0861	PWC gp3 std mult pow opt s/b		Y					
K0862	PWC gp3 hd mult pow opt s/b		Y					
K0863	PWC gp3 vhd mult pow opt s/b		Y					
K0864	PWC gp3 xhd mult pow opt s/b		Y					
K0868	PWC gp 4 std seat/back		Y					
K0869	PWC gp 4 std cap chair		Y					
K0870	PWC gp 4 hd seat/back		Y					
K0871	PWC gp 4 vhd seat/back		Y					
K0877	PWC gp4 std sing pow opt s/b		Y					
K0878	PWC gp4 std sing pow opt cap		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0879	PWC gp4 hd sing pow opt s/b		Y					
K0880	PWC gp4 vhd sing pow opt s/b		Y					
K0884	PWC gp4 std mult pow opt s/b		Y					
K0885	PWC gp4 std mult pow opt cap		Y					
K0886	PWC gp4 hd mult pow s/b		Y					
K0890	PWC gp5 ped sing pow opt s/b		Y					
K0891	PWC gp5 ped mult pow opt s/b		Y					
K0898	Power wheelchair NOC		Y					
K0899	Pow mobil dev no SADMERC		Y					
L0112	Cranial cervical orthosis		A					
L0113	Cranial cervical torticollis		A					
L0120	Cerv flexible non-adjustable		A					
L0130	Flex thermoplastic collar mo		A					
L0140	Cervical semi-rigid adjustab		A					
L0150	Cerv semi-rig adj molded chn		A					
L0160	Cerv semi-rig wire occ/mand		A					
L0170	Cervical collar molded to pt		A					
L0172	Cerv col thermplas foam 2 pi		A					
L0174	Cerv col foam 2 piece w thor		A					
L0180	Cer post col occ/man sup adj		A					
L0190	Cerv collar supp adj cerv ba		A					
L0200	Cerv col supp adj bar & thor		A					
L0220	Thor rib belt custom fabrica		A					
L0430	Dewall posture protector		A					
L0450	TLSO flex prefab thoracic		A					
L0452	tlso flex custom fab thoraci		A					
L0454	TLSO flex prefab sacrococ-T9		A					
L0456	TLSO flex prefab		A					
L0458	TLSO 2Mod symphis-xipho pre		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L0460	TLSO2Mod symphysis-stern pre		A					
L0462	TLSO 3Mod sacro-scap pre		A					
L0464	TLSO 4Mod sacro-scap pre		A					
L0466	TLSO rigid frame pre soft ap		A					
L0468	TLSO rigid frame prefab pelv		A					
L0470	TLSO rigid frame pre subclav		A					
L0472	TLSO rigid frame hyperex pre		A					
L0480	TLSO rigid plastic custom fa		A					
L0482	TLSO rigid lined custom fab		A					
L0484	TLSO rigid plastic cust fab		A					
L0486	TLSO rigidlined cust fab two		A					
L0488	TLSO rigid lined pre one pie		A					
L0490	TLSO rigid plastic pre one		A					
L0491	TLSO 2 piece rigid shell		A					
L0492	TLSO 3 piece rigid shell		A					
L0621	SIO flex pelvisacral prefab		A					
L0622	SIO flex pelvisacral custom		A					
L0623	SIO panel prefab		A					
L0624	SIO panel custom		A					
L0625	LO flexibl L1-below L5 pre		A					
L0626	LO sag stays/panels pre-fab		A					
L0627	LO sagitt rigid panel prefab		A					
L0628	LO flex w/o rigid stays pre		A					
L0629	LSO flex w/rigid stays cust		A					
L0630	LSO post rigid panel pre		A					
L0631	LSO sag-coro rigid frame pre		A					
L0632	LSO sag rigid frame cust		A					
L0633	LSO flexion control prefab		A					
L0634	LSO flexion control custom		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L0635	LSO sagit rigid panel prefab		A					
L0636	LSO sagittal rigid panel cus		A					
L0637	LSO sag-coronal panel prefab		A					
L0638	LSO sag-coronal panel custom		A					
L0639	LSO s/c shell/panel prefab		A					
L0640	LSO s/c shell/panel custom		A					
L0700	Ctlso a-p-l control molded		A					
L0710	Ctlso a-p-l control w/ inter		A					
L0810	Halo cervical into jckt vest		A					
L0820	Halo cervical into body jack		A					
L0830	Halo cerv into milwaukee typ		A					
L0859	MRI compatible system		A					
L0861	Halo repl liner/interface		A					
L0970	Tlso corset front		A					
L0972	Lso corset front		A					
L0974	Tlso full corset		A					
L0976	Lso full corset		A					
L0978	Axillary crutch extension		A					
L0980	Peroneal straps pair		A					
L0982	Stocking supp grips set of f		A					
L0984	Protective body sock each		A					
L0999	Add to spinal orthosis NOS		A					
L1000	Ctlso milwauke initial model		A					
L1001	CTLSO infant immobilizer		A					
L1005	Tension based scoliosis orth		A					
L1010	Ctlso axilla sling		A					
L1020	Kyphosis pad		A					
L1025	Kyphosis pad floating		A					
L1030	Lumbar bolster pad		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L1040	Lumbar or lumbar rib pad		A					
L1050	Sternal pad		A					
L1060	Thoracic pad		A					
L1070	Trapezius sling		A					
L1080	Outrigger		A					
L1085	Outrigger bil w/ vert extens		A					
L1090	Lumbar sling		A					
L1100	Ring flange plastic/leather		A					
L1110	Ring flange plas/leather mol		A					
L1120	Covers for upright each		A					
L1200	Furnsh initial orthosis only		A					
L1210	Lateral thoracic extension		A					
L1220	Anterior thoracic extension		A					
L1230	Milwaukee type superstructur		A					
L1240	Lumbar derotation pad		A					
L1250	Anterior asis pad		A					
L1260	Anterior thoracic derotation		A					
L1270	Abdominal pad		A					
L1280	Rib gusset (elastic) each		A					
L1290	Lateral trochanteric pad		A					
L1300	Body jacket mold to patient		A					
L1310	Post-operative body jacket		A					
L1499	Spinal orthosis NOS		A					
L1500	Thkao mobility frame		A					
L1510	Thkao standing frame		A					
L1520	Thkao swivel walker		A					
L1600	Abduct hip flex frejka w cvr		A					
L1610	Abduct hip flex frejka covr		A					
L1620	Abduct hip flex pavlik harne		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L1630	Abduct control hip semi-flex		A					
L1640	Pelv band/spread bar thigh c		A					
L1650	HO abduction hip adjustable		A					
L1652	HO bi thighcuffs w sprdr bar		A					
L1660	HO abduction static plastic		A					
L1680	Pelvic & hip control thigh c		A					
L1685	Post-op hip abduct custom fa		A					
L1686	HO post-op hip abduction		A					
L1690	Combination bilateral HO		A					
L1700	Leg perthes orth toronto typ		A					
L1710	Legg perthes orth newington		A					
L1720	Legg perthes orthosis trilat		A					
L1730	Legg perthes orth scottish r		A					
L1755	Legg perthes patten bottom t		A					
L1810	Ko elastic with joints		A					
L1820	Ko elas w/ condyle pads & jo		A					
L1830	Ko immobilizer canvas longit		A					
L1831	Knee orth pos locking joint		A					
L1832	KO adj jnt pos rigid support		A					
L1834	Ko w/0 joint rigid molded to		A					
L1836	Rigid KO wo joints		A					
L1840	Ko derot ant cruciate custom		A					
L1843	KO single upright custom fit		A					
L1844	Ko w/adj jt rot cntrl molded		A					
L1845	Ko w/ adj flex/ext rotat cus		A					
L1846	Ko w adj flex/ext rotat mold		A					
L1847	KO adjustable w air chambers		A					
L1850	Ko swedish type		A					
L1860	Ko supracondylar socket mold		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L1900	Afo sprng wir drsflx calf bd		A					
L1902	Afo ankle gauntlet		A					
L1904	Afo molded ankle gauntlet		A					
L1906	Afo multiligamentus ankle su		A					
L1907	AFO supramalleolar custom		A					
L1910	Afo sing bar clasp attach sh		A					
L1920	Afo sing upright w/ adjust s		A					
L1930	Afo plastic		A					
L1932	Afo rig ant tib prefab TCF/=		A					
L1940	Afo molded to patient plasti		A					
L1945	Afo molded plas rig ant tib		A					
L1950	Afo spiral molded to pt plas		A					
L1951	AFO spiral prefabricated		A					
L1960	Afo pos solid ank plastic mo		A					
L1970	Afo plastic molded w/ankle j		A					
L1971	AFO w/ankle joint, prefab		A					
L1980	Afo sing solid stirrup calf		A					
L1990	Afo doub solid stirrup calf		A					
L2000	Kafo sing fre stirr thi/calf		A					
L2005	KAFO sng/dbl mechanical act		A					
L2010	Kafo sng solid stirrup w/o j		A					
L2020	Kafo dbl solid stirrup band/		A					
L2030	Kafo dbl solid stirrup w/o j		A					
L2034	KAFO pla sin up w/wo k/a cus		A					
L2035	KAFO plastic pediatric size		A					
L2036	Kafo plas doub free knee mol		A					
L2037	Kafo plas sing free knee mol		A					
L2038	Kafo w/o joint multi-axis an		A					
L2040	Hkafo torsion bil rot straps		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2050	Hkafo torsion cable hip pelv		A					
L2060	Hkafo torsion ball bearing j		A					
L2070	Hkafo torsion unilat rot str		A					
L2080	Hkafo unilat torsion cable		A					
L2090	Hkafo unilat torsion ball br		A					
L2106	Afo tib fx cast plaster mold		A					
L2108	Afo tib fx cast molded to pt		A					
L2112	Afo tibial fracture soft		A					
L2114	Afo tib fx semi-rigid		A					
L2116	Afo tibial fracture rigid		A					
L2126	Kafo fem fx cast thermoplas		A					
L2128	Kafo fem fx cast molded to p		A					
L2132	Kafo femoral fx cast soft		A					
L2134	Kafo fem fx cast semi-rigid		A					
L2136	Kafo femoral fx cast rigid		A					
L2180	Plas shoe insert w ank joint		A					
L2182	Drop lock knee		A					
L2184	Limited motion knee joint		A					
L2186	Adj motion knee jnt lerman t		A					
L2188	Quadrilateral brim		A					
L2190	Waist belt		A					
L2192	Pelvic band & belt thigh fla		A					
L2200	Limited ankle motion ea jnt		A					
L2210	Dorsiflexion assist each joi		A					
L2220	Dorsi & plantar flex ass/res		A					
L2230	Split flat caliper stirr & p		A					
L2232	Rocker bottom, contact AFO		A					
L2240	Round caliper and plate atta		A					
L2250	Foot plate molded stirrup at		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2260	Reinforced solid stirrup		A					
L2265	Long tongue stirrup		A					
L2270	Varus/valgus strap padded/li		A					
L2275	Plastic mod low ext pad/line		A					
L2280	Molded inner boot		A					
L2300	Abduction bar jointed adjust		A					
L2310	Abduction bar-straight		A					
L2320	Non-molded lacer		A					
L2330	Lacer molded to patient mode		A					
L2335	Anterior swing band		A					
L2340	Pre-tibial shell molded to p		A					
L2350	Prosthetic type socket molde		A					
L2360	Extended steel shank		A					
L2370	Patten bottom		A					
L2375	Torsion ank & half solid sti		A					
L2380	Torsion straight knee joint		A					
L2385	Straight knee joint heavy du		A					
L2387	Add LE poly knee custom KAFO		A					
L2390	Offset knee joint each		A					
L2395	Offset knee joint heavy duty		A					
L2397	Suspension sleeve lower ext		A					
L2405	Knee joint drop lock ea jnt		A					
L2415	Knee joint cam lock each joi		A					
L2425	Knee disc/dial lock/adj flex		A					
L2430	Knee jnt ratchet lock ea jnt		A					
L2492	Knee lift loop drop lock rin		A					
L2500	Thi/glut/ischia wgt bearing		A					
L2510	Th/wght bear quad-lat brim m		A					
L2520	Th/wght bear quad-lat brim c		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2525	Th/wght bear nar m-l brim mo		A					
L2526	Th/wght bear nar m-l brim cu		A					
L2530	Thigh/wght bear lacer non-mo		A					
L2540	Thigh/wght bear lacer molded		A					
L2550	Thigh/wght bear high roll cu		A					
L2570	Hip clevis type 2 posit jnt		A					
L2580	Pelvic control pelvic sling		A					
L2600	Hip clevis/thrust bearing fr		A					
L2610	Hip clevis/thrust bearing lo		A					
L2620	Pelvic control hip heavy dut		A					
L2622	Hip joint adjustable flexion		A					
L2624	Hip adj flex ext abduct cont		A					
L2627	Plastic mold recipro hip & c		A					
L2628	Metal frame recipro hip & ca		A					
L2630	Pelvic control band & belt u		A					
L2640	Pelvic control band & belt b		A					
L2650	Pelv & thor control gluteal		A					
L2660	Thoracic control thoracic ba		A					
L2670	Thorac cont paraspinal uprig		A					
L2680	Thorac cont lat support upri		A					
L2750	Plating chrome/nickel pr bar		A					
L2755	Carbon graphite lamination		A					
L2760	Extension per extension per		A					
L2768	Ortho sidebar disconnect		A					
L2780	Non-corrosive finish		A					
L2785	Drop lock retainer each		A					
L2795	Knee control full kneecap		A					
L2800	Knee cap medial or lateral p		A					
L2810	Knee control condylar pad		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2820	Soft interface below knee se		A					
L2830	Soft interface above knee se		A					
L2840	Tibial length sock fx or equ		A					
L2850	Femoral lgth sock fx or equa		A					
L2861	Torsion mechanism knee/ankle		E					
L2999	Lower extremity orthosis NOS		A					
L3000	Ft insert ucb berkeley shell		A					
L3001	Foot insert remov molded spe		A					
L3002	Foot insert plastazote or eq		A					
L3003	Foot insert silicone gel eac		A					
L3010	Foot longitudinal arch suppo		A					
L3020	Foot longitud/metatarsal sup		A					
L3030	Foot arch support remov prem		A					
L3031	Foot lamin/prepreg composite		A					
L3040	Ft arch suprt premold longit		A					
L3050	Foot arch supp premold metat		A					
L3060	Foot arch supp longitud/meta		A					
L3070	Arch suprt att to sho longit		A					
L3080	Arch supp att to shoe metata		A					
L3090	Arch supp att to shoe long/m		A					
L3100	Hallus-valgus nght dynamic s		A					
L3140	Abduction rotation bar shoe		A					
L3150	Abduct rotation bar w/o shoe		A					
L3160	Shoe styled positioning dev		A					
L3170	Foot plastic heel stabilizer		A					
L3201	Oxford w supinat/pronat inf		A					
L3202	Oxford w/ supinat/pronator c		A					
L3203	Oxford w/ supinator/pronator		A					
L3204	Hightop w/ supp/pronator inf		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3206	Hightop w/ supp/pronator chi		A					
L3207	Hightop w/ supp/pronator jun		A					
L3208	Surgical boot each infant		A					
L3209	Surgical boot each child		A					
L3211	Surgical boot each junior		A					
L3212	Benesch boot pair infant		A					
L3213	Benesch boot pair child		A					
L3214	Benesch boot pair junior		A					
L3215	Orthopedic ftwear ladies oxf		E					
L3216	Orthoped ladies shoes dpth i		E					
L3217	Ladies shoes hightop depth i		E					
L3219	Orthopedic mens shoes oxford		E					
L3221	Orthopedic mens shoes dpth i		E					
L3222	Mens shoes hightop depth inl		E					
L3224	Woman's shoe oxford brace		A					
L3225	Man's shoe oxford brace		A					
L3230	Custom shoes depth inlay		A					
L3250	Custom mold shoe remov prost		A					
L3251	Shoe molded to pt silicone s		A					
L3252	Shoe molded plastazote cust		A					
L3253	Shoe molded plastazote cust		A					
L3254	Orth foot non-stndard size/w		A					
L3255	Orth foot non-standard size/		A					
L3257	Orth foot add charge split s		A					
L3260	Ambulatory surgical boot eac		E					
L3265	Plastazote sandal each		A					
L3300	Sho lift taper to metatarsal		A					
L3310	Shoe lift elev heel/sole neo		A					
L3320	Shoe lift elev heel/sole cor		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3330	Lifts elevation metal extens		A					
L3332	Shoe lifts tapered to one-ha		A					
L3334	Shoe lifts elevation heel /i		A					
L3340	Shoe wedge sach		A					
L3350	Shoe heel wedge		A					
L3360	Shoe sole wedge outside sole		A					
L3370	Shoe sole wedge between sole		A					
L3380	Shoe clubfoot wedge		A					
L3390	Shoe outflare wedge		A					
L3400	Shoe metatarsal bar wedge ro		A					
L3410	Shoe metatarsal bar between		A					
L3420	Full sole/heel wedge btween		A					
L3430	Sho heel count plast reinfor		A					
L3440	Heel leather reinforced		A					
L3450	Shoe heel sach cushion type		A					
L3455	Shoe heel new leather standa		A					
L3460	Shoe heel new rubber standar		A					
L3465	Shoe heel thomas with wedge		A					
L3470	Shoe heel thomas extend to b		A					
L3480	Shoe heel pad & depress for		A					
L3485	Shoe heel pad removable for		A					
L3500	Ortho shoe add leather insol		A					
L3510	Orthopedic shoe add rub insl		A					
L3520	O shoe add felt w leath insl		A					
L3530	Ortho shoe add half sole		A					
L3540	Ortho shoe add full sole		A					
L3550	O shoe add standard toe tap		A					
L3560	O shoe add horseshoe toe tap		A					
L3570	O shoe add instep extension		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3580	O shoe add instep velcro clo		A					
L3590	O shoe convert to sof counte		A					
L3595	Ortho shoe add march bar		A					
L3600	Trans shoe calip plate exist		A					
L3610	Trans shoe caliper plate new		A					
L3620	Trans shoe solid stirrup exi		A					
L3630	Trans shoe solid stirrup new		A					
L3640	Shoe dennis browne splint bo		A					
L3649	Orthopedic shoe modifica NOS		A					
L3650	Shlder fig 8 abduct restrain		A					
L3660	Abduct restrainer canvas&web		A					
L3670	Acromio/clavicular canvas&we		A					
L3671	SO cap design w/o jnts CF		A					
L3672	SO airplane w/o jnts CF		A					
L3673	SO airplane w/joint CF		A					
L3675	Canvas vest SO		A					
L3677	SO hard plastic stabilizer		E					
L3702	EO w/o joints CF		A					
L3710	Elbow elastic with metal joi		A					
L3720	Forearm/arm cuffs free motio		A					
L3730	Forearm/arm cuffs ext/flex a		A					
L3740	Cuffs adj lock w/ active con		A					
L3760	EO withjoint, Prefabricated		A					
L3762	Rigid EO wo joints		A					
L3763	EWHO rigid w/o jnts CF		A					
L3764	EWHO w/joint(s) CF		A					
L3765	EWHFO rigid w/o jnts CF		A					
L3766	EWHFO w/joint(s) CF		A					
L3806	WHFO w/joint(s) custom fab		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3807	WHFO,no joint, prefabricated		A					
L3808	WHFO, rigid w/o joints		A					
L3891	Torsion mechanism wrist/elbo		E					
L3900	Hinge extension/flex wrist/f		A					
L3901	Hinge ext/flex wrist finger		A					
L3904	Whfo electric custom fitted		A					
L3905	WHO w/nontorsion jnt(s) CF		A					
L3906	WHO w/o joints CF		A					
L3908	Wrist cock-up non-molded		A					
L3912	Flex glove w/elastic finger		A					
L3913	HFO w/o joints CF		A					
L3915	WHO w nontor jnt(s) prefab		A					
L3917	Prefab metacarpl fx orthosis		A					
L3919	HO w/o joints CF		A					
L3921	HFO w/joint(s) CF		A					
L3923	HFO w/o joints PF		A					
L3925	FO pip/dip with joint/spring		A					
L3927	FO pip/dip w/o joint/spring		A					
L3929	HFO nontorsion joint, prefab		A					
L3931	WHFO nontorsion joint prefab		A					
L3933	FO w/o joints CF		A					
L3935	FO nontorsion joint CF		A					
L3956	Add joint upper ext orthosis		A					
L3960	Sewho airplan desig abdu pos		A					
L3961	SEWHO cap design w/o jnts CF		A					
L3962	Sewho erbs palsey design abd		A					
L3964	Seo mobile arm sup att to wc		Y					
L3965	Arm supp att to wc rancho ty		Y					
L3966	Mobile arm supports reclinin		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3967	SEWHO airplane w/o jnts CF		A					
L3968	Friction dampening arm supp		Y					
L3969	Monosuspension arm/hand supp		Y					
L3970	Elevat proximal arm support		Y					
L3971	SEWHO cap design w/jnt(s) CF		A					
L3972	Offset/lat rocker arm w/ ela		Y					
L3973	SEWHO airplane w/jnt(s) CF		A					
L3974	Mobile arm support supinator		Y					
L3975	SEWHFO cap design w/o jnt CF		A					
L3976	SEWHFO airplane w/o jnts CF		A					
L3977	SEWHFO cap desgn w/jnt(s) CF		A					
L3978	SEWHFO airplane w/jnt(s) CF		A					
L3980	Upp ext fx orthosis humeral		A					
L3982	Upper ext fx orthosis rad/ul		A					
L3984	Upper ext fx orthosis wrist		A					
L3995	Sock fracture or equal each		A					
L3999	Upper limb orthosis NOS		A					
L4000	Repl girdle milwaukee orth		A					
L4002	Replace strap, any orthosis		A					
L4010	Replace trilateral socket br		A					
L4020	Replace quadlat socket brim		A					
L4030	Replace socket brim cust fit		A					
L4040	Replace molded thigh lacer		A					
L4045	Replace non-molded thigh lac		A					
L4050	Replace molded calf lacer		A					
L4055	Replace non-molded calf lace		A					
L4060	Replace high roll cuff		A					
L4070	Replace prox & dist upright		A					
L4080	Repl met band kafo-afo prox		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L4090	Repl met band kafo-afo calf/		A					
L4100	Repl leath cuff kafo prox th		A					
L4110	Repl leath cuff kafo-afo cal		A					
L4130	Replace pretibial shell		A					
L4205	Ortho dvc repair per 15 min		A					
L4210	Orth dev repair/repl minor p		A					
L4350	Ankle control orthosi prefab		A					
L4360	Pneumati walking boot prefab		A					
L4370	Pneumatic full leg splint		A					
L4380	Pneumatic knee splint		A					
L4386	Non-pneum walk boot prefab		A					
L4392	Replace AFO soft interface		A					
L4394	Replace foot drop spint		A					
L4396	Static AFO		A					
L4398	Foot drop splint recumbent		A					
L5000	Sho insert w arch toe filler		A					
L5010	Mold socket ank hgt w/ toe f		A					
L5020	Tibial tubercle hgt w/ toe f		A					
L5050	Ank symes mold sckt sach ft		A					
L5060	Symes met fr leath socket ar		A					
L5100	Molded socket shin sach foot		A					
L5105	Plast socket jts/thgh lacer		A					
L5150	Mold sckt ext knee shin sach		A					
L5160	Mold socket bent knee shin s		A					
L5200	Kne sing axis fric shin sach		A					
L5210	No knee/ankle joints w/ ft b		A					
L5220	No knee joint with artic ali		A					
L5230	Fem focal defic constant fri		A					
L5250	Hip canad sing axi cons fric		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5270	Tilt table locking hip sing		A					
L5280	Hemipelvect canad sing axis		A					
L5301	BK mold socket SACH ft endo		A					
L5311	Knee disart, SACH ft, endo		A					
L5321	AK open end SACH		A					
L5331	Hip disart canadian SACH ft		A					
L5341	Hemipelvectomy canadian SACH		A					
L5400	Postop dress & 1 cast chg bk		A					
L5410	Postop dsg bk ea add cast ch		A					
L5420	Postop dsg & 1 cast chg ak/d		A					
L5430	Postop dsg ak ea add cast ch		A					
L5450	Postop app non-wgt bear dsg		A					
L5460	Postop app non-wgt bear dsg		A					
L5500	Init bk ptb plaster direct		A					
L5505	Init ak ischal plstr direct		A					
L5510	Prep BK ptb plaster molded		A					
L5520	Perp BK ptb thermopls direct		A					
L5530	Prep BK ptb thermopls molded		A					
L5535	Prep BK ptb open end socket		A					
L5540	Prep BK ptb laminated socket		A					
L5560	Prep AK ischial plast molded		A					
L5570	Prep AK ischial direct form		A					
L5580	Prep AK ischial thermo mold		A					
L5585	Prep AK ischial open end		A					
L5590	Prep AK ischial laminated		A					
L5595	Hip disartic sach thermopls		A					
L5600	Hip disart sach laminat mold		A					
L5610	Above knee hydracadence		A					
L5611	Ak 4 bar link w/fric swing		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5613	Ak 4 bar ling w/hydraul swig		A					
L5614	4-bar link above knee w/swng		A					
L5616	Ak univ multiplex sys frict		A					
L5617	AK/BK self-aligning unit ea		A					
L5618	Test socket symes		A					
L5620	Test socket below knee		A					
L5622	Test socket knee disarticula		A					
L5624	Test socket above knee		A					
L5626	Test socket hip disarticulat		A					
L5628	Test socket hemipelvectomy		A					
L5629	Below knee acrylic socket		A					
L5630	Syme typ expandabl wall sckt		A					
L5631	Ak/knee disartic acrylic soc		A					
L5632	Symes type ptb brim design s		A					
L5634	Symes type poster opening so		A					
L5636	Symes type medial opening so		A					
L5637	Below knee total contact		A					
L5638	Below knee leather socket		A					
L5639	Below knee wood socket		A					
L5640	Knee disarticulat leather so		A					
L5642	Above knee leather socket		A					
L5643	Hip flex inner socket ext fr		A					
L5644	Above knee wood socket		A					
L5645	Bk flex inner socket ext fra		A					
L5646	Below knee cushion socket		A					
L5647	Below knee suction socket		A					
L5648	Above knee cushion socket		A					
L5649	Isch containmt/narrow m-l so		A					
L5650	Tot contact ak/knee disart s		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5651	Ak flex inner socket ext fra		A					
L5652	Suction susp ak/knee disart		A					
L5653	Knee disart expand wall sock		A					
L5654	Socket insert symes		A					
L5655	Socket insert below knee		A					
L5656	Socket insert knee articulat		A					
L5658	Socket insert above knee		A					
L5661	Multi-durometer symes		A					
L5665	Multi-durometer below knee		A					
L5666	Below knee cuff suspension		A					
L5668	Socket insert w/o lock lower		A					
L5670	Bk molded supracondylar susp		A					
L5671	BK/AK locking mechanism		A					
L5672	Bk removable medial brim sus		A					
L5673	Socket insert w lock mech		A					
L5676	Bk knee joints single axis p		A					
L5677	Bk knee joints polycentric p		A					
L5678	Bk joint covers pair		A					
L5679	Socket insert w/o lock mech		A					
L5680	Bk thigh lacer non-molded		A					
L5681	Intl custm cong/latyp insert		A					
L5682	Bk thigh lacer glut/ischia m		A					
L5683	Initial custom socket insert		A					
L5684	Bk fork strap		A					
L5685	Below knee sus/seal sleeve		A					
L5686	Bk back check		A					
L5688	Bk waist belt webbing		A					
L5690	Bk waist belt padded and lin		A					
L5692	Ak pelvic control belt light		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5694	Ak pelvic control belt pad/l		A					
L5695	Ak sleeve susp neoprene/equa		A					
L5696	Ak/knee disartic pelvic join		A					
L5697	Ak/knee disartic pelvic band		A					
L5698	Ak/knee disartic silesian ba		A					
L5699	Shoulder harness		A					
L5700	Replace socket below knee		A					
L5701	Replace socket above knee		A					
L5702	Replace socket hip		A					
L5703	Symes ankle w/o (SACH) foot		A					
L5704	Custom shape cover BK		A					
L5705	Custom shape cover AK		A					
L5706	Custom shape cvr knee disart		A					
L5707	Custom shape cvr hip disart		A					
L5710	Kne-shin exo sng axi mnl loc		A					
L5711	Knee-shin exo mnl lock ultra		A					
L5712	Knee-shin exo frict swg & st		A					
L5714	Knee-shin exo variable frict		A					
L5716	Knee-shin exo mech stance ph		A					
L5718	Knee-shin exo frct swg & sta		A					
L5722	Knee-shin pneum swg frct exo		A					
L5724	Knee-shin exo fluid swing ph		A					
L5726	Knee-shin ext jnts fld swg e		A					
L5728	Knee-shin fluid swg & stance		A					
L5780	Knee-shin pneum/hydra pneum		A					
L5781	Lower limb pros vacuum pump		A					
L5782	HD low limb pros vacuum pump		A					
L5785	Exoskeletal bk ultralt mater		A					
L5790	Exoskeletal ak ultra-light m		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5795	Exoskel hip ultra-light mate		A					
L5810	Endoskel knee-shin mnl lock		A					
L5811	Endo knee-shin mnl lck ultra		A					
L5812	Endo knee-shin frct swg & st		A					
L5814	Endo knee-shin hydral swg ph		A					
L5816	Endo knee-shin polyc mch sta		A					
L5818	Endo knee-shin frct swg & st		A					
L5822	Endo knee-shin pneum swg frc		A					
L5824	Endo knee-shin fluid swing p		A					
L5826	Miniature knee joint		A					
L5828	Endo knee-shin fluid swg/sta		A					
L5830	Endo knee-shin pneum/swg pha		A					
L5840	Multi-axial knee/shin system		A					
L5845	Knee-shin sys stance flexion		A					
L5848	Knee-shin sys hydraul stance		A					
L5850	Endo ak/hip knee extens assi		A					
L5855	Mech hip extension assist		A					
L5856	Elec knee-shin swing/stance		A					
L5857	Elec knee-shin swing only		A					
L5858	Stance phase only		A					
L5910	Endo below knee alignable sy		A					
L5920	Endo ak/hip alignable system		A					
L5925	Above knee manual lock		A					
L5930	High activity knee frame		A					
L5940	Endo bk ultra-light material		A					
L5950	Endo ak ultra-light material		A					
L5960	Endo hip ultra-light materia		A					
L5962	Below knee flex cover system		A					
L5964	Above knee flex cover system		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5966	Hip flexible cover system		A					
L5968	Multiaxial ankle w dorsiflex		A					
L5970	Foot external keel sach foot		A					
L5971	SACH foot, replacement		A					
L5972	Flexible keel foot		A					
L5973	Ank-foot sys dors-plant flex		A					
L5974	Foot single axis ankle/foot		A					
L5975	Combo ankle/foot prosthesis		A					
L5976	Energy storing foot		A					
L5978	Ft prosth multiaxial ankl/ft		A					
L5979	Multi-axial ankle/ft prosth		A					
L5980	Flex foot system		A					
L5981	Flex-walk sys low ext prosth		A					
L5982	Exoskeletal axial rotation u		A					
L5984	Endoskeletal axial rotation		A					
L5985	Lwr ext dynamic prosth pylon		A					
L5986	Multi-axial rotation unit		A					
L5987	Shank ft w vert load pylon		A					
L5988	Vertical shock reducing pylo		A					
L5990	User adjustable heel height		A					
L5999	Lowr extremity prosthes NOS		A					
L6000	Par hand robin-aids thum rem		A					
L6010	Hand robin-aids little/ring		A					
L6020	Part hand robin-aids no fing		A					
L6025	Part hand disart myoelectric		A					
L6050	Wrst MLd sck flx hng tri pad		A					
L6055	Wrst mold sock w/exp interfa		A					
L6100	Elb mold sock flex hinge pad		A					
L6110	Elbow mold sock suspension t		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6120	Elbow mold doub splt soc ste		A					
L6130	Elbow stump activated lock h		A					
L6200	Elbow mold outsid lock hinge		A					
L6205	Elbow molded w/ expand inter		A					
L6250	Elbow inter loc elbow forarm		A					
L6300	Shlder disart int lock elbow		A					
L6310	Shoulder passive restor comp		A					
L6320	Shoulder passive restor cap		A					
L6350	Thoracic intern lock elbow		A					
L6360	Thoracic passive restor comp		A					
L6370	Thoracic passive restor cap		A					
L6380	Postop dsg cast chg wrst/elb		A					
L6382	Postop dsg cast chg elb dis/		A					
L6384	Postop dsg cast chg shlder/t		A					
L6386	Postop ea cast chg & realign		A					
L6388	Postop applicat rigid dsg on		A					
L6400	Below elbow prosth tiss shap		A					
L6450	Elb disart prosth tiss shap		A					
L6500	Above elbow prosth tiss shap		A					
L6550	Shldr disar prosth tiss shap		A					
L6570	Scap thorac prosth tiss shap		A					
L6580	Wrist/elbow bowden cable mol		A					
L6582	Wrist/elbow bowden cbl dir f		A					
L6584	Elbow fair lead cable molded		A					
L6586	Elbow fair lead cable dir fo		A					
L6588	Shdr fair lead cable molded		A					
L6590	Shdr fair lead cable direct		A					
L6600	Polycentric hinge pair		A					
L6605	Single pivot hinge pair		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6610	Flexible metal hinge pair		A					
L6611	Additional switch, ext power		A					
L6615	Disconnect locking wrist uni		A					
L6616	Disconnect insert locking wr		A					
L6620	Flexion/extension wrist unit		A					
L6621	Flex/ext wrist w/wo friction		A					
L6623	Spring-ass rot wrst w/ latch		A					
L6624	Flex/ext/rotation wrist unit		A					
L6625	Rotation wrst w/ cable lock		A					
L6628	Quick disconn hook adapter o		A					
L6629	Lamination collar w/ couplin		A					
L6630	Stainless steel any wrist		A					
L6632	Latex suspension sleeve each		A					
L6635	Lift assist for elbow		A					
L6637	Nudge control elbow lock		A					
L6638	Elec lock on manual pw elbow		A					
L6640	Shoulder abduction joint pai		A					
L6641	Excursion amplifier pulley t		A					
L6642	Excursion amplifier lever ty		A					
L6645	Shoulder flexion-abduction j		A					
L6646	Multipo locking shoulder jnt		A					
L6647	Shoulder lock actuator		A					
L6648	Ext pwrd shlder lock/unlock		A					
L6650	Shoulder universal joint		A					
L6655	Standard control cable extra		A					
L6660	Heavy duty control cable		A					
L6665	Teflon or equal cable lining		A					
L6670	Hook to hand cable adapter		A					
L6672	Harness chest/shlder saddle		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6675	Harness figure of 8 sing con		A					
L6676	Harness figure of 8 dual con		A					
L6677	UE triple control harness		A					
L6680	Test sock wrist disart/bel e		A					
L6682	Test sock elbw disart/above		A					
L6684	Test socket shldr disart/tho		A					
L6686	Suction socket		A					
L6687	Frame typ socket bel elbow/w		A					
L6688	Frame typ sock above elb/dis		A					
L6689	Frame typ socket shoulder di		A					
L6690	Frame typ sock interscap-tho		A					
L6691	Removable insert each		A					
L6692	Silicone gel insert or equal		A					
L6693	Lockingelbow forearm cntrbal		A					
L6694	Elbow socket ins use w/lock		A					
L6695	Elbow socket ins use w/o lck		A					
L6696	Cus elbo skt in for con/atyp		A					
L6697	Cus elbo skt in not con/atyp		A					
L6698	Below/above elbow lock mech		A					
L6703	Term dev, passive hand mitt		A					
L6704	Term dev, sport/rec/work att		A					
L6706	Term dev mech hook vol open		A					
L6707	Term dev mech hook vol close		A					
L6708	Term dev mech hand vol open		A					
L6709	Term dev mech hand vol close		A					
L6711	Ped term dev, hook, vol open		A					
L6712	Ped term dev, hook, vol clos		A					
L6713	Ped term dev, hand, vol open		A					
L6714	Ped term dev, hand, vol clos		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6721	Hook/hand, hvy dty, vol open		A					
L6722	Hook/hand, hvy dty, vol clos		A					
L6805	Term dev modifier wrist unit		A					
L6810	Term dev precision pinch dev		A					
L6881	Term dev auto grasp feature		A					
L6882	Microprocessor control uplmb		A					
L6883	Replc sockt below e/w disa		A					
L6884	Replc sockt above elbow disa		A					
L6885	Replc sockt shldr dis/interc		A					
L6890	Prefab glove for term device		A					
L6895	Custom glove for term device		A					
L6900	Hand restorat thumb/1 finger		A					
L6905	Hand restoration multiple fi		A					
L6910	Hand restoration no fingers		A					
L6915	Hand restoration replacmnt g		A					
L6920	Wrist disarticul switch ctrl		A					
L6925	Wrist disart myoelectronic c		A					
L6930	Below elbow switch control		A					
L6935	Below elbow myoelectronic ct		A					
L6940	Elbow disarticulation switch		A					
L6945	Elbow disart myoelectronic c		A					
L6950	Above elbow switch control		A					
L6955	Above elbow myoelectronic ct		A					
L6960	Shldr disartic switch contro		A					
L6965	Shldr disartic myoelectronic		A					
L6970	Interscapular-thor switch ct		A					
L6975	Interscap-thor myoelectronic		A					
L7007	Adult electric hand		A					
L7008	Pediatric electric hand		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L7009	Adult electric hook		A					
L7040	Prehensile actuator		A					
L7045	Pediatric electric hook		A					
L7170	Electronic elbow hosmer swit		A					
L7180	Electronic elbow sequential		A					
L7181	Electronic elbo simultaneous		A					
L7185	Electron elbow adolescent sw		A					
L7186	Electron elbow child switch		A					
L7190	Elbow adolescent myoelectron		A					
L7191	Elbow child myoelectronic ct		A					
L7260	Electron wrist rotator otto		A					
L7261	Electron wrist rotator utah		A					
L7266	Servo control steeper or equ		A					
L7272	Analogue control unb or equa		A					
L7274	Proportional ctl 12 volt uta		A					
L7360	Six volt bat otto bock/eq ea		A					
L7362	Battery chrgr six volt otto		A					
L7364	Twelve volt battery utah/equ		A					
L7366	Battery chrgr 12 volt utah/e		A					
L7367	Replacemnt lithium ionbatter		A					
L7368	Lithium ion battery charger		A					
L7400	Add UE prost be/wd, ultlite		A					
L7401	Add UE prost a/e ultlite mat		A					
L7402	Add UE prost s/d ultlite mat		A					
L7403	Add UE prost b/e acrylic		A					
L7404	Add UE prost a/e acrylic		A					
L7405	Add UE prost s/d acrylic		A					
L7499	Upper extremity prosthes NOS		A					
L7500	Prosthetic dvc repair hourly		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L7510	Prosthetic device repair rep		A					
L7520	Repair prosthesis per 15 min		A					
L7600	Prosthetic donning sleeve		E					
L7900	Male vacuum erection system		A					
L8000	Mastectomy bra		A					
L8001	Breast prosthesis bra & form		A					
L8002	Brst prsth bra & bilat form		A					
L8010	Mastectomy sleeve		A					
L8015	Ext breastprosthesis garment		A					
L8020	Mastectomy form		A					
L8030	Breast prosthes w/o adhesive		A					
L8031	Breast prosthesis w adhesive		A					
L8032	Reusable nipple prosthesis		A					
L8035	Custom breast prosthesis		A					
L8039	Breast prosthesis NOS		A					
L8040	Nasal prosthesis		A					
L8041	Midfacial prosthesis		A					
L8042	Orbital prosthesis		A					
L8043	Upper facial prosthesis		A					
L8044	Hemi-facial prosthesis		A					
L8045	Auricular prosthesis		A					
L8046	Partial facial prosthesis		A					
L8047	Nasal septal prosthesis		A					
L8048	Unspec maxillofacial prosth		A					
L8049	Repair maxillofacial prosth		A					
L8300	Truss single w/ standard pad		A					
L8310	Truss double w/ standard pad		A					
L8320	Truss addition to std pad wa		A					
L8330	Truss add to std pad scrotal		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8400	Sheath below knee		A					
L8410	Sheath above knee		A					
L8415	Sheath upper limb		A					
L8417	Pros sheath/sock w gel cushn		A					
L8420	Prosthetic sock multi ply BK		A					
L8430	Prosthetic sock multi ply AK		A					
L8435	Pros sock multi ply upper lm		A					
L8440	Shrinker below knee		A					
L8460	Shrinker above knee		A					
L8465	Shrinker upper limb		A					
L8470	Pros sock single ply BK		A					
L8480	Pros sock single ply AK		A					
L8485	Pros sock single ply upper l		A					
L8499	Unlisted misc prosthetic ser		A					
L8500	Artificial larynx		A					
L8501	Tracheostomy speaking valve		A					
L8505	Artificial larynx, accessory		A					
L8507	Trach-esoph voice pros pt in		A					
L8509	Trach-esoph voice pros md in		A					
L8510	Voice amplifier		A					
L8511	Indwelling trach insert		A					
L8512	Gel cap for trach voice pros		A					
L8513	Trach pros cleaning device		A					
L8514	Repl trach puncture dilator		A					
L8515	Gel cap app device for trach		A					
L8600	Implant breast silicone/eq		N					
L8603	Collagen imp urinary 2.5 ml		N					
L8604	Dextranomer/hyaluronic acid		N					
L8606	Synthetic implnt urinary 1ml		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8609	Artificial cornea		N					
L8610	Ocular implant		N					
L8612	Aqueous shunt prosthesis		N					
L8613	Ossicular implant		N					
L8614	Cochlear device		N					
L8615	Coch implant headset replace		A					
L8616	Coch implant microphone repl		A					
L8617	Coch implant trans coil repl		A					
L8618	Coch implant tran cable repl		A					
L8619	Coch imp ext proc/contr rplc		A					
L8621	Repl zinc air battery		A					
L8622	Repl alkaline battery		A					
L8623	Lith ion batt CID,non-earlvl		A					
L8624	Lith ion batt CID, ear level		A					
L8627	CID ext speech process repl		A					
L8628	CID ext controller repl		A					
L8629	CID transmit coil and cable		A					
L8630	Metacarpophalangeal implant		N					
L8631	MCP joint repl 2 pc or more		N					
L8641	Metatarsal joint implant		N					
L8642	Hallux implant		N					
L8658	Interphalangeal joint spacer		N					
L8659	Interphalangeal joint repl		N					
L8670	Vascular graft, synthetic		N					
L8680	Implt neurostim elctr each		N					
L8681	Pt prgrm for implt neurostim		A					
L8682	Implt neurostim radiofq rec		N					
L8683	Radiofq trsmtr for implt neu		A					
L8684	Radiof trsmtr implt scrl neu		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8685	Implt nrostm pls gen sng rec		N					
L8686	Implt nrostm pls gen sng non		N					
L8687	Implt nrostm pls gen dua rec		N					
L8688	Implt nrostm pls gen dua non		N					
L8689	External recharg sys intern		A					
L8690	Aud osseo dev, int/ext comp		N					
L8691	Osseointegrated snd proc rpl		A					
L8692	Non-osseointegrated snd proc		E					
L8695	External recharg sys extern		A					
L8699	Prosthetic implant NOS		N					
L9900	O&P supply/accessory/service		N					
M0064	Visit for drug monitoring		Q3	0607	1.7939	$122.46	.	$24.50
M0075	Cellular therapy		E					
M0076	Prolotherapy		E					
M0100	Intragastric hypothermia		E					
M0300	IV chelationtherapy		E					
M0301	Fabric wrapping of aneurysm		E					
P2028	Cephalin floculation test		A					
P2029	Congo red blood test		A					
P2031	Hair analysis		E					
P2033	Blood thymol turbidity		A					
P2038	Blood mucoprotein		A					
P3000	Screen pap by tech w md supv		A					
P3001	Screening pap smear by phys		B					
P7001	Culture bacterial urine		E					
P9010	Whole blood for transfusion		R	0950	2.9637	$202.32	.	$40.47
P9011	Blood split unit		R	0967	2.9552	$201.74	.	$40.35
P9012	Cryoprecipitate each unit		R	0952	0.7391	$50.46	.	$10.10
P9016	RBC leukocytes reduced		R	0954	2.7694	$189.06	.	$37.82

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
P9017	Plasma 1 donor frz w/in 8 hr		R	9508	1.1671	$79.67	.	$15.94
P9019	Platelets, each unit		R	0957	1.0506	$71.72	.	$14.35
P9020	Plaelet rich plasma unit		R	0958	2.052	$140.08	.	$28.02
P9021	Red blood cells unit		R	0959	2.186	$149.23	.	$29.85
P9022	Washed red blood cells unit		R	0960	4.3079	$294.09	.	$58.82
P9023	Frozen plasma, pooled, sd		R	0949	0.8126	$55.47	.	$11.10
P9031	Platelets leukocytes reduced		R	1013	1.5839	$108.13	.	$21.63
P9032	Platelets, irradiated		R	9500	2.2804	$155.68	.	$31.14
P9033	Platelets leukoreduced irrad		R	0968	2.0209	$137.96	.	$27.60
P9034	Platelets, pheresis		R	9507	6.5766	$448.96	.	$89.80
P9035	Platelet pheres leukoreduced		R	9501	7.7397	$528.37	.	$105.68
P9036	Platelet pheresis irradiated		R	9502	6.8837	$469.93	.	$93.99
P9037	Plate pheres leukoredu irrad		R	1019	9.6439	$658.36	.	$131.68
P9038	RBC irradiated		R	9505	3.162	$215.86	.	$43.18
P9039	RBC deglycerolized		R	9504	5.1865	$354.07	.	$70.82
P9040	RBC leukoreduced irradiated		R	0969	3.6796	$251.20	.	$50.24
P9041	Albumin (human),5%, 50ml		K	0961		$16.89	.	$3.38
P9043	Plasma protein fract,5%,50ml		R	0956	0.3751	$25.61	.	$5.13
P9044	Cryoprecipitatereducedplasma		R	1009	1.1663	$79.62	.	$15.93
P9045	Albumin (human), 5%, 250 ml		K	0963		$60.58	.	$12.12
P9046	Albumin (human), 25%, 20 ml		K	0964		$25.67	.	$5.14
P9047	Albumin (human), 25%, 50ml		K	0965		$62.05	.	$12.41
P9048	Plasmaprotein fract,5%,250ml		R	0966	1.6989	$115.98	.	$23.20
P9050	Granulocytes, pheresis unit		R	9506	23.7666	$1,622.47	.	$324.50
P9051	Blood, l/r, cmv-neg		R	1010	2.76	$188.42	.	$37.69
P9052	Platelets, hla-m, l/r, unit		R	1011	10.5854	$722.63	.	$144.53
P9053	Plt, pher, l/r cmv-neg, irr		R	1020	8.5688	$584.97	.	$117.00
P9054	Blood, l/r, froz/degly/wash		R	1016	1.4749	$100.69	.	$20.14
P9055	Plt, aph/pher, l/r, cmv-neg		R	1017	6.2876	$429.24	.	$85.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
P9056	Blood, l/r, irradiated		R	1018	2.4465	$167.02	.	$33.41
P9057	RBC, frz/deg/wsh, l/r, irrad		R	1021	4.1093	$280.53	.	$56.11
P9058	RBC, l/r, cmv-neg, irrad		R	1022	4.387	$299.49	.	$59.90
P9059	Plasma, frz between 8-24hour		R	0955	1.0672	$72.85	.	$14.57
P9060	Fr frz plasma donor retested		R	9503	0.9734	$66.45	.	$13.29
P9603	One-way allow prorated miles		A					
P9604	One-way allow prorated trip		A					
P9612	Catheterize for urine spec		A					
P9615	Urine specimen collect mult		N					
Q0035	Cardiokymography		X	0100	2.6301	$179.55	$41.44	$35.91
Q0081	Infusion ther other than che		B					
Q0083	Chemo by other than infusion		B					
Q0084	Chemotherapy by infusion		B					
Q0085	Chemo by both infusion and o		B					
Q0091	Obtaining screen pap smear		T	0191	0.1514	$10.34		
Q0092	Set up port xray equipment		N					
Q0111	Wet mounts/ w preparations		A					
Q0112	Potassium hydroxide preps		A					
Q0113	Pinworm examinations		A					
Q0114	Fern test		A					
Q0115	Post-coital mucous exam		A					
Q0138	Ferumoxytol, non-esrd		G	1297		$0.82	.	$0.17
Q0139	Ferumoxytol, esrd use		A					
Q0144	Azithromycin dihydrate, oral		E					
Q0163	Diphenhydramine HCl 50mg		N					
Q0164	Prochlorperazine maleate 5mg		N					
Q0165	Prochlorperazine maleate10mg		N					
Q0166	Granisetron hcl 1 mg oral		N					
Q0167	Dronabinol 2.5mg oral		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q0168	Dronabinol 5mg oral		N					
Q0169	Promethazine HCl 12.5mg oral		N					
Q0170	Promethazine HCl 25 mg oral		N					
Q0171	Chlorpromazine HCl 10mg oral		N					
Q0172	Chlorpromazine HCl 25mg oral		N					
Q0173	Trimethobenzamide HCl 250mg		N					
Q0174	Thiethylperazine maleate10mg	CH	E					
Q0175	Perphenazine 4mg oral		N					
Q0176	Perphenazine 8mg oral		N					
Q0177	Hydroxyzine pamoate 25mg		N					
Q0178	Hydroxyzine pamoate 50mg		N					
Q0179	Ondansetron hcl 8 mg oral		N					
Q0180	Dolasetron mesylate oral		N					
Q0181	Unspecified oral anti-emetic		E					
Q0480	Driver pneumatic vad, rep		A					
Q0481	Microprcsr cu elec vad, rep		A					
Q0482	Microprcsr cu combo vad, rep		A					
Q0483	Monitor elec vad, rep		A					
Q0484	Monitor elec or comb vad rep		A					
Q0485	Monitor cable elec vad, rep		A					
Q0486	Mon cable elec/pneum vad rep		A					
Q0487	Leads any type vad, rep only		A					
Q0488	Pwr pack base elec vad, rep		A					
Q0489	Pwr pck base combo vad, rep		A					
Q0490	Emr pwr source elec vad, rep		A					
Q0491	Emr pwr source combo vad rep		A					
Q0492	Emr pwr cbl elec vad, rep		A					
Q0493	Emr pwr cbl combo vad, rep		A					
Q0494	Emr hd pmp elec/combo, rep		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q0495	Charger elec/combo vad, rep		A					
Q0496	Battery elec/combo vad, rep		A					
Q0497	Bat clps elec/comb vad, rep		A					
Q0498	Holster elec/combo vad, rep		A					
Q0499	Belt/vest elec/combo vad rep		A					
Q0500	Filters elec/combo vad, rep		A					
Q0501	Shwr cov elec/combo vad, rep		A					
Q0502	Mobility cart pneum vad, rep		A					
Q0503	Battery pneum vad replacemnt		A					
Q0504	Pwr adpt pneum vad, rep veh		A					
Q0505	Miscl supply/accessory vad		A					
Q0506	Lith-ion batt elec/pneum VAD		A					
Q0510	Dispens fee immunosupressive		B					
Q0511	Sup fee antiem,antica,immuno		B					
Q0512	Px sup fee anti-can sub pres		B					
Q0513	Disp fee inhal drugs/30 days		B					
Q0514	Disp fee inhal drugs/90 days		B					
Q0515	Sermorelin acetate injection		K	3050		$1.80	.	$0.36
Q1003	Ntiol category 3		N					
Q1004	Ntiol category 4		E					
Q1005	Ntiol category 5		E					
Q2004	Bladder calculi irrig sol	CH	N					
Q2009	Fosphenytoin inj PE		N					
Q2017	Teniposide, 50 mg		K	7035		$324.55	.	$64.91
Q3001	Brachytherapy Radioelements		B					
Q3014	Telehealth facility fee		A					
Q3025	IM inj interferon beta 1-a		K	9022		$193.93	.	$38.79
Q3026	Subc inj interferon beta-1a		E					
Q3031	Collagen skin test		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q4001	Cast sup body cast plaster		B					
Q4002	Cast sup body cast fiberglas		B					
Q4003	Cast sup shoulder cast plstr		B					
Q4004	Cast sup shoulder cast fbrgl		B					
Q4005	Cast sup long arm adult plst		B					
Q4006	Cast sup long arm adult fbrg		B					
Q4007	Cast sup long arm ped plster		B					
Q4008	Cast sup long arm ped fbrgls		B					
Q4009	Cast sup sht arm adult plstr		B					
Q4010	Cast sup sht arm adult fbrgl		B					
Q4011	Cast sup sht arm ped plaster		B					
Q4012	Cast sup sht arm ped fbrglas		B					
Q4013	Cast sup gauntlet plaster		B					
Q4014	Cast sup gauntlet fiberglass		B					
Q4015	Cast sup gauntlet ped plster		B					
Q4016	Cast sup gauntlet ped fbrgls		B					
Q4017	Cast sup lng arm splint plst		B					
Q4018	Cast sup lng arm splint fbrg		B					
Q4019	Cast sup lng arm splnt ped p		B					
Q4020	Cast sup lng arm splnt ped f		B					
Q4021	Cast sup sht arm splint plst		B					
Q4022	Cast sup sht arm splint fbrg		B					
Q4023	Cast sup sht arm splnt ped p		B					
Q4024	Cast sup sht arm splnt ped f		B					
Q4025	Cast sup hip spica plaster		B					
Q4026	Cast sup hip spica fiberglas		B					
Q4027	Cast sup hip spica ped plstr		B					
Q4028	Cast sup hip spica ped fbrgl		B					
Q4029	Cast sup long leg plaster		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q4030	Cast sup long leg fiberglass		B					
Q4031	Cast sup lng leg ped plaster		B					
Q4032	Cast sup lng leg ped fbrgls		B					
Q4033	Cast sup lng leg cylinder pl		B					
Q4034	Cast sup lng leg cylinder fb		B					
Q4035	Cast sup lngleg cylndr ped p		B					
Q4036	Cast sup lngleg cylndr ped f		B					
Q4037	Cast sup shrt leg plaster		B					
Q4038	Cast sup shrt leg fiberglass		B					
Q4039	Cast sup shrt leg ped plster		B					
Q4040	Cast sup shrt leg ped fbrgls		B					
Q4041	Cast sup lng leg splnt plstr		B					
Q4042	Cast sup lng leg splnt fbrgl		B					
Q4043	Cast sup lng leg splnt ped p		B					
Q4044	Cast sup lng leg splnt ped f		B					
Q4045	Cast sup sht leg splnt plstr		B					
Q4046	Cast sup sht leg splnt fbrgl		B					
Q4047	Cast sup sht leg splnt ped p		B					
Q4048	Cast sup sht leg splnt ped f		B					
Q4049	Finger splint, static		B					
Q4050	Cast supplies unlisted		B					
Q4051	Splint supplies misc		B					
Q4074	Iloprost non-comp unit dose		Y					
Q4081	Epoetin alfa, 100 units ESRD		A					
Q4082	Drug/bio NOC part B drug CAP		B					
Q4100	Skin substitute, NOS		N					
Q4101	Apligraf skin sub		K	1240		$32.71	.	$6.55
Q4102	Oasis wound matrix skin sub		K	1241		$4.62	.	$0.93
Q4103	Oasis burn matrix skin sub		K	1242		$4.62	.	$0.93

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q4104	Integra BMWD skin sub		K	1243		$14.84	.	$2.97
Q4105	Integra DRT skin sub		K	1244		$10.00	.	$2.00
Q4106	Dermagraft skin sub		K	1245		$40.10	.	$8.02
Q4107	Graftjacket skin sub		K	1246		$92.04	.	$18.41
Q4108	Integra matrix skin sub		K	1247		$17.99	.	$3.60
Q4109	Tissuemend skin sub		N					
Q4110	Primatrix skin sub		K	1248		$34.35	.	$6.87
Q4111	Gammagraft skin sub		K	1252		$7.40	.	$1.48
Q4112	Cymetra allograft		K	1249		$342.34	.	$68.47
Q4113	Graftjacket express allograf		K	1250		$342.34	.	$68.47
Q4114	Integra flowable wound matri	CH	K	1251		$914.43	.	$182.89
Q4115	Alloskin skin sub		K	1287		$7.34	.	$1.47
Q4116	Alloderm skin sub		K	1270		$32.57	.	$6.52
Q5001	Hospice in patient home		B					
Q5002	Hospice in assisted living		B					
Q5003	Hospice in LT/non-skilled NF		B					
Q5004	Hospice in SNF		B					
Q5005	Hospice, inpatient hospital		B					
Q5006	Hospice in hospice facility		B					
Q5007	Hospice in LTCH		B					
Q5008	Hospice in inpatient psych		B					
Q5009	Hospice care, NOS		B					
Q9951	LOCM >= 400 mg/ml iodine,1ml		N					
Q9953	Inj Fe-based MR contrast,1ml		N					
Q9954	Oral MR contrast, 100 ml		N					
Q9955	Inj perflexane lip micros,ml		N					
Q9956	Inj octafluoropropane mic,ml		N					
Q9957	Inj perflutren lip micros,ml		N					
Q9958	HOCM <=149 mg/ml iodine, 1ml		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q9959	HOCM 150-199mg/ml iodine,1ml		N					
Q9960	HOCM 200-249mg/ml iodine,1ml		N					
Q9961	HOCM 250-299mg/ml iodine,1ml		N					
Q9962	HOCM 300-349mg/ml iodine,1ml		N					
Q9963	HOCM 350-399mg/ml iodine,1ml		N					
Q9964	HOCM>= 400mg/ml iodine, 1ml		N					
Q9965	LOCM 100-199mg/ml iodine,1ml		N					
Q9966	LOCM 200-299mg/ml iodine,1ml		N					
Q9967	LOCM 300-399mg/ml iodine,1ml		N					
Q9968	Visualization adjunct		K	1288		$1.82	.	$0.37
R0070	Transport portable x-ray		B					
R0075	Transport port x-ray multipl		B					
R0076	Transport portable EKG		B					
V2020	Vision svcs frames purchases		A					
V2025	Eyeglasses delux frames		E					
V2100	Lens spher single plano 4.00		A					
V2101	Single visn sphere 4.12-7.00		A					
V2102	Singl visn sphere 7.12-20.00		A					
V2103	Spherocylindr 4.00d/12-2.00d		A					
V2104	Spherocylindr 4.00d/2.12-4d		A					
V2105	Spherocylinder 4.00d/4.25-6d		A					
V2106	Spherocylinder 4.00d/>6.00d		A					
V2107	Spherocylinder 4.25d/12-2d		A					
V2108	Spherocylinder 4.25d/2.12-4d		A					
V2109	Spherocylinder 4.25d/4.25-6d		A					
V2110	Spherocylinder 4.25d/over 6d		A					
V2111	Spherocylindr 7.25d/.25-2.25		A					
V2112	Spherocylindr 7.25d/2.25-4d		A					
V2113	Spherocylindr 7.25d/4.25-6d		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2114	Spherocylinder over 12.00d		A					
V2115	Lens lenticular bifocal		A					
V2118	Lens aniseikonic single		A					
V2121	Lenticular lens, single		A					
V2199	Lens single vision not oth c		A					
V2200	Lens spher bifoc plano 4.00d		A					
V2201	Lens sphere bifocal 4.12-7.0		A					
V2202	Lens sphere bifocal 7.12-20.		A					
V2203	Lens sphcyl bifocal 4.00d/.1		A					
V2204	Lens sphcy bifocal 4.00d/2.1		A					
V2205	Lens sphcy bifocal 4.00d/4.2		A					
V2206	Lens sphcy bifocal 4.00d/ove		A					
V2207	Lens sphcy bifocal 4.25-7d/.		A					
V2208	Lens sphcy bifocal 4.25-7/2.		A					
V2209	Lens sphcy bifocal 4.25-7/4.		A					
V2210	Lens sphcy bifocal 4.25-7/ov		A					
V2211	Lens sphcy bifo 7.25-12/.25-		A					
V2212	Lens sphcyl bifo 7.25-12/2.2		A					
V2213	Lens sphcyl bifo 7.25-12/4.2		A					
V2214	Lens sphcyl bifocal over 12.		A					
V2215	Lens lenticular bifocal		A					
V2218	Lens aniseikonic bifocal		A					
V2219	Lens bifocal seg width over		A					
V2220	Lens bifocal add over 3.25d		A					
V2221	Lenticular lens, bifocal		A					
V2299	Lens bifocal speciality		A					
V2300	Lens sphere trifocal 4.00d		A					
V2301	Lens sphere trifocal 4.12-7.		A					
V2302	Lens sphere trifocal 7.12-20		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2303	Lens sphcy trifocal 4.0/.12-		A					
V2304	Lens sphcy trifocal 4.0/2.25		A					
V2305	Lens sphcy trifocal 4.0/4.25		A					
V2306	Lens sphcyl trifocal 4.00/>6		A					
V2307	Lens sphcy trifocal 4.25-7/.		A					
V2308	Lens sphc trifocal 4.25-7/2.		A					
V2309	Lens sphc trifocal 4.25-7/4.		A					
V2310	Lens sphc trifocal 4.25-7/>6		A					
V2311	Lens sphc trifo 7.25-12/.25-		A					
V2312	Lens sphc trifo 7.25-12/2.25		A					
V2313	Lens sphc trifo 7.25-12/4.25		A					
V2314	Lens sphcyl trifocal over 12		A					
V2315	Lens lenticular trifocal		A					
V2318	Lens aniseikonic trifocal		A					
V2319	Lens trifocal seg width > 28		A					
V2320	Lens trifocal add over 3.25d		A					
V2321	Lenticular lens, trifocal		A					
V2399	Lens trifocal speciality		A					
V2410	Lens variab asphericity sing		A					
V2430	Lens variable asphericity bi		A					
V2499	Variable asphericity lens		A					
V2500	Contact lens pmma spherical		A					
V2501	Cntct lens pmma-toric/prism		A					
V2502	Contact lens pmma bifocal		A					
V2503	Cntct lens pmma color vision		A					
V2510	Cntct gas permeable sphericl		A					
V2511	Cntct toric prism ballast		A					
V2512	Cntct lens gas permbl bifocl		A					
V2513	Contact lens extended wear		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2520	Contact lens hydrophilic		A					
V2521	Cntct lens hydrophilic toric		A					
V2522	Cntct lens hydrophil bifocl		A					
V2523	Cntct lens hydrophil extend		A					
V2530	Contact lens gas impermeable		A					
V2531	Contact lens gas permeable		A					
V2599	Contact lens/es other type		A					
V2600	Hand held low vision aids		A					
V2610	Single lens spectacle mount		A					
V2615	Telescop/othr compound lens		A					
V2623	Plastic eye prosth custom		A					
V2624	Polishing artifical eye		A					
V2625	Enlargemnt of eye prosthesis		A					
V2626	Reduction of eye prosthesis		A					
V2627	Scleral cover shell		A					
V2628	Fabrication & fitting		A					
V2629	Prosthetic eye other type		A					
V2630	Anter chamber intraocul lens		N					
V2631	Iris support intraoclr lens		N					
V2632	Post chmbr intraocular lens		N					
V2700	Balance lens		A					
V2702	Deluxe lens feature		E					
V2710	Glass/plastic slab off prism		A					
V2715	Prism lens/es		A					
V2718	Fresnell prism press-on lens		A					
V2730	Special base curve		A					
V2744	Tint photochromatic lens/es		A					
V2745	Tint, any color/solid/grad		A					
V2750	Anti-reflective coating		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2755	UV lens/es		A					
V2756	Eye glass case		E					
V2760	Scratch resistant coating		A					
V2761	Mirror coating		B					
V2762	Polarization, any lens		A					
V2770	Occluder lens/es		A					
V2780	Oversize lens/es		A					
V2781	Progressive lens per lens		B					
V2782	Lens, 1.54-1.65 p/1.60-1.79g		A					
V2783	Lens, >= 1.66 p/>=1.80 g		A					
V2784	Lens polycarb or equal		A					
V2785	Corneal tissue processing		F					
V2786	Occupational multifocal lens		A					
V2787	Astigmatism-correct function		E					
V2788	Presbyopia-correct function		E					
V2790	Amniotic membrane		N					
V2797	Vis item/svc in other code		A					
V2799	Miscellaneous vision service		A					
V5008	Hearing screening		E					
V5010	Assessment for hearing aid		E					
V5011	Hearing aid fitting/checking		E					
V5014	Hearing aid repair/modifying		E					
V5020	Conformity evaluation		E					
V5030	Body-worn hearing aid air		E					
V5040	Body-worn hearing aid bone		E					
V5050	Hearing aid monaural in ear		E					
V5060	Behind ear hearing aid		E					
V5070	Glasses air conduction		E					
V5080	Glasses bone conduction		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V5090	Hearing aid dispensing fee		E					
V5095	Implant mid ear hearing pros		E					
V5100	Body-worn bilat hearing aid		E					
V5110	Hearing aid dispensing fee		E					
V5120	Body-worn binaur hearing aid		E					
V5130	In ear binaural hearing aid		E					
V5140	Behind ear binaur hearing ai		E					
V5150	Glasses binaural hearing aid		E					
V5160	Dispensing fee binaural		E					
V5170	Within ear cros hearing aid		E					
V5180	Behind ear cros hearing aid		E					
V5190	Glasses cros hearing aid		E					
V5200	Cros hearing aid dispens fee		E					
V5210	In ear bicros hearing aid		E					
V5220	Behind ear bicros hearing ai		E					
V5230	Glasses bicros hearing aid		E					
V5240	Dispensing fee bicros		E					
V5241	Dispensing fee, monaural		E					
V5242	Hearing aid, monaural, cic		E					
V5243	Hearing aid, monaural, itc		E					
V5244	Hearing aid, prog, mon, cic		E					
V5245	Hearing aid, prog, mon, itc		E					
V5246	Hearing aid, prog, mon, ite		E					
V5247	Hearing aid, prog, mon, bte		E					
V5248	Hearing aid, binaural, cic		E					
V5249	Hearing aid, binaural, itc		E					
V5250	Hearing aid, prog, bin, cic		E					
V5251	Hearing aid, prog, bin, itc		E					
V5252	Hearing aid, prog, bin, ite		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V5253	Hearing aid, prog, bin, bte		E					
V5254	Hearing id, digit, mon, cic		E					
V5255	Hearing aid, digit, mon, itc		E					
V5256	Hearing aid, digit, mon, ite		E					
V5257	Hearing aid, digit, mon, bte		E					
V5258	Hearing aid, digit, bin, cic		E					
V5259	Hearing aid, digit, bin, itc		E					
V5260	Hearing aid, digit, bin, ite		E					
V5261	Hearing aid, digit, bin, bte		E					
V5262	Hearing aid, disp, monaural		E					
V5263	Hearing aid, disp, binaural		E					
V5264	Ear mold/insert		E					
V5265	Ear mold/insert, disp		E					
V5266	Battery for hearing device		E					
V5267	Hearing aid supply/accessory		E					
V5268	ALD Telephone Amplifier		E					
V5269	Alerting device, any type		E					
V5270	ALD, TV amplifier, any type		E					
V5271	ALD, TV caption decoder		E					
V5272	Tdd		E					
V5273	ALD for cochlear implant		E					
V5274	ALD unspecified		E					
V5275	Ear impression		E					
V5298	Hearing aid noc		E					
V5299	Hearing service		B					
V5336	Repair communication device		E					
V5362	Speech screening		E					
V5363	Language screening		E					
V5364	Dysphagia screening		E					

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)					
HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
0042T	Ct perfusion w/contrast, cbf		N1		
0073T	Delivery, comp imrt		Z2	5.8592	$245.49
0126T	Chd risk imt study		N1		
0159T	Cad breast mri		N1		
0174T	Cad cxr with interp		N1		
0175T	Cad cxr remote		N1		
0182T	Hdr elect brachytherapy		Z2	9.4592	$396.32
0185T	Comptr probability analysis		N1		
70010	Contrast x-ray of brain		N1		
70015	Contrast x-ray of brain		N1		
70030	X-ray eye for foreign body		Z3		$14.24
70100	X-ray exam of jaw		Z3		$16.94
70110	X-ray exam of jaw		Z3		$19.15
70120	X-ray exam of mastoids		Z3		$18.17
70130	X-ray exam of mastoids		Z2	0.6075	$25.45
70134	X-ray exam of middle ear		Z3		$20.87
70140	X-ray exam of facial bones		Z3		$14.49
70150	X-ray exam of facial bones	CH	Z3		$21.11
70160	X-ray exam of nasal bones		Z3		$17.19
70170	X-ray exam of tear duct		N1		
70190	X-ray exam of eye sockets		Z3		$17.92
70200	X-ray exam of eye sockets	CH	Z3		$21.36
70210	X-ray exam of sinuses		Z3		$15.47
70220	X-ray exam of sinuses		Z3		$18.91
70240	X-ray exam, pituitary saddle		Z3		$14.24
70250	X-ray exam of skull		Z3		$17.68
70260	X-ray exam of skull		Z3		$21.85
70300	X-ray exam of teeth		Z3		$6.14
70310	X-ray exam of teeth		Z2	0.4411	$18.48
70320	Full mouth x-ray of teeth		Z2	0.4411	$18.48
70328	X-ray exam of jaw joint		Z3		$15.22
70330	X-ray exam of jaw joints	CH	Z3		$25.29
70332	X-ray exam of jaw joint		N1		
70336	Magnetic image, jaw joint		Z2	4.6406	$194.43
70350	X-ray head for orthodontia		Z3		$8.35

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
70355	Panoramic x-ray of jaws		Z3		$7.86
70360	X-ray exam of neck		Z3		$13.26
70370	Throat x-ray & fluoroscopy	CH	Z3		$46.16
70371	Speech evaluation, complex	CH	Z3		$37.56
70373	Contrast x-ray of larynx		N1		
70380	X-ray exam of salivary gland	CH	Z3		$21.36
70390	X-ray exam of salivary duct		N1		
70450	Ct head/brain w/o dye		Z2	2.5969	$108.80
70460	Ct head/brain w/dye	CH	Z3		$141.91
70470	Ct head/brain w/o & w/dye	CH	Z3		$174.81
70480	Ct orbit/ear/fossa w/o dye		Z2	2.5969	$108.80
70481	Ct orbit/ear/fossa w/dye		Z2	4.0105	$168.03
70482	Ct orbit/ear/fossa w/o&w/dye		Z2	4.447	$186.32
70486	Ct maxillofacial w/o dye		Z2	2.5969	$108.80
70487	Ct maxillofacial w/dye		Z2	4.0105	$168.03
70488	Ct maxillofacial w/o & w/dye		Z2	4.447	$186.32
70490	Ct soft tissue neck w/o dye		Z2	2.5969	$108.80
70491	Ct soft tissue neck w/dye		Z2	4.0105	$168.03
70492	Ct sft tsue nck w/o & w/dye		Z2	4.447	$186.32
70496	Ct angiography, head		Z2	4.6	$192.73
70498	Ct angiography, neck		Z2	4.6	$192.73
70540	Mri orbit/face/neck w/o dye		Z2	4.6406	$194.43
70542	Mri orbit/face/neck w/dye		Z2	5.868	$245.86
70543	Mri orbt/fac/nck w/o & w/dye		Z2	7.2057	$301.90
70544	Mr angiography head w/o dye		Z2	4.6406	$194.43
70545	Mr angiography head w/dye		Z2	5.868	$245.86
70546	Mr angiograph head w/o&w/dye		Z2	7.2057	$301.90
70547	Mr angiography neck w/o dye		Z2	4.6406	$194.43
70548	Mr angiography neck w/dye		Z2	5.868	$245.86
70549	Mr angiograph neck w/o&w/dye		Z2	7.2057	$301.90
70551	Mri brain w/o dye		Z2	4.6406	$194.43
70552	Mri brain w/dye		Z2	5.868	$245.86
70553	Mri brain w/o & w/dye		Z2	7.2057	$301.90
70554	Fmri brain by tech		Z2	4.6406	$194.43
70555	Fmri brain by phys/psych		Z2	4.6406	$194.43
70557	Mri brain w/o dye		Z2	4.6406	$194.43
70558	Mri brain w/dye		Z2	5.868	$245.86
70559	Mri brain w/o & w/dye		Z2	7.2057	$301.90
71010	Chest x-ray		Z3		$10.31
71015	Chest x-ray		Z3		$13.75

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
71020	Chest x-ray		Z3		$13.99
71021	Chest x-ray		Z3		$17.68
71022	Chest x-ray	CH	Z3		$22.10
71023	Chest x-ray and fluoroscopy		Z3		$35.60
71030	Chest x-ray	CH	Z3		$21.61
71034	Chest x-ray and fluoroscopy	CH	Z3		$46.40
71035	Chest x-ray		Z3		$18.41
71040	Contrast x-ray of bronchi		N1		
71060	Contrast x-ray of bronchi		N1		
71090	X-ray & pacemaker insertion		N1		
71100	X-ray exam of ribs		Z3		$15.22
71101	X-ray exam of ribs/chest		Z3		$18.41
71110	X-ray exam of ribs		Z3		$19.40
71111	X-ray exam of ribs/chest		Z3		$26.27
71120	X-ray exam of breastbone		Z3		$15.47
71130	X-ray exam of breastbone		Z3		$18.66
71250	Ct thorax w/o dye		Z2	2.5969	$108.80
71260	Ct thorax w/dye		Z2	4.0105	$168.03
71270	Ct thorax w/o & w/dye		Z2	4.447	$186.32
71275	Ct angiography, chest		Z2	4.6	$192.73
71550	Mri chest w/o dye		Z2	4.6406	$194.43
71551	Mri chest w/dye		Z2	5.868	$245.86
71552	Mri chest w/o & w/dye		Z2	7.2057	$301.90
72010	X-ray exam of spine	CH	Z3		$36.58
72020	X-ray exam of spine		Z3		$11.29
72040	X-ray exam of neck spine		Z3		$19.15
72050	X-ray exam of neck spine		Z3		$26.03
72052	X-ray exam of neck spine	CH	Z3		$34.37
72069	X-ray exam of trunk spine		Z3		$17.92
72070	X-ray exam of thoracic spine		Z3		$15.96
72072	X-ray exam of thoracic spine		Z3		$18.91
72074	X-ray exam of thoracic spine	CH	Z3		$23.57
72080	X-ray exam of trunk spine		Z3		$17.43
72090	X-ray exam of trunk spine		Z3		$24.31
72100	X-ray exam of lower spine		Z3		$20.38
72110	X-ray exam of lower spine		Z3		$27.99
72114	X-ray exam of lower spine	CH	Z3		$39.28
72120	X-ray exam of lower spine	CH	Z2	0.6075	$25.45
72125	Ct neck spine w/o dye		Z2	2.5969	$108.80
72126	Ct neck spine w/dye		Z2	4.0105	$168.03

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
72127	Ct neck spine w/o & w/dye		Z2	4.447	$186.32
72128	Ct chest spine w/o dye		Z2	2.5969	$108.80
72129	Ct chest spine w/dye		Z2	4.0105	$168.03
72130	Ct chest spine w/o & w/dye		Z2	4.447	$186.32
72131	Ct lumbar spine w/o dye		Z2	2.5969	$108.80
72132	Ct lumbar spine w/dye		Z2	4.0105	$168.03
72133	Ct lumbar spine w/o & w/dye		Z2	4.447	$186.32
72141	Mri neck spine w/o dye		Z2	4.6406	$194.43
72142	Mri neck spine w/dye		Z2	5.868	$245.86
72146	Mri chest spine w/o dye		Z2	4.6406	$194.43
72147	Mri chest spine w/dye		Z2	5.868	$245.86
72148	Mri lumbar spine w/o dye		Z2	4.6406	$194.43
72149	Mri lumbar spine w/dye		Z2	5.868	$245.86
72156	Mri neck spine w/o & w/dye		Z2	7.2057	$301.90
72157	Mri chest spine w/o & w/dye		Z2	7.2057	$301.90
72158	Mri lumbar spine w/o & w/dye		Z2	7.2057	$301.90
72170	X-ray exam of pelvis		Z3		$12.52
72190	X-ray exam of pelvis	CH	Z3		$21.61
72191	Ct angiograph pelv w/o&w/dye		Z2	4.6	$192.73
72192	Ct pelvis w/o dye		Z2	2.5969	$108.80
72193	Ct pelvis w/dye	CH	Z3		$167.20
72194	Ct pelvis w/o & w/dye		Z2	4.447	$186.32
72195	Mri pelvis w/o dye		Z2	4.6406	$194.43
72196	Mri pelvis w/dye		Z2	5.868	$245.86
72197	Mri pelvis w/o & w/dye		Z2	7.2057	$301.90
72200	X-ray exam sacroiliac joints		Z3		$14.73
72202	X-ray exam sacroiliac joints		Z3		$17.68
72220	X-ray exam of tailbone		Z3		$14.49
72240	Contrast x-ray of neck spine		N1		
72255	Contrast x-ray, thorax spine		N1		
72265	Contrast x-ray, lower spine		N1		
72270	Contrast x-ray, spine		N1		
72275	Epidurography		N1		
72285	X-ray c/t spine disk		N1		
72291	Perq verte/sacroplsty, fluor		N1		
72292	Perq verte/sacroplsty, ct		N1		
72295	X-ray of lower spine disk		N1		
73000	X-ray exam of collar bone		Z3		$14.24
73010	X-ray exam of shoulder blade		Z3		$14.98
73020	X-ray exam of shoulder		Z3		$11.29

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
73030	X-ray exam of shoulder		Z3		$14.73
73040	Contrast x-ray of shoulder		N1		
73050	X-ray exam of shoulders		Z3		$19.40
73060	X-ray exam of humerus		Z3		$14.49
73070	X-ray exam of elbow		Z3		$14.49
73080	X-ray exam of elbow		Z3		$18.91
73085	Contrast x-ray of elbow		N1		
73090	X-ray exam of forearm		Z3		$13.99
73092	X-ray exam of arm, infant		Z3		$15.96
73100	X-ray exam of wrist		Z3		$15.47
73110	X-ray exam of wrist		Z3		$19.40
73115	Contrast x-ray of wrist		N1		
73120	X-ray exam of hand		Z3		$13.75
73130	X-ray exam of hand		Z3		$16.45
73140	X-ray exam of finger(s)		Z3		$17.43
73200	Ct upper extremity w/o dye		Z2	2.5969	$108.80
73201	Ct upper extremity w/dye		Z2	4.0105	$168.03
73202	Ct uppr extremity w/o&w/dye		Z2	4.447	$186.32
73206	Ct angio upr extrm w/o&w/dye		Z2	4.6	$192.73
73218	Mri upper extremity w/o dye		Z2	4.6406	$194.43
73219	Mri upper extremity w/dye		Z2	5.868	$245.86
73220	Mri uppr extremity w/o&w/dye		Z2	7.2057	$301.90
73221	Mri joint upr extrem w/o dye		Z2	4.6406	$194.43
73222	Mri joint upr extrem w/dye		Z2	5.868	$245.86
73223	Mri joint upr extr w/o&w/dye		Z2	7.2057	$301.90
73500	X-ray exam of hip		Z3		$12.28
73510	X-ray exam of hip		Z3		$19.15
73520	X-ray exam of hips		Z3		$19.40
73525	Contrast x-ray of hip		N1		
73530	X-ray exam of hip		N1		
73540	X-ray exam of pelvis & hips		Z3		$21.11
73542	X-ray exam, sacroiliac joint		N1		
73550	X-ray exam of thigh		Z3		$13.75
73560	X-ray exam of knee, 1 or 2		Z3		$14.73
73562	X-ray exam of knee, 3		Z3		$18.66
73564	X-ray exam, knee, 4 or more	CH	Z3		$21.36
73565	X-ray exam of knees		Z3		$16.94
73580	Contrast x-ray of knee joint		N1		
73590	X-ray exam of lower leg		Z3		$13.50
73592	X-ray exam of leg, infant		Z3		$16.20

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
73600	X-ray exam of ankle		Z3		$14.24
73610	X-ray exam of ankle		Z3		$16.94
73615	Contrast x-ray of ankle		N1		
73620	X-ray exam of foot		Z3		$13.75
73630	X-ray exam of foot		Z3		$16.70
73650	X-ray exam of heel		Z3		$13.99
73660	X-ray exam of toe(s)		Z3		$15.96
73700	Ct lower extremity w/o dye		Z2	2.5969	$108.80
73701	Ct lower extremity w/dye		Z2	4.0105	$168.03
73702	Ct lwr extremity w/o&w/dye		Z2	4.447	$186.32
73706	Ct angio lwr extr w/o&w/dye		Z2	4.6	$192.73
73718	Mri lower extremity w/o dye		Z2	4.6406	$194.43
73719	Mri lower extremity w/dye		Z2	5.868	$245.86
73720	Mri lwr extremity w/o&w/dye		Z2	7.2057	$301.90
73721	Mri jnt of lwr extre w/o dye		Z2	4.6406	$194.43
73722	Mri joint of lwr extr w/dye		Z2	5.868	$245.86
73723	Mri joint lwr extr w/o&w/dye		Z2	7.2057	$301.90
74000	X-ray exam of abdomen		Z3		$11.29
74010	X-ray exam of abdomen		Z3		$18.91
74020	X-ray exam of abdomen		Z3		$18.91
74022	X-ray exam series, abdomen		Z3		$22.83
74150	Ct abdomen w/o dye		Z2	2.5969	$108.80
74160	Ct abdomen w/dye		Z2	4.0105	$168.03
74170	Ct abdomen w/o & w/dye		Z2	4.447	$186.32
74175	Ct angio abdom w/o & w/dye		Z2	4.6	$192.73
74181	Mri abdomen w/o dye		Z2	4.6406	$194.43
74182	Mri abdomen w/dye		Z2	5.868	$245.86
74183	Mri abdomen w/o & w/dye		Z2	7.2057	$301.90
74190	X-ray exam of peritoneum		N1		
74210	Contrst x-ray exam of throat	CH	Z3		$42.47
74220	Contrast x-ray, esophagus	CH	Z3		$47.39
74230	Cine/vid x-ray, throat/esoph	CH	Z3		$45.67
74235	Remove esophagus obstruction		N1		
74240	X-ray exam, upper gi tract		Z2	1.1717	$49.09
74241	X-ray exam, upper gi tract		Z2	1.1717	$49.09
74245	X-ray exam, upper gi tract		Z2	1.9013	$79.66
74246	Contrst x-ray uppr gi tract		Z2	1.1717	$49.09
74247	Contrst x-ray uppr gi tract		Z2	1.1717	$49.09
74249	Contrst x-ray uppr gi tract		Z2	1.9013	$79.66
74250	X-ray exam of small bowel		Z2	1.1717	$49.09

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
74251	X-ray exam of small bowel		Z2	1.9013	$79.66
74260	X-ray exam of small bowel		Z2	1.1717	$49.09
74261	Ct colonography, w/o dye		Z2	2.5969	$108.80
74262	Ct colonography, w/dye		Z2	4.0105	$168.03
74270	Contrast x-ray exam of colon		Z2	1.1717	$49.09
74280	Contrast x-ray exam of colon		Z2	1.9013	$79.66
74283	Contrast x-ray exam of colon		Z2	1.1717	$49.09
74290	Contrast x-ray, gallbladder		Z3		$36.83
74291	Contrast x-rays, gallbladder		Z3		$38.06
74300	X-ray bile ducts/pancreas		N1		
74301	X-rays at surgery add-on		N1		
74305	X-ray bile ducts/pancreas		N1		
74320	Contrast x-ray of bile ducts		N1		
74327	X-ray bile stone removal		N1		
74328	X-ray bile duct endoscopy		N1		
74329	X-ray for pancreas endoscopy		N1		
74330	X-ray bile/panc endoscopy		N1		
74340	X-ray guide for GI tube		N1		
74355	X-ray guide, intestinal tube		N1		
74360	X-ray guide, GI dilation		N1		
74363	X-ray, bile duct dilation		N1		
74400	Contrst x-ray, urinary tract		Z3		$61.63
74410	Contrst x-ray, urinary tract		Z3		$64.08
74415	Contrst x-ray, urinary tract	CH	Z3		$79.06
74420	Contrst x-ray, urinary tract		Z2	2.3552	$98.68
74425	Contrst x-ray, urinary tract		N1		
74430	Contrast x-ray, bladder		N1		
74440	X-ray, male genital tract		N1		
74445	X-ray exam of penis		N1		
74450	X-ray, urethra/bladder		N1		
74455	X-ray, urethra/bladder		N1		
74470	X-ray exam of kidney lesion		N1		
74475	X-ray control, cath insert		N1		
74480	X-ray control, cath insert		N1		
74485	X-ray guide, GU dilation		N1		
74710	X-ray measurement of pelvis		Z3		$16.20
74740	X-ray, female genital tract		N1		
74742	X-ray, fallopian tube		N1		
74775	X-ray exam of perineum		Z2	2.3552	$98.68
75557	Cardiac mri for morph		Z2	4.6406	$194.43

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
75559	Cardiac mri w/stress img		Z2	4.6406	$194.43
75561	Cardiac mri for morph w/dye		Z2	7.2057	$301.90
75563	Card mri w/stress img & dye		Z2	7.2057	$301.90
75565	Card mri vel flw map add-on		N1		
75571	Ct hrt w/o dye w/ca test		Z2	0.6271	$26.27
75572	Ct hrt w/3d image		Z2	3.4356	$143.94
75573	Ct hrt w/3d image, congen		Z2	3.4356	$143.94
75574	Ct angio hrt w/3d image		Z2	3.4356	$143.94
75600	Contrast x-ray exam of aorta		N1		
75605	Contrast x-ray exam of aorta		N1		
75625	Contrast x-ray exam of aorta		N1		
75630	X-ray aorta, leg arteries		N1		
75635	Ct angio abdominal arteries		N1		
75650	Artery x-rays, head & neck		N1		
75658	Artery x-rays, arm		N1		
75660	Artery x-rays, head & neck		N1		
75662	Artery x-rays, head & neck		N1		
75665	Artery x-rays, head & neck		N1		
75671	Artery x-rays, head & neck		N1		
75676	Artery x-rays, neck		N1		
75680	Artery x-rays, neck		N1		
75685	Artery x-rays, spine		N1		
75705	Artery x-rays, spine		N1		
75710	Artery x-rays, arm/leg		N1		
75716	Artery x-rays, arms/legs		N1		
75722	Artery x-rays, kidney		N1		
75724	Artery x-rays, kidneys		N1		
75726	Artery x-rays, abdomen		N1		
75731	Artery x-rays, adrenal gland		N1		
75733	Artery x-rays, adrenals		N1		
75736	Artery x-rays, pelvis		N1		
75741	Artery x-rays, lung		N1		
75743	Artery x-rays, lungs		N1		
75746	Artery x-rays, lung		N1		
75756	Artery x-rays, chest		N1		
75774	Artery x-ray, each vessel		N1		
75791	Av dialysis shunt imaging		N1		
75801	Lymph vessel x-ray, arm/leg		N1		
75803	Lymph vessel x-ray,arms/legs		N1		
75805	Lymph vessel x-ray, trunk		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
75807	Lymph vessel x-ray, trunk		N1		
75809	Nonvascular shunt, x-ray		N1		
75810	Vein x-ray, spleen/liver		N1		
75820	Vein x-ray, arm/leg		N1		
75822	Vein x-ray, arms/legs		N1		
75825	Vein x-ray, trunk		N1		
75827	Vein x-ray, chest		N1		
75831	Vein x-ray, kidney		N1		
75833	Vein x-ray, kidneys		N1		
75840	Vein x-ray, adrenal gland		N1		
75842	Vein x-ray, adrenal glands		N1		
75860	Vein x-ray, neck		N1		
75870	Vein x-ray, skull		N1		
75872	Vein x-ray, skull		N1		
75880	Vein x-ray, eye socket		N1		
75885	Vein x-ray, liver		N1		
75887	Vein x-ray, liver		N1		
75889	Vein x-ray, liver		N1		
75891	Vein x-ray, liver		N1		
75893	Venous sampling by catheter		N1		
75894	X-rays, transcath therapy		N1		
75896	X-rays, transcath therapy		N1		
75898	Follow-up angiography		N1		
75901	Remove cva device obstruct		N1		
75902	Remove cva lumen obstruct		N1		
75940	X-ray placement, vein filter		N1		
75945	Intravascular us		N1		
75946	Intravascular us add-on		N1		
75960	Transcath iv stent rs&i		N1		
75961	Retrieval, broken catheter		N1		
75962	Repair arterial blockage		N1		
75964	Repair artery blockage, each		N1		
75966	Repair arterial blockage		N1		
75968	Repair artery blockage, each		N1		
75970	Vascular biopsy		N1		
75978	Repair venous blockage		N1		
75980	Contrast xray exam bile duct		N1		
75982	Contrast xray exam bile duct		N1		
75984	Xray control catheter change		N1		
75989	Abscess drainage under x-ray		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
75992	Atherectomy, x-ray exam		N1		
75993	Atherectomy, x-ray exam		N1		
75994	Atherectomy, x-ray exam		N1		
75995	Atherectomy, x-ray exam		N1		
75996	Atherectomy, x-ray exam		N1		
76000	Fluoroscope examination		N1		
76001	Fluoroscope exam, extensive		N1		
76010	X-ray, nose to rectum		Z3		$13.01
76080	X-ray exam of fistula		N1		
76098	X-ray exam, breast specimen		N1		
76100	X-ray exam of body section		Z2	1.0284	$43.09
76101	Complex body section x-ray	CH	Z3		$101.89
76102	Complex body section x-rays		Z2	3.0792	$129.01
76120	Cine/video x-rays	CH	Z3		$41.00
76125	Cine/video x-rays add-on		N1		
76150	X-ray exam, dry process		Z3		$14.98
76350	Special x-ray contrast study		N1		
76376	3d render w/o postprocess		N1		
76377	3d rendering w/postprocess		N1		
76380	CAT scan follow-up study		Z2	1.6032	$67.17
76496	Fluoroscopic procedure		Z2	1.1337	$47.50
76497	Ct procedure		Z2	1.6032	$67.17
76498	Mri procedure		Z2	4.6406	$194.43
76499	Radiographic procedure		Z2	0.6075	$25.45
76506	Echo exam of head		Z2	0.8419	$35.27
76510	Ophth us, b & quant a		Z3		$53.03
76511	Ophth us, quant a only		Z3		$34.62
76512	Ophth us, b w/non-quant a		Z3		$28.73
76513	Echo exam of eye, water bath		Z3		$38.55
76514	Echo exam of eye, thickness		Z3		$2.95
76516	Echo exam of eye	CH	Z3		$30.44
76519	Echo exam of eye		Z3		$33.88
76529	Echo exam of eye	CH	Z3		$29.71
76536	Us exam of head and neck		Z2	1.2964	$54.32
76604	Us exam, chest		Z2	0.8419	$35.27
76645	Us exam, breast(s)		Z2	0.8419	$35.27
76700	Us exam, abdom, complete		Z2	1.2964	$54.32
76705	Echo exam of abdomen		Z2	1.2964	$54.32
76770	Us exam abdo back wall, comp		Z2	1.2964	$54.32
76775	Us exam abdo back wall, lim		Z2	1.2964	$54.32

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
76776	Us exam k transpl w/doppler		Z2	1.2964	$54.32
76800	Us exam, spinal canal		Z2	1.2964	$54.32
76801	Ob us < 14 wks, single fetus		Z2	1.2964	$54.32
76802	Ob us < 14 wks, addl fetus		Z3		$20.38
76805	Ob us >/= 14 wks, sngl fetus		Z2	1.2964	$54.32
76810	Ob us >/= 14 wks, addl fetus		Z3		$34.86
76811	Ob us, detailed, sngl fetus	CH	Z3		$70.71
76812	Ob us, detailed, addl fetus		Z2	0.8419	$35.27
76813	Ob us nuchal meas, 1 gest		Z2	0.8419	$35.27
76814	Ob us nuchal meas, add-on		Z3		$22.83
76815	Ob us, limited, fetus(s)		Z2	0.8419	$35.27
76816	Ob us, follow-up, per fetus		Z2	0.8419	$35.27
76817	Transvaginal us, obstetric		Z2	0.8419	$35.27
76818	Fetal biophys profile w/nst	CH	Z3		$50.09
76819	Fetal biophys profil w/o nst		Z3		$38.06
76820	Umbilical artery echo		Z3		$15.71
76821	Middle cerebral artery echo		Z2	0.8419	$35.27
76825	Echo exam of fetal heart		Z3		$96.24
76826	Echo exam of fetal heart		Z3		$59.91
76827	Echo exam of fetal heart	CH	Z3		$27.01
76828	Echo exam of fetal heart		Z3		$14.98
76830	Transvaginal us, non-ob		Z2	1.2964	$54.32
76831	Echo exam, uterus		Z3		$63.59
76856	Us exam, pelvic, complete		Z2	1.2964	$54.32
76857	Us exam, pelvic, limited		Z2	0.8419	$35.27
76870	Us exam, scrotum		Z2	1.2964	$54.32
76872	Us, transrectal		Z2	1.2964	$54.32
76873	Echograp trans r, pros study		Z2	1.2964	$54.32
76880	Us exam, extremity		Z2	1.2964	$54.32
76885	Us exam infant hips, dynamic		Z2	0.8419	$35.27
76886	Us exam infant hips, static		Z2	0.8419	$35.27
76930	Echo guide, cardiocentesis		N1		
76932	Echo guide for heart biopsy		N1		
76936	Echo guide for artery repair		Z2	1.428	$59.83
76937	Us guide, vascular access		N1		
76940	Us guide, tissue ablation		N1		
76941	Echo guide for transfusion		N1		
76942	Echo guide for biopsy		N1		
76945	Echo guide, villus sampling		N1		
76946	Echo guide for amniocentesis		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
76948	Echo guide, ova aspiration		N1		
76950	Echo guidance radiotherapy		N1		
76965	Echo guidance radiotherapy		N1		
76970	Ultrasound exam follow-up		Z2	0.8419	$35.27
76975	GI endoscopic ultrasound		N1		
76977**	Us bone density measure		Z3		$5.40
76998	Us guide, intraop		N1		
76999	Echo examination procedure		Z2	0.8419	$35.27
77001	Fluoroguide for vein device		N1		
77002	Needle localization by xray		N1		
77003	Fluoroguide for spine inject		N1		
77011	Ct scan for localization		N1		
77012	Ct scan for needle biopsy		N1		
77013	Ct guide for tissue ablation		N1		
77014	Ct scan for therapy guide		N1		
77021	Mr guidance for needle place		N1		
77022	Mri for tissue ablation		N1		
77031	Stereotact guide for brst bx		N1		
77032	Guidance for needle, breast		N1		
77053	X-ray of mammary duct		N1		
77054	X-ray of mammary ducts		N1		
77071	X-ray stress view		Z3		$21.61
77072	X-rays for bone age		Z3		$9.82
77073	X-rays, bone length studies		Z3		$16.94
77074	X-rays, bone survey, limited		Z3		$33.15
77075	X-rays, bone survey complete		Z2	1.0284	$43.09
77076	X-rays, bone survey, infant		Z2	1.0284	$43.09
77077	Joint survey, single view		Z3		$18.17
77078**	Ct bone density, axial		Z2	0.9601	$40.23
77079**	Ct bone density, peripheral		Z3		$28.23
77080**	Dxa bone density, axial		Z2	0.9601	$40.23
77081**	Dxa bone density/peripheral	CH	Z3		$13.50
77082	Dxa bone density, vert fx		Z3		$19.89
77083**	Radiographic absorptiometry		Z3		$10.80
77084	Magnetic image, bone marrow		Z2	4.6406	$194.43
77280	Set radiation therapy field		Z2	1.4	$58.66
77285	Set radiation therapy field		Z2	3.7053	$155.24
77290	Set radiation therapy field		Z2	3.7053	$155.24
77295	Set radiation therapy field		Z3		$242.57
77299	Radiation therapy planning		Z2	1.4	$58.66

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
77300	Radiation therapy dose plan		Z3		$27.99
77301	Radiotherapy dose plan, imrt		Z2	12.3307	$516.63
77305	Teletx isodose plan simple		Z3		$22.59
77310	Teletx isodose plan intermed		Z3		$29.95
77315	Teletx isodose plan complex		Z3		$46.89
77321	Special teletx port plan		Z3		$43.21
77326	Brachytx isodose calc simp		Z2	1.4	$58.66
77327	Brachytx isodose calc interm		Z3		$98.45
77328	Brachytx isodose plan compl	CH	Z3		$125.22
77331	Special radiation dosimetry		Z3		$13.99
77332	Radiation treatment aid(s)		Z3		$37.32
77333	Radiation treatment aid(s)		Z3		$12.52
77334	Radiation treatment aid(s)		Z3		$66.54
77336	Radiation physics consult		Z3		$37.81
77338	Design mlc device for imrt		Z2	2.638	$110.53
77370	Radiation physics consult		Z2	1.4	$58.66
77371	Srs, multisource		Z2	96.1451	$4,028.29
77399	External radiation dosimetry		Z2	1.4	$58.66
77401	Radiation treatment delivery		Z3		$18.17
77402	Radiation treatment delivery		Z2	1.3106	$54.91
77403	Radiation treatment delivery		Z2	1.3106	$54.91
77404	Radiation treatment delivery		Z2	1.3106	$54.91
77406	Radiation treatment delivery		Z2	1.3106	$54.91
77407	Radiation treatment delivery		Z2	1.3106	$54.91
77408	Radiation treatment delivery		Z2	1.3106	$54.91
77409	Radiation treatment delivery		Z2	1.3106	$54.91
77411	Radiation treatment delivery		Z2	2.1581	$90.42
77412	Radiation treatment delivery		Z2	2.1581	$90.42
77413	Radiation treatment delivery		Z2	2.1581	$90.42
77414	Radiation treatment delivery		Z2	2.1581	$90.42
77416	Radiation treatment delivery		Z2	2.1581	$90.42
77417	Radiology port film(s)		N1		
77418	Radiation tx delivery, imrt		Z2	5.8592	$245.49
77421	Stereoscopic x-ray guidance		N1		
77422	Neutron beam tx, simple		Z2	2.1581	$90.42
77423	Neutron beam tx, complex		Z2	2.1581	$90.42
77435	Sbrt management		N1		
77470	Special radiation treatment		Z3		$70.22
77520	Proton trmt, simple w/o comp		Z2	12.0133	$503.33
77522	Proton trmt, simple w/comp		Z2	12.0133	$503.33

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
77523	Proton trmt, intermediate		Z2	15.7152	$658.44
77525	Proton treatment, complex		Z2	15.7152	$658.44
77600	Hyperthermia treatment		Z2	5.1942	$217.63
77605	Hyperthermia treatment		Z2	5.1942	$217.63
77610	Hyperthermia treatment		Z2	5.1942	$217.63
77615	Hyperthermia treatment		Z2	5.1942	$217.63
77620	Hyperthermia treatment		Z2	5.1942	$217.63
77750	Infuse radioactive materials	CH	Z3		$73.66
77761	Apply intrcav radiat simple		Z3		$127.67
77762	Apply intrcav radiat interm	CH	Z3		$149.03
77763	Apply intrcav radiat compl	CH	Z3		$192.98
77776	Apply interstit radiat simpl		Z3		$133.56
77777	Apply interstit radiat inter	CH	Z3		$145.10
77778	Apply interstit radiat compl		Z3		$197.89
77785	Hdr brachytx, 1 channel		Z3		$108.03
77786	Hdr brachytx, 2-12 channel		Z3		$297.32
77787	Hdr brachytx over 12 chan		Z2	9.4592	$396.32
77789	Apply surface radiation		Z3		$39.04
77790	Radiation handling		N1		
77799	Radium/radioisotope therapy		Z2	4.6337	$194.14
78000	Thyroid, single uptake		Z3		$43.70
78001	Thyroid, multiple uptakes	CH	Z3		$55.24
78003	Thyroid suppress/stimul		Z3		$44.68
78006	Thyroid imaging with uptake		Z2	2.9893	$125.25
78007	Thyroid image, mult uptakes		Z3		$118.10
78010	Thyroid imaging		Z2	1.8521	$77.60
78011	Thyroid imaging with flow		Z2	1.8521	$77.60
78015	Thyroid met imaging		Z3		$127.67
78016	Thyroid met imaging/studies		Z2	3.8971	$163.28
78018	Thyroid met imaging, body		Z2	3.8971	$163.28
78020	Thyroid met uptake		N1		
78070	Parathyroid nuclear imaging		Z3		$87.41
78075	Adrenal nuclear imaging		Z3		$273.51
78099	Endocrine nuclear procedure		Z2	1.8521	$77.60
78102	Bone marrow imaging, ltd		Z3		$97.47
78103	Bone marrow imaging, mult	CH	Z3		$128.16
78104	Bone marrow imaging, body		Z2	3.4416	$144.20
78110	Plasma volume, single		Z3		$50.82
78111	Plasma volume, multiple		Z3		$54.26
78120	Red cell mass, single		Z3		$52.79

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
78121	Red cell mass, multiple		Z3		$58.92
78122	Blood volume		Z3		$63.59
78130	Red cell survival study		Z3		$86.18
78135	Red cell survival kinetics	CH	Z3		$218.27
78140	Red cell sequestration		Z3		$75.62
78185	Spleen imaging	CH	Z3		$126.44
78190	Platelet survival, kinetics		Z2	2.366	$99.13
78191	Platelet survival		Z2	2.366	$99.13
78195	Lymph system imaging		Z2	3.4416	$144.20
78199	Blood/lymph nuclear exam		Z2	3.4416	$144.20
78201	Liver imaging		Z3		$114.66
78202	Liver imaging with flow		Z3		$125.22
78205	Liver imaging (3D)	CH	Z3		$135.04
78206	Liver image (3d) with flow		Z2	3.828	$160.39
78215	Liver and spleen imaging		Z3		$117.11
78216	Liver & spleen image/flow		Z3		$71.69
78220	Liver function study		Z3		$79.06
78223	Hepatobiliary imaging		Z2	3.828	$160.39
78230	Salivary gland imaging		Z3		$99.93
78231	Serial salivary imaging		Z3		$71.94
78232	Salivary gland function exam		Z3		$67.03
78258	Esophageal motility study	CH	Z3		$134.05
78261	Gastric mucosa imaging		Z2	3.2798	$137.42
78262	Gastroesophageal reflux exam		Z2	3.2798	$137.42
78264	Gastric emptying study		Z2	3.2798	$137.42
78270	Vit B-12 absorption exam		Z3		$50.09
78271	Vit b-12 absrp exam, int fac		Z3		$53.52
78272	Vit B-12 absorp, combined		Z3		$54.26
78278	Acute GI blood loss imaging		Z2	3.2798	$137.42
78282	GI protein loss exam		Z2	3.2798	$137.42
78290	Meckels divert exam		Z2	3.2798	$137.42
78291	Leveen/shunt patency exam		Z2	3.2798	$137.42
78299	GI nuclear procedure		Z2	3.2798	$137.42
78300	Bone imaging, limited area		Z3		$101.40
78305	Bone imaging, multiple areas	CH	Z3		$134.05
78306	Bone imaging, whole body		Z2	3.3303	$139.53
78315	Bone imaging, 3 phase		Z2	3.3303	$139.53
78320	Bone imaging (3D)	CH	Z3		$135.53
78399	Musculoskeletal nuclear exam		Z2	3.3303	$139.53
78414	Non-imaging heart function		Z2	3.9745	$166.52

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
78428	Cardiac shunt imaging		Z3		$109.26
78445	Vascular flow imaging	CH	Z3		$103.36
78451	Ht muscle image spect, sing		Z3		$194.21
78452	Ht muscle image spect, mult		Z3		$283.58
78453	Ht muscle image,planar,sing		Z3		$170.15
78454	Ht musc image, planar, mult		Z3		$247.98
78456	Acute venous thrombus image		Z2	3.2659	$136.83
78457	Venous thrombosis imaging	CH	Z3		$111.22
78458	Ven thrombosis images, bilat	CH	Z3		$107.78
78459	Heart muscle imaging (PET)		Z2	14.6357	$613.21
78466	Heart infarct image		Z3		$102.63
78468	Heart infarct image (ef)		Z3		$126.20
78469	Heart infarct image (3D)	CH	Z3		$148.29
78472	Gated heart, planar, single	CH	Z3		$142.89
78473	Gated heart, multiple		Z2	3.9745	$166.52
78481	Heart first pass, single		Z3		$113.68
78483	Heart first pass, multiple	CH	Z3		$152.96
78491	Heart image (pet), single		Z2	14.6357	$613.21
78492	Heart image (pet), multiple		Z2	14.6357	$613.21
78494	Heart image, spect	CH	Z3		$147.07
78496	Heart first pass add-on		N1		
78499	Cardiovascular nuclear exam		Z2	3.9745	$166.52
78580	Lung perfusion imaging		Z2	2.7182	$113.89
78584	Lung V/Q image single breath		Z3		$71.94
78585	Lung V/Q imaging		Z2	4.3339	$181.58
78586	Aerosol lung image, single	CH	Z3		$102.38
78587	Aerosol lung image, multiple		Z2	2.7182	$113.89
78588	Perfusion lung image		Z2	4.3339	$181.58
78591	Vent image, 1 breath, 1 proj	CH	Z3		$103.85
78593	Vent image, 1 proj, gas		Z2	2.7182	$113.89
78594	Vent image, mult proj, gas		Z2	2.7182	$113.89
78596	Lung differential function		Z2	4.3339	$181.58
78599	Respiratory nuclear exam		Z2	2.7182	$113.89
78600	Brain image < 4 views	CH	Z3		$109.99
78601	Brain image w/flow < 4 views		Z3		$131.35
78605	Brain image 4+ views	CH	Z3		$118.83
78606	Brain image w/flow 4 + views		Z3		$204.76
78607	Brain imaging (3D)		Z3		$213.11
78608	Brain imaging (PET)		Z2	13.9981	$586.49
78610	Brain flow imaging only	CH	Z3		$113.43

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
78630	Cerebrospinal fluid scan		Z3		$211.88
78635	CSF ventriculography		Z3		$203.05
78645	CSF shunt evaluation		Z2	3.1002	$129.89
78647	Cerebrospinal fluid scan		Z3		$213.11
78650	CSF leakage imaging		Z3		$209.67
78660	Nuclear exam of tear flow	CH	Z3		$105.33
78699	Nervous system nuclear exam		Z2	3.1002	$129.89
78700	Kidney imaging, morphol		Z3		$107.54
78701	Kidney imaging with flow		Z3		$131.84
78707	K flow/funct image w/o drug		Z3		$133.56
78708	K flow/funct image w/drug		Z3		$84.46
78709	K flow/funct image, multiple		Z2	4.2985	$180.10
78710	Kidney imaging (3D)		Z3		$134.30
78725	Kidney function study		Z3		$58.43
78730	Urinary bladder retention		Z3		$47.14
78740	Ureteral reflux study		Z3		$135.77
78761	Testicular imaging w/flow		Z3		$124.48
78799	Genitourinary nuclear exam		Z2	4.2985	$180.10
78800	Tumor imaging, limited area		Z3		$108.03
78801	Tumor imaging, mult areas		Z3		$149.77
78802	Tumor imaging, whole body		Z3		$199.61
78803	Tumor imaging (3D)		Z3		$209.43
78804	Tumor imaging, whole body		Z3		$370.49
78805	Abscess imaging, ltd area		Z3		$103.85
78806	Abscess imaging, whole body		Z3		$207.46
78807	Nuclear localization/abscess		Z2	3.8971	$163.28
78808	Iv inj ra drug dx study		N1		
78811	Pet image, ltd area		Z2	13.9981	$586.49
78812	Pet image, skull-thigh		Z2	13.9981	$586.49
78813	Pet image, full body		Z2	13.9981	$586.49
78814	Pet image w/ct, lmtd		Z2	13.9981	$586.49
78815	Pet image w/ct, skull-thigh		Z2	13.9981	$586.49
78816	Pet image w/ct, full body		Z2	13.9981	$586.49
78999	Nuclear diagnostic exam		Z2	1.4335	$60.06
79005	Nuclear rx, oral admin		Z3		$38.55
79101	Nuclear rx, iv admin		Z3		$41.98
79200	Nuclear rx, intracav admin		Z3		$47.39
79300	Nuclr rx, interstit colloid		Z2	2.988	$125.19
79403	Hematopoietic nuclear tx		Z3		$65.55
79440	Nuclear rx, intra-articular		Z3		$40.02

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
79445	Nuclear rx, intra-arterial		Z2	2.988	$125.19
79999	Nuclear medicine therapy		Z2	2.988	$125.19
90371	Hep b ig, im		K2		$115.97
90375	Rabies ig, im/sc		K2		$139.75
90376	Rabies ig, heat treated		K2		$152.38
90378	Rsv, mab, im, 50mg		K2		$510.69
90385	Rh ig, minidose, im		N1		
90396	Varicella-zoster ig, im		K2		$147.58
90476	Adenovirus vaccine, type 4		K2		$173.84
90585	Bcg vaccine, percut		K2		$109.47
90632	Hep a vaccine, adult im		N1		
90633	Hep a vacc, ped/adol, 2 dose		N1		
90634	Hep a vacc, ped/adol, 3 dose		N1		
90636	Hep a/hep b vacc, adult im		N1		
90645	Hib vaccine, hboc, im		N1		
90646	Hib vaccine, prp-d, im		N1		
90647	Hib vaccine, prp-omp, im		N1		
90648	Hib vaccine, prp-t, im		N1		
90655**	Flu vaccine no preserv 6-35m		L1		
90656**	Flu vaccine no preserv 3 & >		L1		
90657**	Flu vaccine, 3 yrs, im		L1		
90658**	Flu vaccine, 3 yrs & >, im		L1		
90660**	Flu vaccine, nasal		L1		
90665	Lyme disease vaccine, im	CH	N1		
90669**	Pneumococcal vacc, 7 val im		L1		
90670**	Pneumococcal vacc, 13 val im	CH	L1		
90675	Rabies vaccine, im		K2		$181.27
90676	Rabies vaccine, id		K2		$98.12
90680	Rotovirus vacc 3 dose, oral		K2		$73.76
90681	Rotavirus vacc 2 dose oral		K2		$102.50
90690	Typhoid vaccine, oral		N1		
90691	Typhoid vaccine, im		N1		
90692	Typhoid vaccine, h-p, sc/id		N1		
90696	Dtap-ipv vacc 4-6 yr im		N1		
90698	Dtap-hib-ip vaccine, im		N1		
90700	Dtap vaccine, < 7 yrs, im		N1		
90701	Dtp vaccine, im		N1		
90702	Dt vaccine < 7, im		N1		
90703	Tetanus vaccine, im		N1		
90704	Mumps vaccine, sc		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
90705	Measles vaccine, sc		N1		
90706	Rubella vaccine, sc		N1		
90707	Mmr vaccine, sc		N1		
90708	Measles-rubella vaccine, sc		N1		
90710	Mmrv vaccine, sc		N1		
90712	Oral poliovirus vaccine		N1		
90713	Poliovirus, ipv, sc/im		N1		
90714	Td vaccine no prsrv >/= 7 im		N1		
90715	Tdap vaccine >7 im		N1		
90717	Yellow fever vaccine, sc		N1		
90718	Td vaccine > 7, im		N1		
90719	Diphtheria vaccine, im		N1		
90720	Dtp/hib vaccine, im		N1		
90721	Dtap/hib vaccine, im		N1		
90725	Cholera vaccine, injectable		K2		$103.90
90732**	Pneumococcal vaccine		L1		
90733	Meningococcal vaccine, sc		K2		$103.41
90734	Meningococcal vaccine, im		K2		$103.41
90735	Encephalitis vaccine, sc		K2		$102.08
90740**	Hepb vacc, ill pat 3 dose im		F4		
90743**	Hep b vacc, adol, 2 dose, im		F4		
90744**	Hepb vacc ped/adol 3 dose im		F4		
90746**	Hep b vaccine, adult, im		F4		
90747**	Hepb vacc, ill pat 4 dose im		F4		
90749	Vaccine toxoid		N1		
A4218	Sterile saline or water		N1		
A4220	Infusion pump refill kit		N1		
A4248	Chlorhexidine antisept		N1		
A4262	Temporary tear duct plug		N1		
A4263	Permanent tear duct plug		N1		
A4270	Disposable endoscope sheath		N1		
A4300	Cath impl vasc access portal		N1		
A4301	Implantable access syst perc		N1		
A4305	Drug delivery system >=50 ML		N1		
A4306	Drug delivery system <=50 ml		N1		
A4641	Radiopharm dx agent noc		N1		
A4642	In111 satumomab		N1		
A4648	Implantable tissue marker		N1		
A4650	Implant radiation dosimeter		N1		
A9500	Tc99m sestamibi		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
A9501	Technetium TC-99m teboroxime		N1		
A9502	Tc99m tetrofosmin		N1		
A9503	Tc99m medronate		N1		
A9504	Tc99m apcitide		N1		
A9505	TL201 thallium		N1		
A9507	In111 capromab		N1		
A9508	I131 iodobenguate, dx		N1		
A9509	Iodine I-123 sod iodide mil		N1		
A9510	Tc99m disofenin		N1		
A9512	Tc99m pertechnetate		N1		
A9516	Iodine I-123 sod iodide mic		N1		
A9521	Tc99m exametazime		N1		
A9524	I131 serum albumin, dx		N1		
A9526	Nitrogen N-13 ammonia		N1		
A9527	Iodine I-125 sodium iodide		H2		$21.01
A9528	Iodine I-131 iodide cap, dx		N1		
A9529	I131 iodide sol, dx		N1		
A9531	I131 max 100uCi		N1		
A9532	I125 serum albumin, dx		N1		
A9536	Tc99m depreotide		N1		
A9537	Tc99m mebrofenin		N1		
A9538	Tc99m pyrophosphate		N1		
A9539	Tc99m pentetate		N1		
A9540	Tc99m MAA		N1		
A9541	Tc99m sulfur colloid		N1		
A9542	In111 ibritumomab, dx		N1		
A9544	I131 tositumomab, dx		N1		
A9546	Co57/58		N1		
A9547	In111 oxyquinoline		N1		
A9548	In111 pentetate		N1		
A9550	Tc99m gluceptate		N1		
A9551	Tc99m succimer		N1		
A9552	F18 fdg		N1		
A9553	Cr51 chromate		N1		
A9554	I125 iothalamate, dx		N1		
A9555	Rb82 rubidium		N1		
A9556	Ga67 gallium		N1		
A9557	Tc99m bicisate		N1		
A9558	Xe133 xenon 10mci		N1		
A9559	Co57 cyano		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
A9560	Tc99m labeled rbc		N1		
A9561	Tc99m oxidronate		N1		
A9562	Tc99m mertiatide		N1		
A9566	Tc99m fanolesomab		N1		
A9567	Technetium TC-99m aerosol		N1		
A9568	Technetium tc99m arcitumomab		N1		
A9569	Technetium TC-99m auto WBC		N1		
A9570	Indium In-111 auto WBC		N1		
A9571	Indium IN-111 auto platelet		N1		
A9572	Indium In-111 pentetreotide		N1		
A9576	Inj prohance multipack		N1		
A9577	Inj multihance		N1		
A9578	Inj multihance multipack		N1		
A9579	Gad-base MR contrast NOS,1ml		N1		
A9580	Sodium fluoride F-18		N1		
A9581	Gadoxetate disodium inj	CH	N1		
A9582	Iodine I-123 iobenguane		K2		$2,282.67
A9583	Gadofosveset trisodium inj		K2		$12.89
A9698	Non-rad contrast materialNOC		N1		
C1713	Anchor/screw bn/bn,tis/bn		N1		
C1714	Cath, trans atherectomy, dir		N1		
C1715	Brachytherapy needle		N1		
C1716	Brachytx, non-str, Gold-198		H2		$184.45
C1717	Brachytx, non-str,HDR Ir-192		H2		$220.22
C1719	Brachytx, NS, Non-HDRIr-192		H2		$22.98
C1721	AICD, dual chamber		N1		
C1722	AICD, single chamber		N1		
C1724	Cath, trans atherec,rotation		N1		
C1725	Cath, translumin non-laser		N1		
C1726	Cath, bal dil, non-vascular		N1		
C1727	Cath, bal tis dis, non-vas		N1		
C1728	Cath, brachytx seed adm		N1		
C1729	Cath, drainage		N1		
C1730	Cath, EP, 19 or few elect		N1		
C1731	Cath, EP, 20 or more elec		N1		
C1732	Cath, EP, diag/abl, 3D/vect		N1		
C1733	Cath, EP, othr than cool-tip		N1		
C1750	Cath, hemodialysis,long-term		N1		
C1751	Cath, inf, per/cent/midline		N1		
C1752	Cath,hemodialysis,short-term		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
C1753	Cath, intravas ultrasound		N1		
C1754	Catheter, intradiscal		N1		
C1755	Catheter, intraspinal		N1		
C1756	Cath, pacing, transesoph		N1		
C1757	Cath, thrombectomy/embolect		N1		
C1758	Catheter, ureteral		N1		
C1759	Cath, intra echocardiography		N1		
C1760	Closure dev, vasc		N1		
C1762	Conn tiss, human(inc fascia)		N1		
C1763	Conn tiss, non-human		N1		
C1764	Event recorder, cardiac		N1		
C1765	Adhesion barrier		N1		
C1766	Intro/sheath,strble,non-peel		N1		
C1767	Generator, neuro non-recharg		N1		
C1768	Graft, vascular		N1		
C1769	Guide wire		N1		
C1770	Imaging coil, MR, insertable		N1		
C1771	Rep dev, urinary, w/sling		N1		
C1772	Infusion pump, programmable		N1		
C1773	Ret dev, insertable		N1		
C1776	Joint device (implantable)		N1		
C1777	Lead, AICD, endo single coil		N1		
C1778	Lead, neurostimulator		N1		
C1779	Lead, pmkr, transvenous VDD		N1		
C1780	Lens, intraocular (new tech)		N1		
C1781	Mesh (implantable)		N1		
C1782	Morcellator		N1		
C1783	Ocular imp, aqueous drain de		N1		
C1784	Ocular dev, intraop, det ret		N1		
C1785	Pmkr, dual, rate-resp		N1		
C1786	Pmkr, single, rate-resp		N1		
C1787	Patient progr, neurostim		N1		
C1788	Port, indwelling, imp		N1		
C1789	Prosthesis, breast, imp		N1		
C1813	Prosthesis, penile, inflatab		N1		
C1814	Retinal tamp, silicone oil		N1		
C1815	Pros, urinary sph, imp		N1		
C1816	Receiver/transmitter, neuro		N1		
C1817	Septal defect imp sys		N1		
C1818	Integrated keratoprosthesis		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
C1819	Tissue localization-excision		N1		
C1820	Generator neuro rechg bat sy		N1		
C1821	Interspinous implant		N1		
C1874	Stent, coated/cov w/del sys		N1		
C1875	Stent, coated/cov w/o del sy		N1		
C1876	Stent, non-coa/non-cov w/del		N1		
C1877	Stent, non-coat/cov w/o del		N1		
C1878	Matrl for vocal cord		N1		
C1879	Tissue marker, implantable		N1		
C1880	Vena cava filter		N1		
C1881	Dialysis access system		N1		
C1882	AICD, other than sing/dual		N1		
C1883	Adapt/ext, pacing/neuro lead		N1		
C1884	Embolization Protect syst		N1		
C1885	Cath, translumin angio laser		N1		
C1887	Catheter, guiding		N1		
C1888	Endovas non-cardiac abl cath		N1		
C1891	Infusion pump,non-prog, perm		N1		
C1892	Intro/sheath,fixed,peel-away		N1		
C1893	Intro/sheath, fixed,non-peel		N1		
C1894	Intro/sheath, non-laser		N1		
C1895	Lead, AICD, endo dual coil		N1		
C1896	Lead, AICD, non sing/dual		N1		
C1897	Lead, neurostim test kit		N1		
C1898	Lead, pmkr, other than trans		N1		
C1899	Lead, pmkr/AICD combination		N1		
C1900	Lead, coronary venous		N1		
C2614	Probe, perc lumb disc		N1		
C2615	Sealant, pulmonary, liquid		N1		
C2616	Brachytx, non-str,Yttrium-90		H2		$16,775.76
C2617	Stent, non-cor, tem w/o del		N1		
C2618	Probe, cryoablation		N1		
C2619	Pmkr, dual, non rate-resp		N1		
C2620	Pmkr, single, non rate-resp		N1		
C2621	Pmkr, other than sing/dual		N1		
C2622	Prosthesis, penile, non-inf		N1		
C2625	Stent, non-cor, tem w/del sy		N1		
C2626	Infusion pump, non-prog,temp		N1		
C2627	Cath, suprapubic/cystoscopic		N1		
C2628	Catheter, occlusion		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
C2629	Intro/sheath, laser		N1		
C2630	Cath, EP, cool-tip		N1		
C2631	Rep dev, urinary, w/o sling		N1		
C2634	Brachytx, non-str, HA, I-125		H2		$51.86
C2635	Brachytx, non-str, HA, P-103		H2		$29.61
C2636	Brachy linear, non-str,P-103		H2		$36.04
C2638	Brachytx, stranded, I-125		H2		$38.65
C2639	Brachytx, non-stranded,I-125		H2		$36.13
C2640	Brachytx, stranded, P-103		H2		$63.72
C2641	Brachytx, non-stranded,P-103		H2		$62.36
C2642	Brachytx, stranded, C-131		H2		$114.51
C2643	Brachytx, non-stranded,C-131		H2		$62.42
C2698	Brachytx, stranded, NOS		H2		$38.65
C2699	Brachytx, non-stranded, NOS		H2		$22.98
C8900	MRA w/cont, abd		Z2	5.868	$245.86
C8901	MRA w/o cont, abd		Z2	4.6406	$194.43
C8902	MRA w/o fol w/cont, abd		Z2	7.2057	$301.90
C8903	MRI w/cont, breast, uni		Z2	5.868	$245.86
C8904	MRI w/o cont, breast, uni		Z2	4.6406	$194.43
C8905	MRI w/o fol w/cont, brst, un		Z2	7.2057	$301.90
C8906	MRI w/cont, breast, bi		Z2	5.868	$245.86
C8907	MRI w/o cont, breast, bi		Z2	4.6406	$194.43
C8908	MRI w/o fol w/cont, breast,		Z2	7.2057	$301.90
C8909	MRA w/cont, chest		Z2	5.868	$245.86
C8910	MRA w/o cont, chest		Z2	4.6406	$194.43
C8911	MRA w/o fol w/cont, chest		Z2	7.2057	$301.90
C8912	MRA w/cont, lwr ext		Z2	5.868	$245.86
C8913	MRA w/o cont, lwr ext		Z2	4.6406	$194.43
C8914	MRA w/o fol w/cont, lwr ext		Z2	7.2057	$301.90
C8918	MRA w/cont, pelvis		Z2	5.868	$245.86
C8919	MRA w/o cont, pelvis		Z2	4.6406	$194.43
C8920	MRA w/o fol w/cont, pelvis		Z2	7.2057	$301.90
C9113	Inj pantoprazole sodium, via		N1		
C9121	Injection, argatroban		K2		$18.39
C9248	Inj, clevidipine butyrate		K2		$2.98
C9250	Artiss fibrin sealant		K2		$136.64
C9254	Injection, lacosamide		K2		$0.18
C9255	Paliperidone palmitate inj		K2		$6.54
C9256	Dexamethasone intravitreal		K2		$196.10
C9257	Bevacizumab injection		K2		$1.44

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
C9258	Telavancin injection		K2		$0.21
C9259	Pralatrexate injection		K2		$165.63
C9260	Ofatumumab injection		K2		$46.64
C9261	Ustekinumab injection		K2		$107.43
C9262	Fludarabine phosphate, oral		K2		$81.77
C9263	Ecallantide injection		K2		$280.90
C9352	Neuragen nerve guide, per cm		N1		
C9353	Neurawrap nerve protector,cm		N1		
C9354	Veritas collagen matrix, cm2		N1		
C9355	Neuromatrix nerve cuff, cm		N1		
C9356	TenoGlide tendon prot, cm2	CH	N1		
C9358	SurgiMend, fetal		K2		$10.67
C9359	Implnt,bon void filler-putty	CH	N1		
C9360	SurgiMend, neonatal		K2		$11.24
C9361	NeuroMend nerve wrap		K2		$265.18
C9362	Implnt,bon void filler-strip		K2		$50.88
C9363	Integra Meshed Bil Wound Mat		K2		$17.88
C9364	Porcine implant, Permacol		K2		$17.67
C9399	Unclassified drugs or biolog		K7		
E0616	Cardiac event recorder		N1		
E0749	Elec osteogen stim implanted		N1		
E0782	Non-programble infusion pump		N1		
E0783	Programmable infusion pump		N1		
E0785	Replacement impl pump cathet		N1		
E0786	Implantable pump replacement		N1		
G0130**	Single energy x-ray study		Z3		$15.71
G0173	Linear acc stereo radsur com		Z2	45.4605	$1,904.70
G0251	Linear acc based stero radio		Z2	12.5279	$524.89
G0288	Recon, CTA for surg plan		N1		
G0339	Robot lin-radsurg com, first		Z2	45.4605	$1,904.70
G0340	Robt lin-radsurg fractx 2-5		Z2	33.5039	$1,403.75
J0120	Tetracyclin injection		N1		
J0129	Abatacept injection		K2		$19.96
J0130	Abciximab injection		K2		$462.83
J0132	Acetylcysteine injection		K2		$2.45
J0133	Acyclovir injection		N1		
J0135	Adalimumab injection		K2		$374.48
J0150	Injection adenosine 6 MG	CH	N1		
J0152	Adenosine injection		K2		$82.72
J0170	Adrenalin epinephrin inject		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J0180	Agalsidase beta injection		K2		$136.24
J0200	Alatrofloxacin mesylate		N1		
J0205	Alglucerase injection		K2		$41.98
J0207	Amifostine		K2		$327.97
J0210	Methyldopate hcl injection		K2		$36.34
J0215	Alefacept		K2		$30.63
J0220	Alglucosidase alfa injection		K2		$127.08
J0256	Alpha 1 proteinase inhibitor		K2		$3.77
J0278	Amikacin sulfate injection		N1		
J0280	Aminophyllin 250 MG inj		N1		
J0282	Amiodarone HCl		N1		
J0285	Amphotericin B		N1		
J0287	Amphotericin b lipid complex		K2		$9.84
J0288	Ampho b cholesteryl sulfate		K2		$14.00
J0289	Amphotericin b liposome inj		K2		$15.78
J0290	Ampicillin 500 MG inj		N1		
J0295	Ampicillin sodium per 1.5 gm		N1		
J0300	Amobarbital 125 MG inj		N1		
J0330	Succinycholine chloride inj		N1		
J0348	Anidulafungin injection	CH	N1		
J0360	Hydralazine hcl injection		N1		
J0364	Apomorphine hydrochloride		N1		
J0365	Aprotonin, 10,000 kiu	CH	N1		
J0380	Inj metaraminol bitartrate		N1		
J0390	Chloroquine injection		N1		
J0400	Aripiprazole injection		N1		
J0456	Azithromycin		N1		
J0461	Atropine sulfate injection		N1		
J0470	Dimecaprol injection	CH	N1		
J0475	Baclofen 10 MG injection		K2		$203.89
J0476	Baclofen intrathecal trial		K2		$73.50
J0480	Basiliximab		K2		$1,755.73
J0500	Dicyclomine injection		N1		
J0515	Inj benztropine mesylate	CH	K2		$42.16
J0520	Bethanechol chloride inject		N1		
J0559	PenG benzathine/procaine inj		N1		
J0560	Penicillin g benzathine inj		N1		
J0570	Penicillin g benzathine inj		N1		
J0580	Penicillin g benzathine inj		N1		
J0583	Bivalirudin		K2		$2.41

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J0585	Injection,onabotulinumtoxinA		K2		$5.49
J0586	AbobotulinumtoxintypeA		K2		$7.71
J0587	Inj, rimabotulinumtoxinB		K2		$10.58
J0592	Buprenorphine hydrochloride		N1		
J0594	Busulfan injection		K2		$14.45
J0595	Butorphanol tartrate 1 mg		N1		
J0598	C1 esterase inhibitor inj		K2		$42.75
J0600	Edetate calcium disodium inj		K2		$197.37
J0610	Calcium gluconate injection		N1		
J0620	Calcium glycer & lact/10 ML		N1		
J0630	Calcitonin salmon injection		K2		$49.26
J0636	Inj calcitriol per 0.1 mcg		N1		
J0637	Caspofungin acetate		K2		$11.59
J0640	Leucovorin calcium injection		N1		
J0641	Levoleucovorin injection		K2		$0.78
J0670	Inj mepivacaine HCL/10 ml		N1		
J0690	Cefazolin sodium injection		N1		
J0692	Cefepime HCl for injection		N1		
J0694	Cefoxitin sodium injection		N1		
J0696	Ceftriaxone sodium injection		N1		
J0697	Sterile cefuroxime injection		N1		
J0698	Cefotaxime sodium injection		N1		
J0702	Betamethasone acet&sod phosp		N1		
J0704	Betamethasone sod phosp/4 MG		N1		
J0706	Caffeine citrate injection		N1		
J0710	Cephapirin sodium injection		N1		
J0713	Inj ceftazidime per 500 mg		N1		
J0715	Ceftizoxime sodium / 500 MG		N1		
J0718	Certolizumab pegol inj		K2		$3.78
J0720	Chloramphenicol sodium injec		N1		
J0725	Chorionic gonadotropin/1000u		N1		
J0735	Clonidine hydrochloride		K2		$98.64
J0740	Cidofovir injection		K2		$761.10
J0743	Cilastatin sodium injection		N1		
J0744	Ciprofloxacin iv		N1		
J0745	Inj codeine phosphate /30 MG		N1		
J0760	Colchicine injection		N1		
J0770	Colistimethate sodium inj		N1		
J0780	Prochlorperazine injection		N1		
J0795	Corticorelin ovine triflutal		K2		$4.48

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J0800	Corticotropin injection		K2		$2,441.70
J0833	Cosyntropin injection NOS		K2		$73.19
J0834	Cosyntropin cortrosyn inj		K2		$90.95
J0850	Cytomegalovirus imm IV /vial		K2		$878.82
J0878	Daptomycin injection		K2		$0.43
J0881	Darbepoetin alfa, non-esrd		K2		$2.88
J0885	Epoetin alfa, non-esrd		K2		$9.44
J0894	Decitabine injection		K2		$29.65
J0895	Deferoxamine mesylate inj		N1		
J0900	Testosterone enanthate inj		N1		
J0945	Brompheniramine maleate inj		K2		$9.24
J0970	Estradiol valerate injection		N1		
J1000	Depo-estradiol cypionate inj		N1		
J1020	Methylprednisolone 20 MG inj		N1		
J1030	Methylprednisolone 40 MG inj		N1		
J1040	Methylprednisolone 80 MG inj		N1		
J1051	Medroxyprogesterone inj		N1		
J1060	Testosterone cypionate 1 ML		N1		
J1070	Testosterone cypionat 100 MG		N1		
J1080	Testosterone cypionat 200 MG		N1		
J1094	Inj dexamethasone acetate		N1		
J1100	Dexamethasone sodium phos		N1		
J1110	Inj dihydroergotamine mesylt		N1		
J1120	Acetazolamid sodium injectio		N1		
J1160	Digoxin injection		N1		
J1162	Digoxin immune fab (ovine)		K2		$487.78
J1165	Phenytoin sodium injection		N1		
J1170	Hydromorphone injection		N1		
J1180	Dyphylline injection		N1		
J1190	Dexrazoxane HCl injection		K2		$261.24
J1200	Diphenhydramine hcl injectio		N1		
J1205	Chlorothiazide sodium inj		K2		$352.37
J1212	Dimethyl sulfoxide 50% 50 ML		K2		$69.98
J1230	Methadone injection		N1		
J1240	Dimenhydrinate injection		N1		
J1245	Dipyridamole injection		N1		
J1250	Inj dobutamine HCL/250 mg		N1		
J1260	Dolasetron mesylate		N1		
J1265	Dopamine injection		N1		
J1267	Doripenem injection	CH	N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J1270	Injection, doxercalciferol		N1		
J1300	Eculizumab injection		K2		$182.61
J1320	Amitriptyline injection		N1		
J1324	Enfuvirtide injection	CH	N1		
J1325	Epoprostenol injection		N1		
J1327	Eptifibatide injection		K2		$19.00
J1330	Ergonovine maleate injection		N1		
J1335	Ertapenem injection		N1		
J1364	Erythro lactobionate /500 MG		N1		
J1380	Estradiol valerate 10 MG inj		N1		
J1390	Estradiol valerate 20 MG inj		N1		
J1410	Inj estrogen conjugate 25 MG		K2		$88.68
J1430	Ethanolamine oleate 100 mg		K2		$149.97
J1436	Etidronate disodium inj	CH	N1		
J1438	Etanercept injection		K2		$191.55
J1440	Filgrastim 300 mcg injection		K2		$223.05
J1441	Filgrastim 480 mcg injection		K2		$348.68
J1450	Fluconazole		N1		
J1451	Fomepizole, 15 mg		K2		$7.64
J1453	Fosaprepitant injection		K2		$1.62
J1455	Foscarnet sodium injection		N1		
J1457	Gallium nitrate injection		K2		$2.03
J1458	Galsulfase injection		K2		$339.90
J1459	Inj IVIG privigen 500 mg		K2		$35.10
J1460	Gamma globulin 1 CC inj		K2		$16.03
J1470	Gamma globulin 2 CC inj		K2		$32.07
J1480	Gamma globulin 3 CC inj		K2		$48.10
J1490	Gamma globulin 4 CC inj		K2		$64.13
J1500	Gamma globulin 5 CC inj		K2		$80.16
J1510	Gamma globulin 6 CC inj		K2		$96.23
J1520	Gamma globulin 7 CC inj		K2		$112.17
J1530	Gamma globulin 8 CC inj		K2		$128.27
J1540	Gamma globulin 9 CC inj		K2		$160.34
J1550	Gamma globulin 10 CC inj		K2		$160.34
J1560	Gamma globulin > 10 CC inj		K2		$160.34
J1561	Gamunex injection		K2		$37.63
J1562	Vivaglobin, inj		K2		$7.20
J1566	Immune globulin, powder		K2		$30.86
J1568	Octagam injection		K2		$37.69
J1569	Gammagard liquid injection		K2		$38.53

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J1570	Ganciclovir sodium injection		N1		
J1571	Hepagam b im injection		K2		$50.63
J1572	Flebogamma injection		K2		$37.01
J1573	Hepagam b intravenous, inj		K2		$50.63
J1580	Garamycin gentamicin inj		N1		
J1590	Gatifloxacin injection		N1		
J1595	Injection glatiramer acetate		K2		$82.34
J1600	Gold sodium thiomaleate inj		N1		
J1610	Glucagon hydrochloride/1 MG		K2		$81.41
J1620	Gonadorelin hydroch/ 100 mcg	CH	N1		
J1626	Granisetron hcl injection		N1		
J1630	Haloperidol injection		N1		
J1631	Haloperidol decanoate inj		N1		
J1640	Hemin, 1 mg		K2		$8.18
J1642	Inj heparin sodium per 10 u		N1		
J1644	Inj heparin sodium per 1000u		N1		
J1645	Dalteparin sodium		N1		
J1650	Inj enoxaparin sodium		N1		
J1652	Fondaparinux sodium	CH	N1		
J1655	Tinzaparin sodium injection		N1		
J1670	Tetanus immune globulin inj		K2		$136.81
J1680	Human fibrinogen conc inj		K2		$72.89
J1700	Hydrocortisone acetate inj		N1		
J1710	Hydrocortisone sodium ph inj		N1		
J1720	Hydrocortisone sodium succ i		N1		
J1730	Diazoxide injection		K2		$114.32
J1740	Ibandronate sodium injection		K2		$141.39
J1742	Ibutilide fumarate injection		K2		$416.61
J1743	Idursulfase injection		K2		$455.03
J1745	Infliximab injection		K2		$58.74
J1750	Inj iron dextran		K2		$12.63
J1756	Iron sucrose injection		K2		$0.37
J1785	Injection imiglucerase /unit		K2		$4.20
J1790	Droperidol injection		N1		
J1800	Propranolol injection		N1		
J1815	Insulin injection		N1		
J1817	Insulin for insulin pump use	CH	N1		
J1830	Interferon beta-1b / .25 MG		K2		$176.67
J1835	Itraconazole injection	CH	K2		$42.28
J1840	Kanamycin sulfate 500 MG inj		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J1850	Kanamycin sulfate 75 MG inj		N1		
J1885	Ketorolac tromethamine inj		N1		
J1890	Cephalothin sodium injection		N1		
J1930	Lanreotide injection		K2		$29.30
J1931	Laronidase injection		K2		$25.56
J1940	Furosemide injection		N1		
J1945	Lepirudin		K2		$234.37
J1950	Leuprolide acetate /3.75 MG		K2		$516.09
J1953	Levetiracetam injection	CH	N1		
J1956	Levofloxacin injection		N1		
J1960	Levorphanol tartrate inj		N1		
J1980	Hyoscyamine sulfate inj		N1		
J1990	Chlordiazepoxide injection		N1		
J2001	Lidocaine injection		N1		
J2010	Lincomycin injection		N1		
J2020	Linezolid injection		K2		$32.57
J2060	Lorazepam injection		N1		
J2150	Mannitol injection		N1		
J2170	Mecasermin injection	CH	K2		$125.21
J2175	Meperidine hydrochl /100 MG		N1		
J2180	Meperidine/promethazine inj		N1		
J2185	Meropenem		N1		
J2210	Methylergonovin maleate inj		N1		
J2248	Micafungin sodium injection		K2		$1.10
J2250	Inj midazolam hydrochloride		N1		
J2260	Inj milrinone lactate / 5 MG		N1		
J2270	Morphine sulfate injection		N1		
J2271	Morphine so4 injection 100mg		N1		
J2275	Morphine sulfate injection		N1		
J2278	Ziconotide injection		K2		$6.50
J2280	Inj, moxifloxacin 100 mg		N1		
J2300	Inj nalbuphine hydrochloride		N1		
J2310	Inj naloxone hydrochloride		N1		
J2315	Naltrexone, depot form		K2		$2.43
J2320	Nandrolone decanoate 50 MG		K2		$7.08
J2321	Nandrolone decanoate 100 MG		K2		$71.34
J2322	Nandrolone decanoate 200 MG		K2		$43.59
J2323	Natalizumab injection		K2		$7.97
J2325	Nesiritide injection		K2		$38.37
J2353	Octreotide injection, depot		K2		$109.01

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J2354	Octreotide inj, non-depot		N1		
J2355	Oprelvekin injection		K2		$245.08
J2357	Omalizumab injection		K2		$19.77
J2360	Orphenadrine injection		N1		
J2370	Phenylephrine hcl injection		N1		
J2400	Chloroprocaine hcl injection		N1		
J2405	Ondansetron hcl injection		N1		
J2410	Oxymorphone hcl injection		N1		
J2425	Palifermin injection		K2		$11.34
J2430	Pamidronate disodium /30 MG	CH	N1		
J2440	Papaverin hcl injection		N1		
J2469	Palonosetron hcl		K2		$17.62
J2501	Paricalcitol		N1		
J2503	Pegaptanib sodium injection		K2		$1,030.34
J2504	Pegademase bovine, 25 iu		K2		$247.34
J2505	Injection, pegfilgrastim 6mg		K2		$2,432.50
J2510	Penicillin g procaine inj		N1		
J2513	Pentastarch 10% solution		K2		$161.82
J2515	Pentobarbital sodium inj		N1		
J2540	Penicillin g potassium inj		N1		
J2543	Piperacillin/tazobactam		N1		
J2550	Promethazine hcl injection		N1		
J2560	Phenobarbital sodium inj		N1		
J2562	Plerixafor injection		K2		$268.58
J2590	Oxytocin injection		N1		
J2597	Inj desmopressin acetate		N1		
J2650	Prednisolone acetate inj		N1		
J2670	Totazoline hcl injection		N1		
J2675	Inj progesterone per 50 MG		N1		
J2680	Fluphenazine decanoate 25 MG		N1		
J2690	Procainamide hcl injection		N1		
J2700	Oxacillin sodium injeciton		N1		
J2710	Neostigmine methylslfte inj		N1		
J2720	Inj protamine sulfate/10 MG		N1		
J2724	Protein c concentrate		K2		$12.19
J2725	Inj protirelin per 250 mcg		N1		
J2730	Pralidoxime chloride inj		K2		$90.79
J2760	Phentolaine mesylate inj		N1		
J2765	Metoclopramide hcl injection		N1		
J2770	Quinupristin/dalfopristin		K2		$147.06

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J2778	Ranibizumab injection		K2		$404.70
J2780	Ranitidine hydrochloride inj		N1		
J2783	Rasburicase		K2		$172.53
J2785	Regadenoson injection		K2		$50.73
J2788	Rho d immune globulin 50 mcg		K2		$25.14
J2790	Rho d immune globulin inj		K2		$77.47
J2791	Rhophylac injection		K2		$5.21
J2792	Rho(D) immune globulin h, sd		K2		$18.55
J2793	Rilonacept injection		K2		$24.09
J2794	Risperidone, long acting		K2		$5.06
J2795	Ropivacaine HCl injection		N1		
J2796	Romiplostim injection		K2		$44.18
J2800	Methocarbamol injection		N1		
J2805	Sincalide injection		N1		
J2810	Inj theophylline per 40 MG		N1		
J2820	Sargramostim injection		K2		$25.25
J2850	Inj secretin synthetic human		K2		$20.31
J2910	Aurothioglucose injeciton		N1		
J2916	Na ferric gluconate complex		N1		
J2920	Methylprednisolone injection		N1		
J2930	Methylprednisolone injection		N1		
J2940	Somatrem injection	CH	N1		
J2941	Somatropin injection		K2		$55.46
J2950	Promazine hcl injection		N1		
J2993	Reteplase injection		K2		$1,555.98
J2995	Inj streptokinase /250000 IU		K2		$32.12
J2997	Alteplase recombinant		K2		$37.35
J3000	Streptomycin injection		N1		
J3010	Fentanyl citrate injeciton		N1		
J3030	Sumatriptan succinate / 6 MG	CH	N1		
J3070	Pentazocine injection		N1		
J3101	Tenecteplase injection		K2		$46.74
J3105	Terbutaline sulfate inj		N1		
J3120	Testosterone enanthate inj		N1		
J3130	Testosterone enanthate inj		N1		
J3140	Testosterone suspension inj		N1		
J3150	Testosteron propionate inj		N1		
J3230	Chlorpromazine hcl injection		N1		
J3240	Thyrotropin injection		K2		$1,053.42
J3243	Tigecycline injection		K2		$1.16

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J3246	Tirofiban HCl		K2		$7.39
J3250	Trimethobenzamide hcl inj		N1		
J3260	Tobramycin sulfate injection		N1		
J3265	Injection torsemide 10 mg/ml		N1		
J3280	Thiethylperazine maleate inj		N1		
J3285	Treprostinil injection		K2		$55.88
J3300	Triamcinolone A inj PRS-free		K2		$3.21
J3301	Triamcinolone acet inj NOS		N1		
J3302	Triamcinolone diacetate inj		N1		
J3303	Triamcinolone hexacetonl inj		N1		
J3305	Inj trimetrexate glucoronate	CH	N1		
J3310	Perphenazine injeciton	CH	K2		$29.11
J3315	Triptorelin pamoate		K2		$164.10
J3350	Urea injection	CH	K2		$83.87
J3355	Urofollitropin, 75 iu		K2		$60.01
J3360	Diazepam injection		N1		
J3364	Urokinase 5000 IU injection		N1		
J3365	Urokinase 250,000 IU inj		K2		$457.73
J3370	Vancomycin hcl injection		N1		
J3396	Verteporfin injection		K2		$9.50
J3410	Hydroxyzine hcl injection		N1		
J3411	Thiamine hcl 100 mg		N1		
J3415	Pyridoxine hcl 100 mg		N1		
J3420	Vitamin b12 injection		N1		
J3430	Vitamin k phytonadione inj		N1		
J3465	Injection, voriconazole		K2		$5.82
J3470	Hyaluronidase injection		N1		
J3471	Ovine, up to 999 USP units		N1		
J3472	Ovine, 1000 USP units		N1		
J3473	Hyaluronidase recombinant		N1		
J3475	Inj magnesium sulfate		N1		
J3480	Inj potassium chloride		N1		
J3485	Zidovudine		N1		
J3486	Ziprasidone mesylate		N1		
J3487	Zoledronic acid		K2		$221.12
J3488	Reclast injection		K2		$222.92
J3490	Drugs unclassified injection		N1		
J3530	Nasal vaccine inhalation		N1		
J3590	Unclassified biologics		N1		
J7030	Normal saline solution infus		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J7040	Normal saline solution infus		N1		
J7042	5% dextrose/normal saline		N1		
J7050	Normal saline solution infus		N1		
J7060	5% dextrose/water		N1		
J7070	D5w infusion		N1		
J7100	Dextran 40 infusion		N1		
J7110	Dextran 75 infusion		N1		
J7120	Ringers lactate infusion		N1		
J7130	Hypertonic saline solution		N1		
J7185	Xyntha inj		K2		$1.08
J7186	Antihemophilic viii/vwf comp		K2		$0.92
J7187	Humate-P, inj		K2		$0.88
J7189	Factor viia		K2		$1.36
J7190	Factor viii		K2		$0.87
J7191	Factor VIII (porcine)		K2		$8.21
J7192	Factor viii recombinant NOS		K2		$1.09
J7193	Factor IX non-recombinant		K2		$0.91
J7194	Factor ix complex		K2		$0.88
J7195	Factor IX recombinant		K2		$1.11
J7197	Antithrombin iii injection		K2		$2.31
J7198	Anti-inhibitor		K2		$1.55
J7308	Aminolevulinic acid hcl top		K2		$134.54
J7310	Ganciclovir long act implant		K2		$16,960.00
J7311	Fluocinolone acetonide implt		K2		$19,345.00
J7321	Hyalgan/supartz inj per dose		K2		$91.96
J7323	Euflexxa inj per dose		K2		$113.79
J7324	Orthovisc inj per dose		K2		$176.70
J7325	Synvisc or Synvisc-One		K2		$11.78
J7500	Azathioprine oral 50mg		N1		
J7501	Azathioprine parenteral		K2		$96.29
J7502	Cyclosporine oral 100 mg	CH	N1		
J7504	Lymphocyte immune globulin		K2		$487.88
J7505	Monoclonal antibodies		K2		$1,133.50
J7506	Prednisone oral		N1		
J7507	Tacrolimus oral per 1 MG	CH	N1		
J7509	Methylprednisolone oral		N1		
J7510	Prednisolone oral per 5 mg		N1		
J7511	Antithymocyte globuln rabbit		K2		$386.48
J7513	Daclizumab, parenteral		K2		$351.10
J7515	Cyclosporine oral 25 mg	CH	N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J7516	Cyclosporin parenteral 250mg	CH	N1		
J7517	Mycophenolate mofetil oral	CH	N1		
J7518	Mycophenolic acid		N1		
J7520	Sirolimus, oral	CH	N1		
J7525	Tacrolimus injection		K2		$139.41
J7599	Immunosuppressive drug noc		N1		
J7674	Methacholine chloride, neb		N1		
J7799	Non-inhalation drug for DME		N1		
J8501	Oral aprepitant		K2		$5.67
J8510	Oral busulfan	CH	K2		$3.65
J8520	Capecitabine, oral, 150 mg		K2		$6.28
J8521	Capecitabine, oral, 500 mg		K2		$20.66
J8530	Cyclophosphamide oral 25 MG		N1		
J8540	Oral dexamethasone		N1		
J8560	Etoposide oral 50 MG		K2		$28.26
J8597	Antiemetic drug oral NOS		N1		
J8600	Melphalan oral 2 MG		N1		
J8610	Methotrexate oral 2.5 MG		N1		
J8650	Nabilone oral		N1		
J8700	Temozolomide		K2		$8.83
J8705	Topotecan oral		K2		$74.66
J9000	Doxorubicin hcl injection		N1		
J9001	Doxorubicin hcl liposome inj		K2		$472.01
J9010	Alemtuzumab injection		K2		$578.02
J9015	Aldesleukin injection		K2		$844.43
J9017	Arsenic trioxide injection		K2		$37.43
J9020	Asparaginase injection		K2		$60.94
J9025	Azacitidine injection		K2		$4.99
J9027	Clofarabine injection		K2		$116.49
J9031	Bcg live intravesical vac		K2		$121.25
J9033	Bendamustine injection		K2		$18.47
J9035	Bevacizumab injection		K2		$57.57
J9040	Bleomycin sulfate injection		N1		
J9041	Bortezomib injection		K2		$38.24
J9045	Carboplatin injection		N1		
J9050	Carmustine injection		K2		$176.41
J9055	Cetuximab injection		K2		$49.73
J9060	Cisplatin 10 MG injection		N1		
J9062	Cisplatin 50 MG injection		N1		
J9065	Inj cladribine per 1 MG		K2		$28.22

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J9070	Cyclophosphamide 100 MG inj		N1		
J9080	Cyclophosphamide 200 MG inj		N1		
J9090	Cyclophosphamide 500 MG inj		N1		
J9091	Cyclophosphamide 1.0 grm inj		N1		
J9092	Cyclophosphamide 2.0 grm inj		N1		
J9093	Cyclophosphamide lyophilized		N1		
J9094	Cyclophosphamide lyophilized		N1		
J9095	Cyclophosphamide lyophilized		N1		
J9096	Cyclophosphamide lyophilized		N1		
J9097	Cyclophosphamide lyophilized		N1		
J9098	Cytarabine liposome inj		K2		$488.90
J9100	Cytarabine hcl 100 MG inj		N1		
J9110	Cytarabine hcl 500 MG inj		N1		
J9120	Dactinomycin injection		K2		$570.53
J9130	Dacarbazine 100 mg inj		N1		
J9140	Dacarbazine 200 MG inj		N1		
J9150	Daunorubicin injection		K2		$19.46
J9151	Daunorubicin citrate inj		K2		$56.31
J9155	Degarelix injection		K2		$2.60
J9160	Denileukin diftitox inj		K2		$1,494.82
J9165	Diethylstilbestrol injection	CH	N1		
J9171	Docetaxel injection		K2		$17.86
J9175	Elliotts b solution per ml		N1		
J9178	Inj, epirubicin hcl, 2 mg		K2		$2.48
J9181	Etoposide injection		N1		
J9185	Fludarabine phosphate inj		K2		$205.81
J9190	Fluorouracil injection		N1		
J9200	Floxuridine injection		K2		$42.99
J9201	Gemcitabine hcl injection		K2		$145.10
J9202	Goserelin acetate implant		K2		$195.23
J9206	Irinotecan injection		K2		$9.15
J9207	Ixabepilone injection		K2		$63.74
J9208	Ifosfomide injection		K2		$30.76
J9209	Mesna injection	CH	N1		
J9211	Idarubicin hcl injection		K2		$63.57
J9212	Interferon alfacon-1 inj		K2		$4.80
J9213	Interferon alfa-2a inj	CH	N1		
J9214	Interferon alfa-2b inj		K2		$15.84
J9215	Interferon alfa-n3 inj		K2		$18.23
J9216	Interferon gamma 1-b inj		K2		$430.93

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J9217	Leuprolide acetate suspnsion		K2		$220.41
J9218	Leuprolide acetate injeciton		K2		$4.27
J9219	Leuprolide acetate implant		K2		$4,819.82
J9225	Vantas implant		K2		$1,515.25
J9226	Supprelin LA implant		K2		$14,990.44
J9230	Mechlorethamine hcl inj		K2		$154.50
J9245	Inj melphalan hydrochl 50 MG		K2		$1,500.32
J9250	Methotrexate sodium inj		N1		
J9260	Methotrexate sodium inj		N1		
J9261	Nelarabine injection		K2		$105.91
J9263	Oxaliplatin		K2		$6.83
J9264	Paclitaxel protein bound		K2		$9.43
J9265	Paclitaxel injection	CH	K2		$11.46
J9266	Pegaspargase injection		K2		$2,747.44
J9268	Pentostatin injection		K2		$1,246.38
J9270	Plicamycin (mithramycin) inj		N1		
J9280	Mitomycin 5 MG inj		K2		$20.35
J9290	Mitomycin 20 MG inj		K2		$81.44
J9291	Mitomycin 40 MG inj		K2		$162.86
J9293	Mitoxantrone hydrochl / 5 MG		K2		$45.26
J9300	Gemtuzumab ozogamicin inj		K2		$2,687.21
J9303	Panitumumab injection		K2		$87.24
J9305	Pemetrexed injection		K2		$50.63
J9310	Rituximab injection		K2		$578.40
J9320	Streptozocin injection		K2		$282.86
J9328	Temozolomide injection		K2		$4.90
J9330	Temsirolimus injection		K2		$49.83
J9340	Thiotepa injection		K2		$113.52
J9350	Topotecan injection		K2		$1,058.90
J9355	Trastuzumab injection		K2		$66.41
J9357	Valrubicin injection		K2		$960.22
J9360	Vinblastine sulfate inj		N1		
J9370	Vincristine sulfate 1 MG inj		N1		
J9375	Vincristine sulfate 2 MG inj		N1		
J9380	Vincristine sulfate 5 MG inj		N1		
J9390	Vinorelbine tartrate inj		N1		
J9395	Injection, Fulvestrant		K2		$82.22
J9600	Porfimer sodium injection		K2		$2,934.28
J9999	Chemotherapy drug		N1		
L8600	Implant breast silicone/eq		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
L8603	Collagen imp urinary 2.5 ml		N1		
L8604	Dextranomer/hyaluronic acid		N1		
L8606	Synthetic implnt urinary 1ml		N1		
L8609	Artificial cornea		N1		
L8610	Ocular implant		N1		
L8612	Aqueous shunt prosthesis		N1		
L8613	Ossicular implant		N1		
L8614	Cochlear device		N1		
L8630	Metacarpophalangeal implant		N1		
L8631	MCP joint repl 2 pc or more		N1		
L8641	Metatarsal joint implant		N1		
L8642	Hallux implant		N1		
L8658	Interphalangeal joint spacer		N1		
L8659	Interphalangeal joint repl		N1		
L8670	Vascular graft, synthetic		N1		
L8682	Implt neurostim radiofq rec		N1		
L8690	Aud osseo dev, int/ext comp		N1		
L8699	Prosthetic implant NOS		N1		
P9041	Albumin (human),5%, 50ml		K2		$16.89
P9045	Albumin (human), 5%, 250 ml		K2		$60.58
P9046	Albumin (human), 25%, 20 ml		K2		$25.67
P9047	Albumin (human), 25%, 50ml		K2		$62.05
Q0138	Ferumoxytol, non-esrd		K2		$0.82
Q0163	Diphenhydramine HCl 50mg		N1		
Q0164	Prochlorperazine maleate 5mg		N1		
Q0166	Granisetron hcl 1 mg oral		N1		
Q0167	Dronabinol 2.5mg oral		N1		
Q0169	Promethazine HCl 12.5mg oral		N1		
Q0171	Chlorpromazine HCl 10mg oral		N1		
Q0173	Trimethobenzamide HCl 250mg		N1		
Q0175	Perphenazine 4mg oral		N1		
Q0177	Hydroxyzine pamoate 25mg		N1		
Q0179	Ondansetron hcl 8 mg oral		N1		
Q0180	Dolasetron mesylate oral		N1		
Q0515	Sermorelin acetate injection		K2		$1.80
Q1003	Ntiol category 3		L6		$50.00
Q2004	Bladder calculi irrig sol	CH	N1		
Q2009	Fosphenytoin inj PE		N1		
Q2017	Teniposide, 50 mg		K2		$324.55
Q3025	IM inj interferon beta 1-a		K2		$193.93

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
Q4100	Skin substitute, NOS		N1		
Q4101	Apligraf skin sub		K2		$32.71
Q4102	Oasis wound matrix skin sub		K2		$4.62
Q4103	Oasis burn matrix skin sub		K2		$4.62
Q4104	Integra BMWD skin sub		K2		$14.84
Q4105	Integra DRT skin sub		K2		$10.00
Q4106	Dermagraft skin sub		K2		$40.10
Q4107	Graftjacket skin sub		K2		$92.04
Q4108	Integra matrix skin sub		K2		$17.99
Q4109	Tissuemend skin sub		N1		
Q4110	Primatrix skin sub		K2		$34.35
Q4111	Gammagraft skin sub		K2		$7.40
Q4112	Cymetra allograft		K2		$342.34
Q4113	Graftjacket express allograf		K2		$342.34
Q4114	Integra flowable wound matri		K2		$914.43
Q4115	Alloskin skin sub		K2		$7.34
Q4116	Alloderm skin sub		K2		$32.57
Q9951	LOCM >= 400 mg/ml iodine,1ml		N1		
Q9953	Inj Fe-based MR contrast,1ml		N1		
Q9954	Oral MR contrast, 100 ml		N1		
Q9955	Inj perflexane lip micros,ml		N1		
Q9956	Inj octafluoropropane mic,ml		N1		
Q9957	Inj perflutren lip micros,ml		N1		
Q9958	HOCM <=149 mg/ml iodine, 1ml		N1		
Q9959	HOCM 150-199mg/ml iodine,1ml		N1		
Q9960	HOCM 200-249mg/ml iodine,1ml		N1		
Q9961	HOCM 250-299mg/ml iodine,1ml		N1		
Q9962	HOCM 300-349mg/ml iodine,1ml		N1		
Q9963	HOCM 350-399mg/ml iodine,1ml		N1		
Q9964	HOCM>= 400mg/ml iodine, 1ml		N1		
Q9965	LOCM 100-199mg/ml iodine,1ml		N1		
Q9966	LOCM 200-299mg/ml iodine,1ml		N1		
Q9967	LOCM 300-399mg/ml iodine,1ml		N1		
Q9968	Visualization adjunct		K2		$1.82
V2630	Anter chamber intraocul lens		N1		
V2631	Iris support intraoclr lens		N1		
V2632	Post chmbr intraocular lens		N1		
V2785	Corneal tissue processing		F4		
V2790	Amniotic membrane		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment

NOTE 1: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount. Section 4104 of the Affordable Care Act (ACA) waives coinsurance for most preventive services, identified with a double asterisk (**).

NOTE 2: Payment indicators for radiology services (Z2, Z3) are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the MPFS. At the time we compiled this addenda, current law requires a negative update to the MPFS payment rates for CY 2011. For a discussion of those rates, we refer readers to the CY 2011 MPFS proposed rule.

**: Defined as a preventive service with $0 proposed coinsurance as required by section 4104 of the Affordable Care Act (ACA).

ADDENDUM D1.—PROPOSED OPPS PAYMENT STUATS INDICATORS FOR CY 2011

ADDENDUM D1.—PROPOSED OPPS PAYMENT STATUS INDICATORS FOR CY 2011

Indicator	Item/Code/Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital • Diagnostic Mammography • Screening Mammography	Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS. Not subject to deductible or coinsurance. Not subject to deductible.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. • May be paid by fiscal intermediaries/MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: • That are not covered by any Medicare outpatient benefit based on statutory exclusion. • That are not covered by any Medicare outpatient benefit for reasons other than statutory exclusion. • That are not recognized by Medicare for outpatient claims but for which an alternate code for the same item or service may be available. • For which separate payment is not provided on outpatient claims.	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).
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.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; not subject to copayment.
K	Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals	Paid under OPPS; separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary/MAC	Not paid under OPPS.
N	Items and Services Packaged into APC Rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; per diem APC payment.

ADDENDUM D1.—PROPOSED OPPS PAYMENT STATUS INDICATORS FOR CY 2011

Indicator	Item/Code/Service	OPPS Payment Status
Q1	STVX-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "S," "T," "V," or "X." (2) In all other circumstances, payment is made through a separate APC payment.
Q2	T-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T." (2) In all other circumstances, payment is made through a separate APC payment.
Q3	Codes That May Be Paid Through a Composite APC	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service. (2) In all other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
R	Blood and Blood Products	Paid under OPPS; 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.
U	Brachytherapy Sources	Paid under OPPS; separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; separate APC payment.

ADDENDUM D1.—PROPOSED OPPS PAYMENT STATUS INDICATORS FOR CY 2011

Indicator	Item/Code/Service	OPPS Payment Status
X	Ancillary Services	Paid under OPPS; separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

ADDENDUM DD1.—PROPOSED ASC PAYMENT INDICATORS FOR CY 2011

ADDENDUM DD1.—PROPOSED ASC PAYMENT INDICATORS FOR CY 2011	
Indicator	**Payment Indicator Definition**
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
D5	Deleted/discontinued code; no payment made.
F4	Corneal tissue acquisition, hepatitis B vaccine; paid at reasonable cost.
G2	Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
H2	Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
H8	Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate.
J7	OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.
J8	Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate.
K2	Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
K7	Unclassified drugs and biologicals; payment contractor-priced.
L1	Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.
L6	New Technology Intraocular Lens (NTIOL); special payment.
N1	Packaged service/item; no separate payment made.
P2	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
P3	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
R2	Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.

ADDENDUM DD1.—PROPOSED ASC PAYMENT INDICATORS FOR CY 2011	
Indicator	**Payment Indicator Definition**
Z2	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.
Z3	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.

ADDENDUM D2.—PROPOSED OPPS COMMENT INDICATORS FOR CY 2011

ADDENDUM D2.—PROPOSED OPPS COMMENT INDICATORS FOR CY 2011	
Comment Indicator	**Descriptor**
NI	New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year as compared to current calendar year, 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 will be discontinued at the end of the current calendar year.

ADDENDUM DD2.—PROPOSED ASC COMMENT INDICATORS FOR CY 2011

ADDENDUM DD2.—PROPOSED ASC COMMENT INDICATORS FOR CY 2011	
CI	**Comment Indicator Meanings**
CH	Active HCPCS code in current year and next calendar year, payment indicator assignment has changed; or active HCPCS code that is newly recognized as payable in ASC; or active HCPCS code that is discontinued at the end of the current calendar year.
NI	New code, interim payment indicator assignment; comments will be accepted on the interim payment assignment for the new code.

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
00176	Anesth, pharyngeal surgery	C	
00192	Anesth, facial bone surgery	C	
00211	Anesth, cran surg, hemotoma	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 hrt surg w/pmp age 1+	C	
00567	Anesth, cabg w/pump	C	
00580	Anesth, heart/lung transplnt	C	
00604	Anesth, sitting procedure	C	
00622	Anesth, removal of nerves	C	
00632	Anesth, removal of nerves	C	
00670	Anesth, spine, cord surgery	C	
00792	Anesth, hemorr/excise liver	C	
00794	Anesth, pancreas removal	C	
00796	Anesth, for liver transplant	C	
00802	Anesth, fat layer removal	C	
00844	Anesth, pelvis surgery	C	
00846	Anesth, hysterectomy	C	
00848	Anesth, pelvic organ surg	C	
00864	Anesth, removal of bladder	C	
00865	Anesth, removal of prostate	C	
00866	Anesth, removal of adrenal	C	
00868	Anesth, kidney transplant	C	
00882	Anesth, major vein ligation	C	
00904	Anesth, perineal surgery	C	
00908	Anesth, removal of prostate	C	
00932	Anesth, amputation of penis	C	
00934	Anesth, penis, nodes removal	C	
00936	Anesth, penis, nodes removal	C	
00944	Anesth, vaginal hysterectomy	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
01140	Anesth, amputation at pelvis	C	
01150	Anesth, pelvic tumor surgery	C	
01212	Anesth, hip disarticulation	C	
01214	Anesth, hip arthroplasty	C	
01232	Anesth, amputation of femur	C	
01234	Anesth, radical femur surg	C	
01272	Anesth, femoral artery surg	C	
01274	Anesth, femoral embolectomy	C	
01402	Anesth, knee arthroplasty	C	
01404	Anesth, amputation at knee	C	
01442	Anesth, knee artery surg	C	
01444	Anesth, knee artery repair	C	
01486	Anesth, ankle replacement	C	
01502	Anesth, lwr leg embolectomy	C	
01634	Anesth, shoulder joint amput	C	
01636	Anesth, forequarter amput	C	
01638	Anesth, shoulder replacement	C	
01652	Anesth, shoulder vessel surg	C	
01654	Anesth, shoulder vessel surg	C	
01656	Anesth, arm-leg vessel surg	C	
01756	Anesth, radical humerus surg	C	
01990	Support for organ donor	C	
11004	Debride genitalia & perineum	C	
11005	Debride abdom wall	C	
11006	Debride genit/per/abdom wall	C	
11008	Remove mesh from abd wall	C	
15756	Free myo/skin flap microvasc	C	
15757	Free skin flap, microvasc	C	
15758	Free fascial flap, microvasc	C	
16036	Escharotomy; addl 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	
20661	Application of head brace	C	
20664	Halo brace application	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
20802	Replantation, arm, complete	C	
20805	Replant forearm, complete	C	
20808	Replantation hand, complete	C	
20816	Replantation digit, complete	C	
20824	Replantation thumb, complete	C	
20827	Replantation thumb, complete	C	
20838	Replantation foot, complete	C	
20930	Sp bone algrft morsel add-on	C	
20931	Sp bone algrft struct add-on	C	
20936	Sp bone agrft local add-on	C	
20937	Sp bone agrft morsel add-on	C	
20938	Sp bone agrft struct add-on	C	
20955	Fibula bone graft, microvasc	C	
20956	Iliac bone graft, microvasc	C	
20957	Mt bone graft, microvasc	C	
20962	Other bone graft, microvasc	C	
20969	Bone/skin graft, microvasc	C	
20970	Bone/skin graft, iliac crest	C	
21045	Extensive jaw surgery	C	
21141	Reconstruct midface, lefort	C	
21142	Reconstruct midface, lefort	C	
21143	Reconstruct midface, lefort	C	
21145	Reconstruct midface, lefort	C	
21146	Reconstruct midface, lefort	C	
21147	Reconstruct midface, lefort	C	
21151	Reconstruct midface, lefort	C	
21154	Reconstruct midface, lefort	C	
21155	Reconstruct midface, lefort	C	
21159	Reconstruct midface, lefort	C	
21160	Reconstruct midface, lefort	C	
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	
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	
21268	Revise eye sockets	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
21343	Treatment of sinus fracture	C	
21344	Treatment of sinus fracture	C	
21346	Treat nose/jaw fracture	C	
21347	Treat nose/jaw fracture	C	
21348	Treat nose/jaw fracture	C	
21366	Treat cheek bone fracture	C	
21422	Treat mouth roof fracture	C	
21423	Treat mouth roof fracture	C	
21431	Treat craniofacial fracture	C	
21432	Treat craniofacial fracture	C	
21433	Treat craniofacial fracture	C	
21435	Treat craniofacial fracture	C	
21436	Treat craniofacial fracture	C	
21510	Drainage of bone lesion	C	
21615	Removal of rib	C	
21616	Removal of rib and nerves	C	
21620	Partial removal of sternum	C	
21627	Sternal debridement	C	
21630	Extensive sternum surgery	C	
21632	Extensive sternum surgery	C	
21705	Revision of neck muscle/rib	C	
21740	Reconstruction of sternum	C	
21750	Repair of sternum separation	C	
21810	Treatment of rib fracture(s)	C	
21825	Treat sternum fracture	C	
22010	I&d, p-spine, c/t/cerv-thor	C	
22015	I&d, p-spine, l/s/ls	C	
22110	Remove part of neck vertebra	C	
22112	Remove part, thorax vertebra	C	
22114	Remove part, lumbar vertebra	C	
22116	Remove extra spine segment	C	
22206	Cut spine 3 col, thor	C	
22207	Cut spine 3 col, lumb	C	
22208	Cut spine 3 col, addl seg	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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
22318	Treat odontoid fx w/o graft	C	
22319	Treat odontoid fx w/graft	C	
22325	Treat spine fracture	C	
22326	Treat neck spine fracture	C	
22327	Treat thorax spine fracture	C	
22328	Treat each add spine fx	C	
22532	Lat thorax spine fusion	C	
22533	Lat lumbar spine fusion	C	
22534	Lat thor/lumb, addl seg	C	
22548	Neck spine fusion	C	
22554	Neck spine fusion	C	
22556	Thorax spine fusion	C	
22558	Lumbar spine fusion	C	
22585	Additional spinal fusion	C	
22590	Spine & skull spinal fusion	C	
22595	Neck spinal fusion	C	
22600	Neck spine fusion	C	
22610	Thorax spine fusion	C	
22630	Lumbar spine fusion	C	
22632	Spine fusion, extra segment	C	
22800	Fusion of spine	C	
22802	Fusion of spine	C	
22804	Fusion of spine	C	
22808	Fusion of spine	C	
22810	Fusion of spine	C	
22812	Fusion of spine	C	
22818	Kyphectomy, 1-2 segments	C	
22819	Kyphectomy, 3 or more	C	
22830	Exploration of spinal fusion	C	
22840	Insert spine fixation device	C	
22841	Insert spine fixation device	C	
22842	Insert spine fixation device	C	
22843	Insert spine fixation device	C	
22844	Insert spine fixation device	C	
22845	Insert spine fixation device	C	
22846	Insert spine fixation device	C	
22847	Insert spine fixation device	C	
22848	Insert pelv fixation device	C	
22849	Reinsert spinal fixation	C	
22850	Remove spine fixation device	C	
22852	Remove spine fixation device	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
22855	Remove spine fixation device	C	
22856	Cerv artific diskectomy	C	
22857	Lumbar artif diskectomy	C	
22861	Revise cerv artific disc	C	
22862	Revise lumbar artif disc	C	
22864	Remove cerv artif disc	C	
22865	Remove lumb artif disc	C	
23200	Resect clavicle tumor	C	
23210	Resect scapula tumor	C	
23220	Resect prox humerus tumor	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	
25915	Amputation of forearm	C	
25920	Amputate hand at wrist	C	
25924	Amputation follow-up surgery	C	
25927	Amputation of hand	C	
26551	Great toe-hand transfer	C	
26553	Single transfer, toe-hand	C	
26554	Double transfer, toe-hand	C	
26556	Toe joint transfer	C	
26992	Drainage of bone lesion	C	
27005	Incision of hip tendon	C	
27025	Incision of hip/thigh fascia	C	
27030	Drainage of hip joint	C	
27036	Excision of hip joint/muscle	C	
27054	Removal of hip joint lining	C	
27070	Partial removal of hip bone	C	
27071	Partial removal of hip bone	C	
27075	Resect hip tumor	C	
27076	Resect hip tum incl acetabul	C	
27077	Resect hip tum w/innom bone	C	
27078	Rsect hip tum incl femur	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
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	
27181	Treat slipped epiphysis	C	
27185	Revision of femur epiphysis	C	
27187	Reinforce hip bones	C	
27222	Treat hip socket fracture	C	
27226	Treat hip wall fracture	C	
27227	Treat hip fracture(s)	C	
27228	Treat hip fracture(s)	C	
27232	Treat thigh fracture	C	
27236	Treat thigh fracture	C	
27240	Treat thigh fracture	C	
27244	Treat thigh fracture	C	
27245	Treat thigh fracture	C	
27248	Treat thigh fracture	C	
27253	Treat hip dislocation	C	
27254	Treat hip dislocation	C	
27258	Treat hip dislocation	C	
27259	Treat hip dislocation	C	
27268	Cltx thigh fx w/mnpj	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
27269	Optx thigh fx	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	Resect femur/knee tumor	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	
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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
27591	Amputate leg at thigh	C	
27592	Amputate leg at thigh	C	
27596	Amputation follow-up surgery	C	
27598	Amputate lower leg at knee	C	
27645	Resect tibia tumor	C	
27646	Resect fibula tumor	C	
27702	Reconstruct ankle joint	C	
27703	Reconstruction, ankle joint	C	
27712	Realignment of lower leg	C	
27715	Revision of lower leg	C	
27724	Repair/graft of tibia	C	
27725	Repair of lower leg	C	
27727	Repair of lower leg	C	
27880	Amputation of lower leg	C	
27881	Amputation of lower leg	C	
27882	Amputation of lower leg	C	
27886	Amputation follow-up surgery	C	
27888	Amputation of foot at ankle	C	
28800	Amputation of midfoot	C	
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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
31781	Reconstruct windpipe	C	
31786	Remove windpipe lesion	C	
31800	Repair of windpipe injury	C	
31805	Repair of windpipe injury	C	
32035	Exploration of chest	C	
32036	Exploration of chest	C	
32095	Biopsy through chest wall	C	
32100	Exploration/biopsy of chest	C	
32110	Explore/repair chest	C	
32120	Re-exploration of chest	C	
32124	Explore chest free adhesions	C	
32140	Removal of lung lesion(s)	C	
32141	Remove/treat lung lesions	C	
32150	Removal of lung lesion(s)	C	
32151	Remove lung foreign body	C	
32160	Open chest heart massage	C	
32200	Drain, open, lung lesion	C	
32215	Treat chest lining	C	
32220	Release of lung	C	
32225	Partial release of lung	C	
32310	Removal of chest lining	C	
32320	Free/remove chest lining	C	
32402	Open biopsy chest lining	C	
32440	Removal of lung	C	
32442	Sleeve pneumonectomy	C	
32445	Removal of lung	C	
32480	Partial removal of lung	C	
32482	Bilobectomy	C	
32484	Segmentectomy	C	
32486	Sleeve lobectomy	C	
32488	Completion pneumonectomy	C	
32491	Lung volume reduction	C	
32500	Partial removal of lung	C	
32501	Repair bronchus add-on	C	
32503	Resect apical lung tumor	C	
32504	Resect apical lung tum/chest	C	
32540	Removal of lung lesion	C	
32650	Thoracoscopy, surgical	C	
32651	Thoracoscopy, surgical	C	
32652	Thoracoscopy, surgical	C	
32653	Thoracoscopy, surgical	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
32654	Thoracoscopy, surgical	C	
32655	Thoracoscopy, surgical	C	
32656	Thoracoscopy, surgical	C	
32657	Thoracoscopy, surgical	C	
32658	Thoracoscopy, surgical	C	
32659	Thoracoscopy, surgical	C	
32660	Thoracoscopy, surgical	C	
32661	Thoracoscopy, surgical	C	
32662	Thoracoscopy, surgical	C	
32663	Thoracoscopy, surgical	C	
32664	Thoracoscopy, surgical	C	
32665	Thoracoscopy, surgical	C	
32800	Repair lung hernia	C	
32810	Close chest after drainage	C	
32815	Close bronchial fistula	C	
32820	Reconstruct injured chest	C	
32850	Donor pneumonectomy	C	
32851	Lung transplant, single	C	
32852	Lung transplant with bypass	C	
32853	Lung transplant, double	C	
32854	Lung transplant with bypass	C	
32855	Prepare donor lung, single	C	
32856	Prepare donor lung, double	C	
32900	Removal of rib(s)	C	
32905	Revise & repair chest wall	C	
32906	Revise & repair chest wall	C	
32940	Revision of lung	C	
32997	Total lung lavage	C	
33015	Incision of heart sac	C	
33020	Incision of heart sac	C	
33025	Incision of heart sac	C	
33030	Partial removal of heart sac	C	
33031	Partial removal of heart sac	C	
33050	Removal of heart sac lesion	C	
33120	Removal of heart lesion	C	
33130	Removal of heart lesion	C	
33140	Heart revascularize (tmr)	C	
33141	Heart tmr w/other procedure	C	
33202	Insert epicard eltrd, open	C	
33203	Insert epicard eltrd, endo	C	
33236	Remove electrode/thoracotomy	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
33237	Remove electrode/thoracotomy	C	
33238	Remove electrode/thoracotomy	C	
33243	Remove eltrd/thoracotomy	C	
33250	Ablate heart dysrhythm focus	C	
33251	Ablate heart dysrhythm focus	C	
33254	Ablate atria, lmtd	C	
33255	Ablate atria w/o bypass, ext	C	
33256	Ablate atria w/bypass, exten	C	
33257	Ablate atria, lmtd, add-on	C	
33258	Ablate atria, x10sv, add-on	C	
33259	Ablate atria w/bypass add-on	C	
33261	Ablate heart dysrhythm focus	C	
33265	Ablate atria, lmtd, endo	C	
33266	Ablate atria, x10sv, endo	C	
33300	Repair of heart wound	C	
33305	Repair of heart wound	C	
33310	Exploratory heart surgery	C	
33315	Exploratory heart surgery	C	
33320	Repair major blood vessel(s)	C	
33321	Repair major vessel	C	
33322	Repair major blood vessel(s)	C	
33330	Insert major vessel graft	C	
33332	Insert major vessel graft	C	
33335	Insert major vessel graft	C	
33400	Repair of aortic valve	C	
33401	Valvuloplasty, open	C	
33403	Valvuloplasty, w/cp bypass	C	
33404	Prepare heart-aorta conduit	C	
33405	Replacement of aortic valve	C	
33406	Replacement of aortic valve	C	
33410	Replacement of aortic valve	C	
33411	Replacement of aortic valve	C	
33412	Replacement of aortic valve	C	
33413	Replacement of aortic valve	C	
33414	Repair of aortic valve	C	
33415	Revision, subvalvular tissue	C	
33416	Revise ventricle muscle	C	
33417	Repair of aortic valve	C	
33420	Revision of mitral valve	C	
33422	Revision of mitral valve	C	
33425	Repair of mitral valve	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
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	
33782	Nikaidoh proc	C	
33783	Nikaidoh proc w/ostia implt	C	
33786	Repair arterial trunk	C	
33788	Revision of pulmonary artery	C	
33800	Aortic suspension	C	
33802	Repair vessel defect	C	
33803	Repair vessel defect	C	
33813	Repair septal defect	C	
33814	Repair septal defect	C	
33820	Revise major vessel	C	
33822	Revise major vessel	C	
33824	Revise major vessel	C	
33840	Remove aorta constriction	C	
33845	Remove aorta constriction	C	
33851	Remove aorta constriction	C	
33852	Repair septal defect	C	
33853	Repair septal defect	C	
33860	Ascending aortic graft	C	
33861	Ascending aortic graft	C	
33863	Ascending aortic graft	C	
33864	Ascending aortic graft	C	
33870	Transverse aortic arch graft	C	
33875	Thoracic aortic graft	C	
33877	Thoracoabdominal graft	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
33880	Endovasc taa repr incl subcl	C	
33881	Endovasc taa repr w/o subcl	C	
33883	Insert endovasc prosth, taa	C	
33884	Endovasc prosth, taa, add-on	C	
33886	Endovasc prosth, delayed	C	
33889	Artery transpose/endovas taa	C	
33891	Car-car bp grft/endovas taa	C	
33910	Remove lung artery emboli	C	
33915	Remove lung artery emboli	C	
33916	Surgery of great vessel	C	
33917	Repair pulmonary artery	C	
33920	Repair pulmonary atresia	C	
33922	Transect pulmonary artery	C	
33924	Remove pulmonary shunt	C	
33925	Rpr pul art unifocal w/o cpb	C	
33926	Repr pul art, unifocal w/cpb	C	
33930	Removal of donor heart/lung	C	
33933	Prepare donor heart/lung	C	
33935	Transplantation, heart/lung	C	
33940	Removal of donor heart	C	
33944	Prepare donor heart	C	
33945	Transplantation of heart	C	
33960	External circulation assist	C	
33961	External circulation assist	C	
33967	Insert ia percut device	C	
33968	Remove aortic assist device	C	
33970	Aortic circulation assist	C	
33971	Aortic circulation assist	C	
33973	Insert balloon device	C	
33974	Remove intra-aortic balloon	C	
33975	Implant ventricular device	C	
33976	Implant ventricular device	C	
33977	Remove ventricular device	C	
33978	Remove ventricular device	C	
33979	Insert intracorporeal device	C	
33980	Remove intracorporeal device	C	
33981	Replace vad pump ext	C	
33982	Replace vad intra w/o bp	C	
33983	Replace vad intra w/bp	C	
34001	Removal of artery clot	C	
34051	Removal of artery clot	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
34151	Removal of artery clot	C	
34401	Removal of vein clot	C	
34451	Removal of vein clot	C	
34502	Reconstruct vena cava	C	
34800	Endovas aaa repr w/sm tube	C	
34802	Endovas aaa repr w/2-p part	C	
34803	Endovas aaa repr w/3-p part	C	
34804	Endovas aaa repr w/1-p part	C	
34805	Endovas aaa repr w/long tube	C	
34806	Aneurysm press sensor add-on	C	
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, addl	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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
35141	Repair defect of artery	C	
35142	Repair artery rupture, thigh	C	
35151	Repair defect of artery	C	
35152	Repair artery rupture, knee	C	
35182	Repair blood vessel lesion	C	
35189	Repair blood vessel lesion	C	
35211	Repair blood vessel lesion	C	
35216	Repair blood vessel lesion	C	
35221	Repair blood vessel lesion	C	
35241	Repair blood vessel lesion	C	
35246	Repair blood vessel lesion	C	
35251	Repair blood vessel lesion	C	
35271	Repair blood vessel lesion	C	
35276	Repair blood vessel lesion	C	
35281	Repair blood vessel lesion	C	
35301	Rechanneling of artery	C	
35302	Rechanneling of artery	C	
35303	Rechanneling of artery	C	
35304	Rechanneling of artery	C	
35305	Rechanneling of artery	C	
35306	Rechanneling of artery	C	
35311	Rechanneling of artery	C	
35331	Rechanneling of artery	C	
35341	Rechanneling of artery	C	
35351	Rechanneling of artery	C	
35355	Rechanneling of artery	C	
35361	Rechanneling of artery	C	
35363	Rechanneling of artery	C	
35371	Rechanneling of artery	C	
35372	Rechanneling of artery	C	
35390	Reoperation, carotid add-on	C	
35400	Angioscopy	C	
35450	Repair arterial blockage	C	
35452	Repair arterial blockage	C	
35454	Repair arterial blockage	C	
35456	Repair arterial blockage	C	
35480	Atherectomy, open	C	
35481	Atherectomy, open	C	
35482	Atherectomy, open	C	
35483	Atherectomy, open	C	
35501	Artery bypass graft	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
35506	Artery bypass graft	C	
35508	Artery bypass graft	C	
35509	Artery bypass graft	C	
35510	Artery bypass graft	C	
35511	Artery bypass graft	C	
35512	Artery bypass graft	C	
35515	Artery bypass graft	C	
35516	Artery bypass graft	C	
35518	Artery bypass graft	C	
35521	Artery bypass graft	C	
35522	Artery bypass graft	C	
35523	Artery bypass graft	C	
35525	Artery bypass graft	C	
35526	Artery bypass graft	C	
35531	Artery bypass graft	C	
35533	Artery bypass graft	C	
35535	Artery bypass graft	C	
35536	Artery bypass graft	C	
35537	Artery bypass graft	C	
35538	Artery bypass graft	C	
35539	Artery bypass graft	C	
35540	Artery bypass graft	C	
35548	Artery bypass graft	C	
35549	Artery bypass graft	C	
35551	Artery bypass graft	C	
35556	Artery bypass graft	C	
35558	Artery bypass graft	C	
35560	Artery bypass graft	C	
35563	Artery bypass graft	C	
35565	Artery bypass graft	C	
35566	Artery bypass graft	C	
35570	Artery bypass graft	C	
35571	Artery bypass graft	C	
35583	Vein bypass graft	C	
35585	Vein bypass graft	C	
35587	Vein bypass graft	C	
35600	Harvest art for cabg add-on	C	
35601	Artery bypass graft	C	
35606	Artery bypass graft	C	
35612	Artery bypass graft	C	
35616	Artery bypass graft	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
35621	Artery bypass graft	C	
35623	Bypass graft, not vein	C	
35626	Artery bypass graft	C	
35631	Artery bypass graft	C	
35632	Artery bypass graft	C	
35633	Artery bypass graft	C	
35634	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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
35907	Excision, graft, abdomen	C	
36660	Insertion catheter, artery	C	
36822	Insertion of cannula(s)	C	
36823	Insertion of cannula(s)	C	
37140	Revision of circulation	C	
37145	Revision of circulation	C	
37160	Revision of circulation	C	
37180	Revision of circulation	C	
37181	Splice spleen/kidney veins	C	
37182	Insert hepatic shunt (tips)	C	
37215	Transcath stent, cca w/eps	C	
37616	Ligation of chest artery	C	
37617	Ligation of abdomen artery	C	
37618	Ligation of extremity artery	C	
37660	Revision of major vein	C	
37788	Revascularization, penis	C	
38100	Removal of spleen, total	C	
38101	Removal of spleen, partial	C	
38102	Removal of spleen, total	C	
38115	Repair of ruptured spleen	C	
38380	Thoracic duct procedure	C	
38381	Thoracic duct procedure	C	
38382	Thoracic duct procedure	C	
38562	Removal, pelvic lymph nodes	C	
38564	Removal, abdomen lymph nodes	C	
38724	Removal of lymph nodes, neck	C	
38746	Remove thoracic lymph nodes	C	
38747	Remove abdominal lymph nodes	C	
38765	Remove groin lymph nodes	C	
38770	Remove pelvis lymph nodes	C	
38780	Remove abdomen lymph nodes	C	
39000	Exploration of chest	C	
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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
39531	Repair of diaphragm hernia	C	
39540	Repair of diaphragm hernia	C	
39541	Repair of diaphragm hernia	C	
39545	Revision of diaphragm	C	
39560	Resect diaphragm, simple	C	
39561	Resect diaphragm, complex	C	
39599	Diaphragm surgery procedure	C	
41130	Partial removal of tongue	C	
41135	Tongue and neck surgery	C	
41140	Removal of tongue	C	
41145	Tongue removal, neck surgery	C	
41150	Tongue, mouth, jaw surgery	C	
41153	Tongue, mouth, neck surgery	C	
41155	Tongue, jaw, & neck surgery	C	
42426	Excise parotid gland/lesion	C	
42845	Extensive surgery of throat	C	
42894	Revision of pharyngeal walls	C	
42953	Repair throat, esophagus	C	
42961	Control throat bleeding	C	
42971	Control nose/throat bleeding	C	
43045	Incision of esophagus	C	
43100	Excision of esophagus lesion	C	
43101	Excision of esophagus lesion	C	
43107	Removal of esophagus	C	
43108	Removal of esophagus	C	
43112	Removal of esophagus	C	
43113	Removal of esophagus	C	
43116	Partial removal of esophagus	C	
43117	Partial removal of esophagus	C	
43118	Partial removal of esophagus	C	
43121	Partial removal of esophagus	C	
43122	Partial removal of esophagus	C	
43123	Partial removal of esophagus	C	
43124	Removal of esophagus	C	
43135	Removal of esophagus pouch	C	
43279	Lap myotomy, heller	C	
43281	Lap paraesophag hern repair	C	
43282	Lap paraesoph her rpr w/mesh	C	
43300	Repair of esophagus	C	
43305	Repair esophagus and fistula	C	
43310	Repair of esophagus	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
43312	Repair esophagus and fistula	C	
43313	Esophagoplasty congenital	C	
43314	Tracheo-esophagoplasty cong	C	
43320	Fuse esophagus & stomach	C	
43324	Revise esophagus & stomach	C	
43325	Revise esophagus & stomach	C	
43326	Revise esophagus & stomach	C	
43330	Repair of esophagus	C	
43331	Repair of esophagus	C	
43340	Fuse esophagus & intestine	C	
43341	Fuse esophagus & intestine	C	
43350	Surgical opening, esophagus	C	
43351	Surgical opening, esophagus	C	
43352	Surgical opening, esophagus	C	
43360	Gastrointestinal repair	C	
43361	Gastrointestinal repair	C	
43400	Ligate esophagus veins	C	
43401	Esophagus surgery for veins	C	
43405	Ligate/staple esophagus	C	
43410	Repair esophagus wound	C	
43415	Repair esophagus wound	C	
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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
43644	Lap gastric bypass/roux-en-y	C	
43645	Lap gastr bypass incl smll i	C	
43770	Lap place gastr adj device	C	
43771	Lap revise gastr adj device	C	
43772	Lap rmvl gastr adj device	C	
43773	Lap replace gastr adj device	C	
43774	Lap rmvl gastr adj all parts	C	
43775	Lap sleeve gastrectomy	C	
43800	Reconstruction of pylorus	C	
43810	Fusion of stomach and bowel	C	
43820	Fusion of stomach and bowel	C	
43825	Fusion of stomach and bowel	C	
43832	Place gastrostomy tube	C	
43840	Repair of stomach lesion	C	
43843	Gastroplasty w/o v-band	C	
43845	Gastroplasty duodenal switch	C	
43846	Gastric bypass for obesity	C	
43847	Gastric bypass incl small i	C	
43848	Revision gastroplasty	C	
43850	Revise stomach-bowel fusion	C	
43855	Revise stomach-bowel fusion	C	
43860	Revise stomach-bowel fusion	C	
43865	Revise stomach-bowel fusion	C	
43880	Repair stomach-bowel fistula	C	
43881	Impl/redo electrd, antrum	C	
43882	Revise/remove electrd antrum	C	
44005	Freeing of bowel adhesion	C	
44010	Incision of small bowel	C	
44015	Insert needle cath bowel	C	
44020	Explore small intestine	C	
44021	Decompress small bowel	C	
44025	Incision of large bowel	C	
44050	Reduce bowel obstruction	C	
44055	Correct malrotation of bowel	C	
44110	Excise intestine lesion(s)	C	
44111	Excision of bowel lesion(s)	C	
44120	Removal of small intestine	C	
44121	Removal of small intestine	C	
44125	Removal of small intestine	C	
44126	Enterectomy w/o taper, cong	C	
44127	Enterectomy w/taper, cong	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
44128	Enterectomy cong, add-on	C	
44130	Bowel to bowel fusion	C	
44132	Enterectomy, cadaver donor	C	
44133	Enterectomy, live donor	C	
44135	Intestine transplnt, cadaver	C	
44136	Intestine transplant, live	C	
44137	Remove intestinal allograft	C	
44139	Mobilization of colon	C	
44140	Partial removal of colon	C	
44141	Partial removal of colon	C	
44143	Partial removal of colon	C	
44144	Partial removal of colon	C	
44145	Partial removal of colon	C	
44146	Partial removal of colon	C	
44147	Partial removal of colon	C	
44150	Removal of colon	C	
44151	Removal of colon/ileostomy	C	
44155	Removal of colon/ileostomy	C	
44156	Removal of colon/ileostomy	C	
44157	Colectomy w/ileoanal anast	C	
44158	Colectomy w/neo-rectum pouch	C	
44160	Removal of colon	C	
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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
44603	Suture, small intestine	C	
44604	Suture, large intestine	C	
44605	Repair of bowel lesion	C	
44615	Intestinal stricturoplasty	C	
44620	Repair bowel opening	C	
44625	Repair bowel opening	C	
44626	Repair bowel opening	C	
44640	Repair bowel-skin fistula	C	
44650	Repair bowel fistula	C	
44660	Repair bowel-bladder fistula	C	
44661	Repair bowel-bladder fistula	C	
44680	Surgical revision, intestine	C	
44700	Suspend bowel w/prosthesis	C	
44715	Prepare donor intestine	C	
44720	Prep donor intestine/venous	C	
44721	Prep donor intestine/artery	C	
44800	Excision of bowel pouch	C	
44820	Excision of mesentery lesion	C	
44850	Repair of mesentery	C	
44899	Bowel surgery procedure	C	
44900	Drain app abscess, open	C	
44960	Appendectomy	C	
45110	Removal of rectum	C	
45111	Partial removal of rectum	C	
45112	Removal of rectum	C	
45113	Partial proctectomy	C	
45114	Partial removal of rectum	C	
45116	Partial removal of rectum	C	
45119	Remove rectum w/reservoir	C	
45120	Removal of rectum	C	
45121	Removal of rectum and colon	C	
45123	Partial proctectomy	C	
45126	Pelvic exenteration	C	
45130	Excision of rectal prolapse	C	
45135	Excision of rectal prolapse	C	
45136	Excise ileoanal reservior	C	
45395	Lap, removal of rectum	C	
45397	Lap, remove rectum w/pouch	C	
45400	Laparoscopic proc	C	
45402	Lap proctopexy w/sig resect	C	
45540	Correct rectal prolapse	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
45550	Repair rectum/remove sigmoid	C	
45562	Exploration/repair of rectum	C	
45563	Exploration/repair of rectum	C	
45800	Repair rect/bladder fistula	C	
45805	Repair fistula w/colostomy	C	
45820	Repair rectourethral fistula	C	
45825	Repair fistula w/colostomy	C	
46705	Repair of anal stricture	C	
46710	Repr per/vag pouch sngl proc	C	
46712	Repr per/vag pouch dbl proc	C	
46715	Rep perf anoper fistu	C	
46716	Rep perf anoper/vestib fistu	C	
46730	Construction of absent anus	C	
46735	Construction of absent anus	C	
46740	Construction of absent anus	C	
46742	Repair of imperforated anus	C	
46744	Repair of cloacal anomaly	C	
46746	Repair of cloacal anomaly	C	
46748	Repair of cloacal anomaly	C	
46751	Repair of anal sphincter	C	
47010	Open drainage, liver lesion	C	
47015	Inject/aspirate liver cyst	C	
47100	Wedge biopsy of liver	C	
47120	Partial removal of liver	C	
47122	Extensive removal of liver	C	
47125	Partial removal of liver	C	
47130	Partial removal of liver	C	
47133	Removal of donor liver	C	
47135	Transplantation of liver	C	
47136	Transplantation of liver	C	
47140	Partial removal, donor liver	C	
47141	Partial removal, donor liver	C	
47142	Partial removal, donor liver	C	
47143	Prep donor liver, whole	C	
47144	Prep donor liver, 3-segment	C	
47145	Prep donor liver, lobe split	C	
47146	Prep donor liver/venous	C	
47147	Prep donor liver/arterial	C	
47300	Surgery for liver lesion	C	
47350	Repair liver wound	C	
47360	Repair liver wound	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
47361	Repair liver wound	C	
47362	Repair liver wound	C	
47380	Open ablate liver tumor rf	C	
47381	Open ablate liver tumor cryo	C	
47400	Incision of liver duct	C	
47420	Incision of bile duct	C	
47425	Incision of bile duct	C	
47460	Incise bile duct sphincter	C	
47480	Incision of gallbladder	C	
47550	Bile duct endoscopy add-on	C	
47570	Laparo cholecystoenterostomy	C	
47600	Removal of gallbladder	C	
47605	Removal of gallbladder	C	
47610	Removal of gallbladder	C	
47612	Removal of gallbladder	C	
47620	Removal of gallbladder	C	
47700	Exploration of bile ducts	C	
47701	Bile duct revision	C	
47711	Excision of bile duct tumor	C	
47712	Excision of bile duct tumor	C	
47715	Excision of bile duct cyst	C	
47720	Fuse gallbladder & bowel	C	
47721	Fuse upper gi structures	C	
47740	Fuse gallbladder & bowel	C	
47741	Fuse gallbladder & bowel	C	
47760	Fuse bile ducts and bowel	C	
47765	Fuse liver ducts & bowel	C	
47780	Fuse bile ducts and bowel	C	
47785	Fuse bile ducts and bowel	C	
47800	Reconstruction of bile ducts	C	
47801	Placement, bile duct support	C	
47802	Fuse liver duct & intestine	C	
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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
48146	Pancreatectomy	C	
48148	Removal of pancreatic duct	C	
48150	Partial removal of pancreas	C	
48152	Pancreatectomy	C	
48153	Pancreatectomy	C	
48154	Pancreatectomy	C	
48155	Removal of pancreas	C	
48400	Injection, intraop add-on	C	
48500	Surgery of pancreatic cyst	C	
48510	Drain pancreatic pseudocyst	C	
48520	Fuse pancreas cyst and bowel	C	
48540	Fuse pancreas cyst and bowel	C	
48545	Pancreatorrhaphy	C	
48547	Duodenal exclusion	C	
48548	Fuse pancreas and bowel	C	
48551	Prep donor pancreas	C	
48552	Prep donor pancreas/venous	C	
48554	Transpl allograft pancreas	C	
48556	Removal, allograft pancreas	C	
49000	Exploration of abdomen	C	
49002	Reopening of abdomen	C	
49010	Exploration behind abdomen	C	
49020	Drain abdominal abscess	C	
49040	Drain, open, abdom abscess	C	
49060	Drain, open, retrop abscess	C	
49062	Drain to peritoneal cavity	C	
49203	Exc abd tum 5 cm or less	C	
49204	Exc abd tum over 5 cm	C	
49205	Exc abd tum over 10 cm	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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
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	Renal biopsy open	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	
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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
50540	Revision of horseshoe kidney	C	
50545	Laparo radical nephrectomy	C	
50546	Laparoscopic nephrectomy	C	
50547	Laparo removal donor kidney	C	
50548	Laparo remove w/ureter	C	
50600	Exploration of ureter	C	
50605	Insert ureteral support	C	
50610	Removal of ureter stone	C	
50620	Removal of ureter stone	C	
50630	Removal of ureter stone	C	
50650	Removal of ureter	C	
50660	Removal of ureter	C	
50700	Revision of ureter	C	
50715	Release of ureter	C	
50722	Release of ureter	C	
50725	Release/revise ureter	C	
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	
51525	Removal of bladder lesion	C	
51530	Removal of bladder lesion	C	
51550	Partial removal of bladder	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
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	
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	
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	
54650	Orchiopexy (Fowler-Stephens)	C	
55605	Incise sperm duct pouch	C	
55650	Remove sperm duct pouch	C	
55801	Removal of prostate	C	
55810	Extensive prostate surgery	C	
55812	Extensive prostate surgery	C	
55815	Extensive prostate surgery	C	
55821	Removal of prostate	C	
55831	Removal of prostate	C	
55840	Extensive prostate surgery	C	
55842	Extensive prostate surgery	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
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	
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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
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	Adhesiolysis tube, ovary	C	
58750	Repair oviduct	C	
58752	Revise ovarian tube(s)	C	
58760	Fimbrioplasty	C	
58822	Drain ovary abscess, percut	C	
58825	Transposition, ovary(s)	C	
58940	Removal of ovary(s)	C	
58943	Removal of ovary(s)	C	
58950	Resect ovarian malignancy	C	
58951	Resect ovarian malignancy	C	
58952	Resect ovarian malignancy	C	
58953	Tah, rad dissect for debulk	C	
58954	Tah rad debulk/lymph remove	C	
58956	Bso, omentectomy w/tah	C	
58957	Resect recurrent gyn mal	C	
58958	Resect recur gyn mal w/lym	C	
58960	Exploration of abdomen	C	
59120	Treat ectopic pregnancy	C	
59121	Treat ectopic pregnancy	C	
59130	Treat ectopic pregnancy	C	
59135	Treat ectopic pregnancy	C	
59136	Treat ectopic pregnancy	C	
59140	Treat ectopic pregnancy	C	
59325	Revision of cervix	C	
59350	Repair of uterus	C	
59514	Cesarean delivery only	C	
59525	Remove uterus after cesarean	C	
59620	Attempted vbac delivery only	C	
59830	Treat uterus infection	C	
59850	Abortion	C	
59851	Abortion	C	
59852	Abortion	C	
59855	Abortion	C	
59856	Abortion	C	
59857	Abortion	C	
60254	Extensive thyroid surgery	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
60270	Removal of thyroid	C	
60505	Explore parathyroid glands	C	
60521	Removal of thymus gland	C	
60522	Removal of thymus gland	C	
60540	Explore adrenal gland	C	
60545	Explore adrenal gland	C	
60600	Remove carotid body lesion	C	
60605	Remove carotid body lesion	C	
60650	Laparoscopy adrenalectomy	C	
61105	Twist drill hole	C	
61107	Drill skull for implantation	C	
61108	Drill skull for drainage	C	
61120	Burr hole for puncture	C	
61140	Pierce skull for biopsy	C	
61150	Pierce skull for drainage	C	
61151	Pierce skull for drainage	C	
61154	Pierce skull & remove clot	C	
61156	Pierce skull for drainage	C	
61210	Pierce skull, implant device	C	
61250	Pierce skull & explore	C	
61253	Pierce skull & explore	C	
61304	Open skull for exploration	C	
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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
61470	Incise skull for surgery	C	
61480	Incise skull for surgery	C	
61490	Incise skull for surgery	C	
61500	Removal of skull lesion	C	
61501	Remove infected skull bone	C	
61510	Removal of brain lesion	C	
61512	Remove brain lining lesion	C	
61514	Removal of brain abscess	C	
61516	Removal of brain lesion	C	
61517	Implt brain chemotx add-on	C	
61518	Removal of brain lesion	C	
61519	Remove brain lining lesion	C	
61520	Removal of brain lesion	C	
61521	Removal of brain lesion	C	
61522	Removal of brain abscess	C	
61524	Removal of brain lesion	C	
61526	Removal of brain lesion	C	
61530	Removal of brain lesion	C	
61531	Implant brain electrodes	C	
61533	Implant brain electrodes	C	
61534	Removal of brain lesion	C	
61535	Remove brain electrodes	C	
61536	Removal of brain lesion	C	
61537	Removal of brain tissue	C	
61538	Removal of brain tissue	C	
61539	Removal of brain tissue	C	
61540	Removal of brain tissue	C	
61541	Incision of brain tissue	C	
61542	Removal of brain tissue	C	
61543	Removal of brain tissue	C	
61544	Remove & treat brain lesion	C	
61545	Excision of brain tumor	C	
61546	Removal of pituitary gland	C	
61548	Removal of pituitary gland	C	
61550	Release of skull seams	C	
61552	Release of skull seams	C	
61556	Incise skull/sutures	C	
61557	Incise skull/sutures	C	
61558	Excision of skull/sutures	C	
61559	Excision of skull/sutures	C	
61563	Excision of skull tumor	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
61564	Excision of skull tumor	C	
61566	Removal of brain tissue	C	
61567	Incision of brain tissue	C	
61570	Remove foreign body, brain	C	
61571	Incise skull for brain wound	C	
61575	Skull base/brainstem surgery	C	
61576	Skull base/brainstem surgery	C	
61580	Craniofacial approach, skull	C	
61581	Craniofacial approach, skull	C	
61582	Craniofacial approach, skull	C	
61583	Craniofacial approach, skull	C	
61584	Orbitocranial approach/skull	C	
61585	Orbitocranial approach/skull	C	
61586	Resect nasopharynx, skull	C	
61590	Infratemporal approach/skull	C	
61591	Infratemporal approach/skull	C	
61592	Orbitocranial approach/skull	C	
61595	Transtemporal approach/skull	C	
61596	Transcochlear approach/skull	C	
61597	Transcondylar approach/skull	C	
61598	Transpetrosal approach/skull	C	
61600	Resect/excise cranial lesion	C	
61601	Resect/excise cranial lesion	C	
61605	Resect/excise cranial lesion	C	
61606	Resect/excise cranial lesion	C	
61607	Resect/excise cranial lesion	C	
61608	Resect/excise cranial lesion	C	
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	
61630	Intracranial angioplasty	C	
61635	Intracran angioplsty w/stent	C	
61680	Intracranial vessel surgery	C	
61682	Intracranial vessel surgery	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
61684	Intracranial vessel surgery	C	
61686	Intracranial vessel surgery	C	
61690	Intracranial vessel surgery	C	
61692	Intracranial vessel surgery	C	
61697	Brain aneurysm repr, complx	C	
61698	Brain aneurysm repr, complx	C	
61700	Brain aneurysm repr, simple	C	
61702	Inner skull vessel surgery	C	
61703	Clamp neck artery	C	
61705	Revise circulation to head	C	
61708	Revise circulation to head	C	
61710	Revise circulation to head	C	
61711	Fusion of skull arteries	C	
61735	Incise skull/brain surgery	C	
61750	Incise skull/brain biopsy	C	
61751	Brain biopsy w/ct/mr guide	C	
61760	Implant brain electrodes	C	
61850	Implant neuroelectrodes	C	
61860	Implant neuroelectrodes	C	
61863	Implant neuroelectrode	C	
61864	Implant neuroelectrde, addl	C	
61867	Implant neuroelectrode	C	
61868	Implant neuroelectrde, addl	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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
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, addl cervical	C	
63044	Laminotomy, addl lumbar	C	
63050	Cervical laminoplasty	C	
63051	C-laminoplasty w/graft/plate	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	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
63196	Incise spinal column & cord	C	
63197	Incise spinal column & cord	C	
63198	Incise spinal column & cord	C	
63199	Incise spinal column & cord	C	
63200	Release of spinal cord	C	
63250	Revise spinal cord vessels	C	
63251	Revise spinal cord vessels	C	
63252	Revise spinal cord vessels	C	
63265	Excise intraspinal lesion	C	
63266	Excise intraspinal lesion	C	
63267	Excise intraspinal lesion	C	
63268	Excise intraspinal lesion	C	
63270	Excise intraspinal lesion	C	
63271	Excise intraspinal lesion	C	
63272	Excise intraspinal lesion	C	
63273	Excise intraspinal lesion	C	
63275	Biopsy/excise spinal tumor	C	
63276	Biopsy/excise spinal tumor	C	
63277	Biopsy/excise spinal tumor	C	
63278	Biopsy/excise spinal tumor	C	
63280	Biopsy/excise spinal tumor	C	
63281	Biopsy/excise spinal tumor	C	
63282	Biopsy/excise spinal tumor	C	
63283	Biopsy/excise spinal tumor	C	
63285	Biopsy/excise spinal tumor	C	
63286	Biopsy/excise spinal tumor	C	
63287	Biopsy/excise spinal tumor	C	
63290	Biopsy/excise spinal tumor	C	
63295	Repair of laminectomy defect	C	
63300	Removal of vertebral body	C	
63301	Removal of vertebral body	C	
63302	Removal of vertebral body	C	
63303	Removal of vertebral body	C	
63304	Removal of vertebral body	C	
63305	Removal of vertebral body	C	
63306	Removal of vertebral body	C	
63307	Removal of vertebral body	C	
63308	Remove vertebral body add-on	C	
63700	Repair of spinal herniation	C	
63702	Repair of spinal herniation	C	
63704	Repair of spinal herniation	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
63706	Repair of spinal herniation	C	
63707	Repair spinal fluid leakage	C	
63709	Repair spinal fluid leakage	C	
63710	Graft repair of spine defect	C	
63740	Install spinal shunt	C	
64752	Incision of vagus nerve	C	
64755	Incision of stomach nerves	C	
64760	Incision of vagus nerve	C	
64809	Remove sympathetic nerves	C	
64818	Remove sympathetic nerves	C	
64866	Fusion of facial/other nerve	C	
64868	Fusion of facial/other nerve	C	
65273	Repair of eye wound	C	
69155	Extensive ear/neck surgery	C	
69535	Remove part of temporal bone	C	
69554	Remove ear lesion	C	
69950	Incise inner ear nerve	C	
75900	Intravascular cath exchange	C	
75952	Endovasc repair abdom aorta	C	
75953	Abdom aneurysm endovas rpr	C	
75954	Iliac aneurysm endovas rpr	C	
75956	Xray, endovasc thor ao repr	C	
75957	Xray, endovasc thor ao repr	C	
75958	Xray, place prox ext thor ao	C	
75959	Xray, place dist ext thor ao	C	
92970	Cardioassist, internal	C	
92971	Cardioassist, external	C	
92975	Dissolve clot, heart vessel	C	
92992	Revision of heart chamber	C	
92993	Revision of heart chamber	C	
99190	Special pump services	C	
99191	Special pump services	C	
99192	Special pump services	C	
99356	Prolonged service, inpatient	C	
99357	Prolonged service, inpatient	C	
99462	Sbsq nb em per day, hosp	C	
99468	Neonate crit care, initial	C	
99469	Neonate crit care, subsq	C	
99471	Ped critical care, initial	C	
99472	Ped critical care, subsq	C	
99475	Ped crit care age 2-5, init	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
99476	Ped crit care age 2-5, subsq	C	
99477	Init day hosp neonate care	C	
99478	Ic, lbw inf < 1500 gm subsq	C	
99479	Ic lbw inf 1500-2500 g subsq	C	
99480	Ic inf pbw 2501-5000 g subsq	C	
0048T	Implant ventricular device	C	
0050T	Removal circulation assist	C	
0051T	Implant total heart system	C	
0052T	Replace component heart syst	C	
0053T	Replace component heart syst	C	
0075T	Perq stent/chest vert art	C	
0076T	S&i stent/chest vert art	C	
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	
0095T	Artific diskectomy addl	C	
0098T	Rev artific disc addl	C	
0157T	Open impl gast curve electrd	C	
0158T	Open remv gast curve electrd	C	
0163T	Lumb artif diskectomy addl	C	
0164T	Remove lumb artif disc addl	C	
0165T	Revise lumb artif disc addl	C	
0166T	Tcath vsd close w/o bypass	C	
0167T	Tcath vsd close w bypass	C	
0169T	Place stereo cath brain	C	
0184T	Exc rectal tumor endoscopic	C	
0195T	Arthrod presac interbody	C	
0196T	Arthrod presac interbody eac	C	
0202T	Post vert arthrplst 1 lumbar	C	
0219T	Fuse spine facet jt cerv	C	
0220T	Fuse spine facet jt thor	C	
G0341	Percutaneous islet celltrans	C	
G0342	Laparoscopy islet cell trans	C	
G0343	Laparotomy islet cell transp	C	
G0406	Telhealth inpt consult 15min	C	
G0407	Telheath inpt consult 25min	C	
G0408	Telhealth inpt consult 35min	C	
G0412	Open tx iliac spine uni/bil	C	
G0414	Pelvic ring fx treat int fix	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
G0415	Open tx post pelvic fxcture	C	
G0425	Inpt telehealth consult 30m	C	
G0426	Inpt telehealth consult 50m	C	
G0427	Inpt telehealth con 70/>m	C	

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
010005	*	0.0315	MARSHALL	01470
010008		0.0336	CRENSHAW	01200
010010		0.0315	MARSHALL	01470
010012		0.0168	DE KALB	01240
010015		0.0055	CLARKE	01120
010021		0.0052	DALE	01220
010022	*	0.0695	CHEROKEE	01090
010025	*	0.0389	CHAMBERS	01080
010027		0.0026	COFFEE	01150
010029	*	0.0504	LEE	01400
010032		0.0315	RANDOLPH	01550
010035	*	0.0226	CULLMAN	01210
010040		0.0061	ETOWAH	01270
010045		0.0178	FAYETTE	01280
010046	*	0.0061	ETOWAH	01270
010047		0.0245	BUTLER	01060
010049		0.0026	COFFEE	01150
010052	*	0.0245	TALLAPOOSA	01610
010059	*	0.0071	LAWRENCE	01390
010061	*	0.0552	JACKSON	01350
010065	*	0.0245	TALLAPOOSA	01610
010083	*	0.0152	BALDWIN	01010
010091		0.0055	CLARKE	01120

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
010100	*	0.0152	BALDWIN	01010
010101	*	0.0190	TALLADEGA	01600
010109		0.0405	PICKENS	01530
010110		0.0415	BULLOCK	01050
010125		0.0429	WINSTON	01660
010128		0.0055	CLARKE	01120
010129		0.0152	BALDWIN	01010
010138		0.0101	SUMTER	01590
010143	*	0.0226	CULLMAN	01210
010150		0.0245	BUTLER	01060
010158	*	0.0103	FRANKLIN	01290
010164	*	0.0190	TALLADEGA	01600
013027		0.0152	BALDWIN	01010
013032		0.0061	ETOWAH	01270
014006		0.0061	ETOWAH	01270
030067		0.0328	LAPAZ	03055
040014	*	0.0158	WHITE	04720
040019		0.0242	ST. FRANCIS	04610
040039	*	0.0055	GREENE	04270
040047		0.0037	RANDOLPH	04600
040067		0.0045	COLUMBIA	04130
040071	*	0.0067	JEFFERSON	04340
040076	*	0.0975	HOT SPRING	04290
040081		0.0398	PIKE	04540
042007		0.0067	JEFFERSON	04340
042011		0.0158	WHITE	04720
050002	*	0.0056	ALAMEDA	05000
050007		0.0234	SAN MATEO	05510
050009	*	0.0174	NAPA	05380
050013	*	0.0174	NAPA	05380
050014	*	0.0138	AMADOR	05020
050042	*	0.0196	TEHAMA	05620
050043	*	0.0056	ALAMEDA	05000
050069	*	0.0013	ORANGE	05400
050070		0.0234	SAN MATEO	05510
050073	*	0.0297	SOLANO	05580

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
050075	*	0.0056	ALAMEDA	05000
050089	*	0.0011	SAN BERNARDINO	05460
050099	*	0.0011	SAN BERNARDINO	05460
050101	*	0.0297	SOLANO	05580
050113		0.0234	SAN MATEO	05510
050129	*	0.0011	SAN BERNARDINO	05460
050133		0.0165	YUBA	05680
050140	*	0.0011	SAN BERNARDINO	05460
050150	*	0.0318	NEVADA	05390
050168	*	0.0013	ORANGE	05400
050173	*	0.0013	ORANGE	05400
050193	*	0.0013	ORANGE	05400
050195	*	0.0056	ALAMEDA	05000
050197	*	0.0234	SAN MATEO	05510
050211	*	0.0056	ALAMEDA	05000
050224	*	0.0013	ORANGE	05400
050226	*	0.0013	ORANGE	05400
050230	*	0.0013	ORANGE	05400
050245	*	0.0011	SAN BERNARDINO	05460
050264	*	0.0056	ALAMEDA	05000
050272	*	0.0011	SAN BERNARDINO	05460
050279	*	0.0011	SAN BERNARDINO	05460
050283	*	0.0056	ALAMEDA	05000
050289		0.0234	SAN MATEO	05510
050298		0.0011	SAN BERNARDINO	05460
050300	*	0.0011	SAN BERNARDINO	05460
050305	*	0.0056	ALAMEDA	05000
050320	*	0.0056	ALAMEDA	05000
050327	*	0.0011	SAN BERNARDINO	05460
050348	*	0.0013	ORANGE	05400
050366	*	0.0050	CALAVERAS	05040
050367	*	0.0297	SOLANO	05580
050426	*	0.0013	ORANGE	05400
050488	*	0.0056	ALAMEDA	05000
050512	*	0.0056	ALAMEDA	05000
050517	*	0.0011	SAN BERNARDINO	05460

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
050526	*	0.0013	ORANGE	05400
050541	*	0.0234	SAN MATEO	05510
050543	*	0.0013	ORANGE	05400
050548	*	0.0013	ORANGE	05400
050551	*	0.0013	ORANGE	05400
050567	*	0.0013	ORANGE	05400
050570	*	0.0013	ORANGE	05400
050580	*	0.0013	ORANGE	05400
050586	*	0.0011	SAN BERNARDINO	05460
050589	*	0.0013	ORANGE	05400
050603	*	0.0013	ORANGE	05400
050609	*	0.0013	ORANGE	05400
050618	*	0.0011	SAN BERNARDINO	05460
050667	*	0.0174	NAPA	05380
050678	*	0.0013	ORANGE	05400
050680	*	0.0297	SOLANO	05580
050693	*	0.0013	ORANGE	05400
050744	*	0.0013	ORANGE	05400
050745	*	0.0013	ORANGE	05400
050746	*	0.0013	ORANGE	05400
050747	*	0.0013	ORANGE	05400
050754		0.0234	SAN MATEO	05510
050758	*	0.0011	SAN BERNARDINO	05460
052034		0.0056	ALAMEDA	05000
052035		0.0013	ORANGE	05400
052037		0.0011	SAN BERNARDINO	05460
052039		0.0013	ORANGE	05400
052040		0.0011	SAN BERNARDINO	05460
052053		0.0013	ORANGE	05400
053034		0.0013	ORANGE	05400
053037		0.0011	SAN BERNARDINO	05460
053301		0.0056	ALAMEDA	05000
053304		0.0013	ORANGE	05400
053306		0.0013	ORANGE	05400
053308		0.0013	ORANGE	05400
054074		0.0297	SOLANO	05580

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
054093		0.0011	SAN BERNARDINO	05460
054110		0.0056	ALAMEDA	05000
054111		0.0011	SAN BERNARDINO	05460
054122		0.0174	NAPA	05380
054135		0.0013	ORANGE	05400
054141		0.0297	SOLANO	05580
054146		0.0056	ALAMEDA	05000
060001	*	0.0096	WELD	06610
060003	*	0.0101	BOULDER	06060
060027	*	0.0101	BOULDER	06060
060103	*	0.0101	BOULDER	06060
060116	*	0.0101	BOULDER	06060
060121	*	0.0096	WELD	06610
063033		0.0096	WELD	06610
064007		0.0101	BOULDER	06060
070003	*	0.0020	WINDHAM	07070
070004	*	0.0134	LITCHFIELD	07020
070011	*	0.0134	LITCHFIELD	07020
070015	*	0.0134	LITCHFIELD	07020
070020		0.0101	MIDDLESEX	07030
070021	*	0.0020	WINDHAM	07070
073026		0.0020	WINDHAM	07070
074003		0.0101	MIDDLESEX	07030
074007		0.0101	MIDDLESEX	07030
080001		0.0044	NEW CASTLE	08010
080003		0.0044	NEW CASTLE	08010
082000		0.0044	NEW CASTLE	08010
083300		0.0044	NEW CASTLE	08010
084001		0.0044	NEW CASTLE	08010
084002		0.0044	NEW CASTLE	08010
084003		0.0044	NEW CASTLE	08010
090001		0.0033	THE DISTRICT	09000
090003		0.0033	THE DISTRICT	09000
090004	*	0.0033	THE DISTRICT	09000
090005		0.0033	THE DISTRICT	09000
090006		0.0033	THE DISTRICT	09000

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
090008		0.0033	THE DISTRICT	09000
090011		0.0033	THE DISTRICT	09000
092002		0.0033	THE DISTRICT	09000
092003		0.0033	THE DISTRICT	09000
093025		0.0033	THE DISTRICT	09000
093300		0.0033	THE DISTRICT	09000
094001		0.0033	THE DISTRICT	09000
094004		0.0033	THE DISTRICT	09000
100014	*	0.0055	VOLUSIA	10630
100017	*	0.0055	VOLUSIA	10630
100023	*	0.0031	CITRUS	10080
100045	*	0.0055	VOLUSIA	10630
100047	*	0.0028	CHARLOTTE	10070
100068	*	0.0055	VOLUSIA	10630
100072	*	0.0055	VOLUSIA	10630
100077	*	0.0028	CHARLOTTE	10070
100081	*	0.0022	WALTON	10650
100118	*	0.0251	FLAGLER	10170
100139	*	0.0006	LEVY	10370
100232	*	0.0068	PUTNAM	10530
100236	*	0.0028	CHARLOTTE	10070
100249	*	0.0031	CITRUS	10080
100252	*	0.0258	OKEECHOBEE	10460
100290	*	0.0338	SUMTER	10590
100292	*	0.0022	WALTON	10650
110023	*	0.0277	GORDON	11500
110040	*	0.1172	JACKSON	11610
110041	*	0.0768	HABERSHAM	11540
110100		0.0810	JEFFERSON	11620
110101		0.0068	COOK	11311
110142		0.0193	EVANS	11441
110146	*	0.0364	CAMDEN	11170
110150	*	0.0190	BALDWIN	11030
110187	*	0.0792	LUMPKIN	11701
110189	*	0.0043	FANNIN	11450
110190	*	0.0094	MACON	11710

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
110205		0.0466	GILMER	11471
114018		0.0190	BALDWIN	11030
130003	*	0.0165	NEZ PERCE	13340
130024		0.0688	BONNER	13080
130049	*	0.0365	KOOTENAI	13270
130066		0.0365	KOOTENAI	13270
130067	*	0.1032	BINGHAM	13050
132001		0.0365	KOOTENAI	13270
134010		0.1032	BINGHAM	13050
140001		0.0321	FULTON	14370
140026		0.0296	LA SALLE	14580
140043	*	0.0038	WHITESIDE	14988
140058	*	0.0119	MORGAN	14770
140110	*	0.0296	LA SALLE	14580
140116	*	0.0014	MC HENRY	14640
140160	*	0.0316	STEPHENSON	14970
140161	*	0.0178	LIVINGSTON	14610
140167	*	0.0768	IROQUOIS	14460
140176	*	0.0014	MC HENRY	14640
140234		0.0296	LA SALLE	14580
150022		0.0251	MONTGOMERY	15530
150030	*	0.0242	HENRY	15320
150072		0.0092	CASS	15080
150076	*	0.0297	MARSHALL	15490
150088	*	0.0038	MADISON	15470
150091	*	0.0089	HUNTINGTON	15340
150102	*	0.0174	STARKE	15740
150113	*	0.0038	MADISON	15470
150133	*	0.0212	KOSCIUSKO	15420
150146	*	0.0087	NOBLE	15560
153040		0.0297	MARSHALL	15490
154014		0.0212	KOSCIUSKO	15420
154035		0.0092	CASS	15080
154047		0.0297	MARSHALL	15490
160013		0.0187	MUSCATINE	16690
160030		0.0013	STORY	16840

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
160032		0.0341	JASPER	16490
160080	*	0.0019	CLINTON	16220
170137	*	0.0421	DOUGLAS	17220
170150		0.0143	COWLEY	17170
180012	*	0.0089	HARDIN	18460
180017	*	0.0092	BARREN	18040
180049	*	0.0329	MADISON	18750
180064		0.0211	MONTGOMERY	18860
180066		0.0517	LOGAN	18700
180070		0.0121	GRAYSON	18420
180079		0.0174	HARRISON	18480
183028		0.0089	HARDIN	18460
184012		0.0089	HARDIN	18460
190003	*	0.0061	IBERIA	19220
190015	*	0.0238	TANGIPAHOA	19520
190017	*	0.0134	ST. LANDRY	19480
190034		0.0135	VERMILION	19560
190044		0.0185	ACADIA	19000
190050		0.0056	BEAUREGARD	19050
190053		0.0102	JEFFRSON DAVIS	19260
190054		0.0061	IBERIA	19220
190078		0.0134	ST. LANDRY	19480
190086	*	0.0038	LINCOLN	19300
190088		0.0281	WEBSTER	19590
190099		0.0105	AVOYELLES	19040
190106	*	0.0081	ALLEN	19010
190116		0.0052	MOREHOUSE	19330
190133		0.0081	ALLEN	19010
190140		0.0021	FRANKLIN	19200
190144	*	0.0281	WEBSTER	19590
190145		0.0050	LA SALLE	19290
190184		0.0075	CALDWELL	19100
190190	*	0.0075	CALDWELL	19100
190191		0.0134	ST. LANDRY	19480
190246		0.0075	CALDWELL	19100
190257	*	0.0038	LINCOLN	19300

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
192022		0.0038	LINCOLN	19300
192026		0.0281	WEBSTER	19590
192034		0.0134	ST. LANDRY	19480
192036		0.0238	TANGIPAHOA	19520
192040		0.0238	TANGIPAHOA	19520
192050		0.0185	ACADIA	19000
193036		0.0134	ST. LANDRY	19480
193044		0.0238	TANGIPAHOA	19520
193047		0.0135	VERMILION	19560
193049		0.0135	VERMILION	19560
193055		0.0075	CALDWELL	19100
193058		0.0052	MOREHOUSE	19330
193063		0.0238	TANGIPAHOA	19520
193067		0.0102	JEFFRSON DAVIS	19260
193068		0.0238	TANGIPAHOA	19520
193069		0.0052	MOREHOUSE	19330
193073		0.0134	ST. LANDRY	19480
193079		0.0238	TANGIPAHOA	19520
193081		0.0185	ACADIA	19000
193088		0.0185	ACADIA	19000
193091		0.0061	IBERIA	19220
194047		0.0281	WEBSTER	19590
194065		0.0038	LINCOLN	19300
194075		0.0102	JEFFRSON DAVIS	19260
194077		0.0038	LINCOLN	19300
194081		0.0056	BEAUREGARD	19050
194082		0.0102	JEFFRSON DAVIS	19260
194083		0.0052	MOREHOUSE	19330
194085		0.0185	ACADIA	19000
194087		0.0038	LINCOLN	19300
194091		0.0238	TANGIPAHOA	19520
194092		0.0021	FRANKLIN	19200
194095		0.0134	ST. LANDRY	19480
194097		0.0134	ST. LANDRY	19480
200024	*	0.0130	ANDROSCOGGIN	20000
200032		0.0367	OXFORD	20080

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
200034	*	0.0130	ANDROSCOGGIN	20000
200050	*	0.0170	HANCOCK	20040
210001		0.0110	WASHINGTON	21210
210023		0.0038	ANNE ARUNDEL	21010
210028		0.0383	ST. MARYS	21180
210043		0.0038	ANNE ARUNDEL	21010
210061		0.0188	WORCESTER	21230
212002		0.0110	WASHINGTON	21210
214001		0.0038	ANNE ARUNDEL	21010
214003		0.0110	WASHINGTON	21210
214015		0.0188	WORCESTER	21230
220001	*	0.0072	WORCESTER	22170
220002	*	0.0446	MIDDLESEX	22090
220010	*	0.0310	ESSEX	22040
220011	*	0.0446	MIDDLESEX	22090
220019	*	0.0072	WORCESTER	22170
220025	*	0.0072	WORCESTER	22170
220029	*	0.0310	ESSEX	22040
220033	*	0.0310	ESSEX	22040
220035	*	0.0310	ESSEX	22040
220049	*	0.0446	MIDDLESEX	22090
220058	*	0.0072	WORCESTER	22170
220062	*	0.0072	WORCESTER	22170
220063	*	0.0446	MIDDLESEX	22090
220070	*	0.0446	MIDDLESEX	22090
220080	*	0.0310	ESSEX	22040
220082	*	0.0446	MIDDLESEX	22090
220084	*	0.0446	MIDDLESEX	22090
220090	*	0.0072	WORCESTER	22170
220095	*	0.0072	WORCESTER	22170
220098	*	0.0446	MIDDLESEX	22090
220101	*	0.0446	MIDDLESEX	22090
220105	*	0.0446	MIDDLESEX	22090
220163	*	0.0072	WORCESTER	22170
220171	*	0.0446	MIDDLESEX	22090
220174	*	0.0310	ESSEX	22040

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
220175	*	0.0446	MIDDLESEX	22090
220176	*	0.0072	WORCESTER	22170
222000		0.0446	MIDDLESEX	22090
222003		0.0446	MIDDLESEX	22090
222024		0.0446	MIDDLESEX	22090
222026		0.0310	ESSEX	22040
222044		0.0310	ESSEX	22040
222047		0.0310	ESSEX	22040
222048		0.0072	WORCESTER	22170
223026		0.0446	MIDDLESEX	22090
223028		0.0310	ESSEX	22040
223029		0.0072	WORCESTER	22170
223033		0.0072	WORCESTER	22170
224007		0.0446	MIDDLESEX	22090
224026		0.0072	WORCESTER	22170
224032		0.0072	WORCESTER	22170
224033		0.0310	ESSEX	22040
224038		0.0446	MIDDLESEX	22090
224039		0.0310	ESSEX	22040
230002	*	0.0043	WAYNE	23810
230003	*	0.0314	OTTAWA	23690
230005		0.0488	LENAWEE	23450
230013	*	0.0021	OAKLAND	23620
230015		0.0314	ST. JOSEPH	23740
230019	*	0.0021	OAKLAND	23620
230020	*	0.0043	WAYNE	23810
230021	*	0.0159	BERRIEN	23100
230022	*	0.0213	BRANCH	23110
230024	*	0.0043	WAYNE	23810
230029	*	0.0021	OAKLAND	23620
230035	*	0.0143	MONTCALM	23580
230037	*	0.0235	HILLSDALE	23290
230041		0.0052	BAY	23080
230047	*	0.0017	MACOMB	23490
230053	*	0.0043	WAYNE	23810
230071	*	0.0021	OAKLAND	23620

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
230072	*	0.0314	OTTAWA	23690
230075		0.0067	CALHOUN	23120
230078	*	0.0159	BERRIEN	23100
230089	*	0.0043	WAYNE	23810
230092		0.0205	JACKSON	23370
230093		0.0088	MECOSTA	23530
230096	*	0.0314	ST. JOSEPH	23740
230099	*	0.0074	MONROE	23570
230104	*	0.0043	WAYNE	23810
230121	*	0.0922	SHIAWASSEE	23770
230130	*	0.0021	OAKLAND	23620
230135	*	0.0043	WAYNE	23810
230142	*	0.0043	WAYNE	23810
230146	*	0.0043	WAYNE	23810
230151	*	0.0021	OAKLAND	23620
230165	*	0.0043	WAYNE	23810
230174	*	0.0314	OTTAWA	23690
230176	*	0.0043	WAYNE	23810
230195	*	0.0017	MACOMB	23490
230204	*	0.0017	MACOMB	23490
230207	*	0.0021	OAKLAND	23620
230208	*	0.0143	MONTCALM	23580
230217		0.0067	CALHOUN	23120
230222	*	0.0098	MIDLAND	23550
230227	*	0.0017	MACOMB	23490
230244	*	0.0043	WAYNE	23810
230254	*	0.0021	OAKLAND	23620
230257	*	0.0017	MACOMB	23490
230264	*	0.0017	MACOMB	23490
230269	*	0.0021	OAKLAND	23620
230270	*	0.0043	WAYNE	23810
230273	*	0.0043	WAYNE	23810
230277	*	0.0021	OAKLAND	23620
230297	*	0.0043	WAYNE	23810
230301	*	0.0021	OAKLAND	23620
230302	*	0.0021	OAKLAND	23620

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
232019		0.0043	WAYNE	23810
232020		0.0052	BAY	23080
232023		0.0017	MACOMB	23490
232025		0.0159	BERRIEN	23100
232027		0.0043	WAYNE	23810
232028		0.0067	CALHOUN	23120
232030		0.0021	OAKLAND	23620
232031		0.0043	WAYNE	23810
232032		0.0043	WAYNE	23810
232036		0.0205	JACKSON	23370
232038		0.0043	WAYNE	23810
233025		0.0067	CALHOUN	23120
233027		0.0043	WAYNE	23810
233028		0.0021	OAKLAND	23620
233300		0.0043	WAYNE	23810
234011		0.0021	OAKLAND	23620
234021		0.0017	MACOMB	23490
234023		0.0021	OAKLAND	23620
234028		0.0043	WAYNE	23810
234034		0.0043	WAYNE	23810
234035		0.0043	WAYNE	23810
234038		0.0043	WAYNE	23810
234039		0.0017	MACOMB	23490
240018		0.0923	GOODHUE	24240
240044		0.0733	WINONA	24840
240064		0.0212	ITASCA	24300
240069	*	0.0312	STEELE	24730
240071	*	0.0404	RICE	24650
240101		0.0145	BECKER	24020
240117		0.0615	MOWER	24490
240211		0.1004	PINE	24570
250023	*	0.0722	PEARL RIVER	25540
250040	*	0.0225	JACKSON	25290
250117	*	0.0722	PEARL RIVER	25540
250128		0.0419	PANOLA	25530
250162		0.0011	HANCOCK	25220

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
252011		0.0419	PANOLA	25530
260059		0.0032	LACLEDE	26520
260064		0.0040	AUDRAIN	26030
260097		0.0362	JOHNSON	26500
260116	*	0.0095	ST. FRANCOIS	26930
260160		0.0144	STODDARD	26985
260163		0.0095	ST. FRANCOIS	26930
264005		0.0095	ST. FRANCOIS	26930
280077	*	0.0085	DODGE	28260
290002	*	0.0150	LYON	29090
300011	*	0.0049	HILLSBOROUGH	30050
300012	*	0.0049	HILLSBOROUGH	30050
300017	*	0.0075	ROCKINGHAM	30070
300020	*	0.0049	HILLSBOROUGH	30050
300023	*	0.0075	ROCKINGHAM	30070
300029	*	0.0075	ROCKINGHAM	30070
300034	*	0.0049	HILLSBOROUGH	30050
303026		0.0075	ROCKINGHAM	30070
304001		0.0075	ROCKINGHAM	30070
310002	*	0.0312	ESSEX	31200
310009	*	0.0312	ESSEX	31200
310015	*	0.0199	MORRIS	31300
310017	*	0.0199	MORRIS	31300
310038	*	0.0232	MIDDLESEX	31270
310039	*	0.0232	MIDDLESEX	31270
310050	*	0.0199	MORRIS	31300
310054	*	0.0312	ESSEX	31200
310070	*	0.0232	MIDDLESEX	31270
310076	*	0.0312	ESSEX	31200
310083	*	0.0312	ESSEX	31200
310096	*	0.0312	ESSEX	31200
310108	*	0.0232	MIDDLESEX	31270
310119	*	0.0312	ESSEX	31200
312018		0.0232	MIDDLESEX	31270
312020		0.0199	MORRIS	31300
313025		0.0312	ESSEX	31200

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
313300		0.0232	MIDDLESEX	31270
314010		0.0312	ESSEX	31200
314011		0.0232	MIDDLESEX	31270
314016		0.0199	MORRIS	31300
314020		0.0312	ESSEX	31200
320003	*	0.0480	SAN MIGUEL	32230
320011		0.0337	RIO ARRIBA	32190
323025		0.0480	SAN MIGUEL	32230
330004	*	0.0908	ULSTER	33740
330008	*	0.0064	WYOMING	33900
330010		0.0060	MONTGOMERY	33380
330027	*	0.0196	NASSAU	33400
330033		0.0179	CHENANGO	33080
330047		0.0060	MONTGOMERY	33380
330073	*	0.0078	GENESEE	33290
330094	*	0.0540	COLUMBIA	33200
330103		0.0136	CATTARAUGUS	33040
330106	*	0.0196	NASSAU	33400
330126	*	0.0488	ORANGE	33540
330132		0.0136	CATTARAUGUS	33040
330135		0.0488	ORANGE	33540
330144		0.0056	STEUBEN	33690
330151		0.0056	STEUBEN	33690
330167	*	0.0196	NASSAU	33400
330175		0.0222	CORTLAND	33210
330181	*	0.0196	NASSAU	33400
330182	*	0.0196	NASSAU	33400
330198	*	0.0196	NASSAU	33400
330205		0.0488	ORANGE	33540
330222		0.0016	SARATOGA	33640
330224	*	0.0908	ULSTER	33740
330225	*	0.0196	NASSAU	33400
330235	*	0.0246	CAYUGA	33050
330259	*	0.0196	NASSAU	33400
330264		0.0488	ORANGE	33540
330276		0.0032	FULTON	33280

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
330277	*	0.0056	STEUBEN	33690
330331	*	0.0196	NASSAU	33400
330332	*	0.0196	NASSAU	33400
330372	*	0.0196	NASSAU	33400
330386	*	0.0820	SULLIVAN	33710
334017		0.0488	ORANGE	33540
334049		0.0016	SARATOGA	33640
334061		0.0488	ORANGE	33540
340020		0.0163	LEE	34520
340021	*	0.0143	CLEVELAND	34220
340024		0.0143	SAMPSON	34810
340027	*	0.0164	LENOIR	34530
340037	*	0.0143	CLEVELAND	34220
340038		0.0329	BEAUFORT	34060
340039	*	0.0091	IREDELL	34480
340068	*	0.0102	COLUMBUS	34230
340070	*	0.0289	ALAMANCE	34000
340071	*	0.0261	HARNETT	34420
340085	*	0.0270	DAVIDSON	34280
340096	*	0.0270	DAVIDSON	34280
340126	*	0.0130	WILSON	34970
340129	*	0.0091	IREDELL	34480
340133		0.0260	MARTIN	34580
340144	*	0.0091	IREDELL	34480
340145	*	0.0305	LINCOLN	34540
340151		0.0084	HALIFAX	34410
360002		0.0101	ASHLAND	36020
360010	*	0.0023	TUSCARAWAS	36800
360013	*	0.0143	SHELBY	36760
360025	*	0.0065	ERIE	36220
360036	*	0.0164	WAYNE	36860
360040		0.0456	KNOX	36430
360044		0.0134	DARKE	36190
360055	*	0.0011	TRUMBULL	36790
360065	*	0.0061	HURON	36400
360070		0.0005	STARK	36770

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
360071		0.0069	VAN WERT	36820
360084		0.0005	STARK	36770
360086	*	0.0086	CLARK	36110
360096		0.0023	COLUMBIANA	36140
360107		0.0170	SANDUSKY	36730
360125	*	0.0106	ASHTABULA	36030
360131		0.0005	STARK	36770
360151		0.0005	STARK	36770
360156		0.0170	SANDUSKY	36730
360161		0.0011	TRUMBULL	36790
360175	*	0.0200	CLINTON	36130
360185	*	0.0023	COLUMBIANA	36140
360245	*	0.0106	ASHTABULA	36030
360355		0.0086	CLARK	36110
362016		0.0005	STARK	36770
362032		0.0005	STARK	36770
363026		0.0011	TRUMBULL	36790
364031		0.0005	STARK	36770
364040		0.0086	CLARK	36110
364043		0.0069	VAN WERT	36820
370014	*	0.0170	BRYAN	37060
370015	*	0.0390	MAYES	37480
370023		0.0072	STEPHENS	37680
370065		0.0102	CRAIG	37170
370149	*	0.0242	POTTAWATOMIE	37620
370156		0.0097	GARVIN	37240
370169		0.0173	MCINTOSH	37450
370214		0.0097	GARVIN	37240
372019		0.0242	POTTAWATOMIE	37620
380022	*	0.0126	LINN	38210
390008		0.0014	LAWRENCE	39450
390016	*	0.0014	LAWRENCE	39450
390030	*	0.0147	SCHUYLKILL	39650
390031	*	0.0147	SCHUYLKILL	39650
390039		0.0037	SOMERSET	39680
390044	*	0.0250	BERKS	39110

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
390052		0.0020	CLEARFIELD	39230
390056		0.0020	HUNTINGDON	39380
390065	*	0.0471	ADAMS	39000
390066	*	0.0274	LEBANON	39460
390086	*	0.0020	CLEARFIELD	39230
390096	*	0.0250	BERKS	39110
390110	*	0.0002	CAMBRIA	39160
390112		0.0037	SOMERSET	39680
390117		0.0001	BEDFORD	39100
390130	*	0.0002	CAMBRIA	39160
390138	*	0.0208	FRANKLIN	39350
390150		0.0006	GREENE	39370
390151	*	0.0208	FRANKLIN	39350
390162	*	0.0217	NORTHAMPTON	39590
390173		0.0037	INDIANA	39390
390183	*	0.0147	SCHUYLKILL	39650
390201		0.0951	MONROE	39550
390313	*	0.0147	SCHUYLKILL	39650
390316	*	0.0250	BERKS	39110
392030		0.0471	ADAMS	39000
392031		0.0002	CAMBRIA	39160
392034		0.0217	NORTHAMPTON	39590
393026		0.0250	BERKS	39110
393050		0.0217	NORTHAMPTON	39590
394014		0.0250	BERKS	39110
394020		0.0274	LEBANON	39460
394052		0.0250	BERKS	39110
420002		0.0001	YORK	42450
420005		0.0012	DILLON	42160
420007	*	0.0030	SPARTANBURG	42410
420019		0.0169	CHESTER	42110
420020	*	0.0008	GEORGETOWN	42210
420027	*	0.0231	ANDERSON	42030
420030	*	0.0148	COLLETON	42140
420036	*	0.0075	LANCASTER	42280
420039	*	0.0110	UNION	42430

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
420043		0.0152	CHEROKEE	42100
420053		0.0103	NEWBERRY	42350
420054		0.0002	MARLBORO	42340
420055		0.0028	MARION	42330
420062		0.0125	CHESTERFIELD	42120
420068	*	0.0068	ORANGEBURG	42370
420069	*	0.0005	CLARENDON	42130
420070	*	0.0051	SUMTER	42420
420082		0.0002	AIKEN	42010
420083	*	0.0030	SPARTANBURG	42410
420098		0.0008	GEORGETOWN	42210
422004		0.0030	SPARTANBURG	42410
423028		0.0001	YORK	42450
423029		0.0231	ANDERSON	42030
424011		0.0231	ANDERSON	42030
430048		0.0355	LAWRENCE	43400
430094		0.0355	LAWRENCE	43400
440007		0.0171	COFFEE	44150
440008		0.0262	HENDERSON	44380
440012		0.0009	SULLIVAN	44810
440016		0.0084	CARROLL	44080
440017		0.0009	SULLIVAN	44810
440025	*	0.0009	GREENE	44290
440035	*	0.0287	MONTGOMERY	44620
440047		0.0197	GIBSON	44260
440050		0.0009	GREENE	44290
440051		0.0048	MC NAIRY	44540
440060		0.0197	GIBSON	44260
440063		0.0033	WASHINGTON	44890
440070		0.0063	DECATUR	44190
440105		0.0033	WASHINGTON	44890
440109		0.0041	HARDIN	44350
440115		0.0197	GIBSON	44260
440137		0.0578	BEDFORD	44010
440144	*	0.0171	COFFEE	44150
440148		0.0232	DE KALB	44200

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
440174	*	0.0232	HAYWOOD	44370
440176		0.0009	SULLIVAN	44810
440181		0.0296	HARDEMAN	44340
440182		0.0084	CARROLL	44080
440184		0.0033	WASHINGTON	44890
440185	*	0.0234	BRADLEY	44050
442016		0.0009	SULLIVAN	44810
443027		0.0009	SULLIVAN	44810
444006		0.0033	WASHINGTON	44890
444008		0.0296	HARDEMAN	44340
450032	*	0.0216	HARRISON	45620
450039	*	0.0049	TARRANT	45910
450052	*	0.0330	BOSQUE	45160
450064	*	0.0049	TARRANT	45910
450087	*	0.0049	TARRANT	45910
450090		0.0699	COOKE	45340
450099	*	0.0084	GRAY	45563
450135	*	0.0049	TARRANT	45910
450137	*	0.0049	TARRANT	45910
450144	*	0.0446	ANDREWS	45010
450163		0.0115	KLEBERG	45743
450192		0.0314	HILL	45651
450194		0.0052	CHEROKEE	45281
450210		0.0128	PANOLA	45842
450224	*	0.0055	WOOD	45974
450236		0.0418	HOPKINS	45654
450270		0.0314	HILL	45651
450283	*	0.0415	VAN ZANDT	45947
450347	*	0.0395	WALKER	45949
450348	*	0.0093	FALLS	45500
450370	*	0.0250	COLORADO	45312
450389	*	0.0405	HENDERSON	45640
450395		0.0470	POLK	45850
450419	*	0.0049	TARRANT	45910
450438	*	0.0250	COLORADO	45312
450451		0.0522	SOMERVELL	45893

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
450460		0.0055	TYLER	45942
450497		0.0511	MONTAGUE	45800
450539		0.0138	HALE	45582
450547	*	0.0055	WOOD	45974
450563	*	0.0049	TARRANT	45910
450565	*	0.0509	PALO PINTO	45841
450573		0.0131	JASPER	45690
450596	*	0.0724	HOOD	45653
450597		0.0003	DE WITT	45420
450615		0.0033	CASS	45260
450639	*	0.0049	TARRANT	45910
450641		0.0511	MONTAGUE	45800
450672	*	0.0049	TARRANT	45910
450675	*	0.0049	TARRANT	45910
450677	*	0.0049	TARRANT	45910
450698		0.0262	LAMB	45751
450747	*	0.0031	ANDERSON	45000
450755		0.0571	HOCKLEY	45652
450770	*	0.0218	MILAM	45795
450779	*	0.0049	TARRANT	45910
450813		0.0031	ANDERSON	45000
450872	*	0.0049	TARRANT	45910
450880	*	0.0049	TARRANT	45910
450886	*	0.0049	TARRANT	45910
450888		0.0049	TARRANT	45910
452018		0.0049	TARRANT	45910
452019		0.0049	TARRANT	45910
452028		0.0049	TARRANT	45910
452088		0.0049	TARRANT	45910
452099		0.0049	TARRANT	45910
452110		0.0049	TARRANT	45910
453040		0.0049	TARRANT	45910
453041		0.0049	TARRANT	45910
453042		0.0049	TARRANT	45910
453089		0.0031	ANDERSON	45000
453094		0.0049	TARRANT	45910

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
453300		0.0049	TARRANT	45910
453303		0.0049	TARRANT	45910
454009		0.0052	CHEROKEE	45281
454012		0.0049	TARRANT	45910
454051		0.0049	TARRANT	45910
454052		0.0049	TARRANT	45910
454061		0.0049	TARRANT	45910
454072		0.0049	TARRANT	45910
454086		0.0049	TARRANT	45910
454101		0.0138	HALE	45582
460001		0.0001	UTAH	46240
460013		0.0001	UTAH	46240
460017		0.0229	BOX ELDER	46010
460023		0.0001	UTAH	46240
460039	*	0.0229	BOX ELDER	46010
460043		0.0001	UTAH	46240
460052		0.0001	UTAH	46240
462005		0.0001	UTAH	46240
490002		0.0003	RUSSELL	49830
490019	*	0.1041	CULPEPER	49230
490038		0.0003	SMYTH	49860
490084		0.0237	ESSEX	49280
490105		0.0003	SMYTH	49860
490110		0.0176	MONTGOMERY	49600
494029		0.0003	SMYTH	49860
500003	*	0.0270	SKAGIT	50280
500007	*	0.0270	SKAGIT	50280
500019		0.0166	LEWIS	50200
500024		0.0064	THURSTON	50330
500039	*	0.0182	KITSAP	50170
500041	*	0.0055	COWLITZ	50070
500139		0.0064	THURSTON	50330
500143		0.0064	THURSTON	50330
510012		0.0110	MASON	51260
510018	*	0.0107	JACKSON	51170
510047	*	0.0234	MARION	51240

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
520009		0.0027	OUTAGAMIE	52430
520028	*	0.0473	GREEN	52220
520035		0.0111	SHEBOYGAN	52580
520044		0.0111	SHEBOYGAN	52580
520045		0.0022	WINNEBAGO	52690
520048		0.0022	WINNEBAGO	52690
520057		0.0296	SAUK	52550
520071	*	0.0332	JEFFERSON	52270
520076	*	0.0275	DODGE	52130
520088		0.0084	FOND DU LAC	52190
520095	*	0.0296	SAUK	52550
520102	*	0.0714	WALWORTH	52630
520116	*	0.0332	JEFFERSON	52270
520160		0.0027	OUTAGAMIE	52430
520198		0.0022	WINNEBAGO	52690
523302		0.0022	WINNEBAGO	52690
524002		0.0022	WINNEBAGO	52690
524025		0.0084	FOND DU LAC	52190
673035		0.0049	TARRANT	45910

* Asterisk indicates hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act for CY 2011.

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO OPPS COMPOSITE APCs FOR CY 2011

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO OPPS COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
90801	Psy dx interview		Q3	0323	0034
90802	Intac psy dx interview		Q3	0323	0034
90804	Psytx, office, 20-30 min		Q3	0322	0034
90805	Psytx, off, 20-30 min w/e&m		Q3	0322	0034
90806	Psytx, off, 45-50 min		Q3	0323	0034
90807	Psytx, off, 45-50 min w/e&m		Q3	0323	0034
90808	Psytx, office, 75-80 min		Q3	0323	0034
90809	Psytx, off, 75-80, w/e&m		Q3	0323	0034
90810	Intac psytx, off, 20-30 min		Q3	0322	0034
90811	Intac psytx, 20-30, w/e&m		Q3	0322	0034
90812	Intac psytx, off, 45-50 min		Q3	0323	0034
90813	Intac psytx, 45-50 min w/e&m		Q3	0323	0034
90814	Intac psytx, off, 75-80 min		Q3	0323	0034
90815	Intac psytx, 75-80 w/e&m		Q3	0323	0034
90845	Psychoanalysis		Q3	0323	0034
90846	Family psytx w/o patient		Q3	0324	0034
90847	Family psytx w/patient		Q3	0324	0034
90849	Multiple family group psytx		Q3	0325	0034
90853	Group psychotherapy		Q3	0325	0034
90857	Intac group psytx		Q3	0325	0034
90862	Medication management	CH	Q3	0605	0034
90865	Narcosynthesis		Q3	0323	0034
90880	Hypnotherapy		Q3	0323	0034
90899	Psychiatric service/therapy		Q3	0322	0034
96101	Psycho testing by psych/phys		Q3	0382	0034
96102	Psycho testing by technician		Q3	0382	0034
96103	Psycho testing admin by comp		Q3	0373	0034
96110	Developmental test, lim		Q3	0373	0034
96111	Developmental test, extend		Q3	0373	0034
96116	Neurobehavioral status exam		Q3	0382	0034
96118	Neuropsych tst by psych/phys		Q3	0382	0034
96119	Neuropsych testing by tec		Q3	0382	0034
96120	Neuropsych tst admin w/comp		Q3	0382	0034
96150	Assess hlth/behave, init		Q3	0432	0034
96151	Assess hlth/behave, subseq		Q3	0432	0034
96152	Intervene hlth/behave, indiv		Q3	0432	0034
96153	Intervene hlth/behave, group		Q3	0432	0034

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO OPPS COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
96154	Interv hlth/behav, fam w/pt		Q3	0432	0034
M0064	Visit for drug monitoring		Q3	0607	0034
93619	Electrophysiology evaluation		Q3	0085	8000
93620	Electrophysiology evaluation		Q3	0085	8000
93650	Ablate heart dysrhythm focus		Q3	0085	8000
93651	Ablate heart dysrhythm focus		Q3	0086	8000
93652	Ablate heart dysrhythm focus		Q3	0086	8000
55875	Transperi needle place, pros		Q3	0163	8001
77778	Apply interstit radiat compl		Q3	0651	8001
99205	Office/outpatient visit, new		Q3	0608	8002
99215	Office/outpatient visit, est		Q3	0607	8002
G0379	Direct refer hospital observ		Q3	0604	8002
99284	Emergency dept visit		Q3	0615	8003
99285	Emergency dept visit		Q3	0616	8003
99291	Critical care, first hour		Q3	0617	8003
G0384	Lev 5 hosp type B ED visit		Q3	0630	8003
76604	Us exam, chest		Q3	0265	8004
76700	Us exam, abdom, complete		Q3	0266	8004
76705	Echo exam of abdomen		Q3	0266	8004
76770	Us exam abdo back wall, comp		Q3	0266	8004
76775	Us exam abdo back wall, lim		Q3	0266	8004
76776	Us exam k transpl w/doppler		Q3	0266	8004
76831	Echo exam, uterus		Q3	0267	8004
76856	Us exam, pelvic, complete		Q3	0266	8004
76857	Us exam, pelvic, limited		Q3	0265	8004
76870	Us exam, scrotum		Q3	0266	8004
70450	Ct head/brain w/o dye		Q3	0332	8005 or 8006
70480	Ct orbit/ear/fossa w/o dye		Q3	0332	8005 or 8006
70486	Ct maxillofacial w/o dye		Q3	0332	8005 or 8006
70490	Ct soft tissue neck w/o dye		Q3	0332	8005 or 8006
71250	Ct thorax w/o dye		Q3	0332	8005 or 8006
72125	Ct neck spine w/o dye		Q3	0332	8005 or 8006
72128	Ct chest spine w/o dye		Q3	0332	8005 or 8006
72131	Ct lumbar spine w/o dye		Q3	0332	8005 or 8006

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO OPPS COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
72192	Ct pelvis w/o dye		Q3	0332	8005 or 8006
73200	Ct upper extremity w/o dye		Q3	0332	8005 or 8006
73700	Ct lower extremity w/o dye		Q3	0332	8005 or 8006
74150	Ct abdomen w/o dye		Q3	0332	8005 or 8006
74261	Ct colonography, w/o dye		Q3	0332	8005 or 8006
70460	Ct head/brain w/dye		Q3	0283	8006
70470	Ct head/brain w/o & w/dye		Q3	0333	8006
70481	Ct orbit/ear/fossa w/dye		Q3	0283	8006
70482	Ct orbit/ear/fossa w/o&w/dye		Q3	0333	8006
70487	Ct maxillofacial w/dye		Q3	0283	8006
70488	Ct maxillofacial w/o & w/dye		Q3	0333	8006
70491	Ct soft tissue neck w/dye		Q3	0283	8006
70492	Ct sft tsue nck w/o & w/dye		Q3	0333	8006
70496	Ct angiography, head		Q3	0662	8006
70498	Ct angiography, neck		Q3	0662	8006
71260	Ct thorax w/dye		Q3	0283	8006
71270	Ct thorax w/o & w/dye		Q3	0333	8006
71275	Ct angiography, chest		Q3	0662	8006
72126	Ct neck spine w/dye		Q3	0283	8006
72127	Ct neck spine w/o & w/dye		Q3	0333	8006
72129	Ct chest spine w/dye		Q3	0283	8006
72130	Ct chest spine w/o & w/dye		Q3	0333	8006
72132	Ct lumbar spine w/dye		Q3	0283	8006
72133	Ct lumbar spine w/o & w/dye		Q3	0333	8006
72191	Ct angiograph pelv w/o&w/dye		Q3	0662	8006
72193	Ct pelvis w/dye		Q3	0283	8006
72194	Ct pelvis w/o & w/dye		Q3	0333	8006
73201	Ct upper extremity w/dye		Q3	0283	8006
73202	Ct uppr extremity w/o&w/dye		Q3	0333	8006
73206	Ct angio upr extrm w/o&w/dye		Q3	0662	8006
73701	Ct lower extremity w/dye		Q3	0283	8006
73702	Ct lwr extremity w/o&w/dye		Q3	0333	8006
73706	Ct angio lwr extr w/o&w/dye		Q3	0662	8006
74160	Ct abdomen w/dye		Q3	0283	8006
74170	Ct abdomen w/o & w/dye		Q3	0333	8006
74175	Ct angio abdom w/o & w/dye		Q3	0662	8006

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO OPPS COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
74262	Ct colonography, w/dye		Q3	0283	8006
75635	Ct angio abdominal arteries		Q3	0662	8006
70336	Magnetic image, jaw joint		Q3	0336	8007 or 8008
70540	Mri orbit/face/neck w/o dye		Q3	0336	8007 or 8008
70544	Mr angiography head w/o dye		Q3	0336	8007 or 8008
70547	Mr angiography neck w/o dye		Q3	0336	8007 or 8008
70551	Mri brain w/o dye		Q3	0336	8007 or 8008
70554	Fmri brain by tech		Q3	0336	8007 or 8008
71550	Mri chest w/o dye		Q3	0336	8007 or 8008
72141	Mri neck spine w/o dye		Q3	0336	8007 or 8008
72146	Mri chest spine w/o dye		Q3	0336	8007 or 8008
72148	Mri lumbar spine w/o dye		Q3	0336	8007 or 8008
72195	Mri pelvis w/o dye		Q3	0336	8007 or 8008
73218	Mri upper extremity w/o dye		Q3	0336	8007 or 8008
73221	Mri joint upr extrem w/o dye		Q3	0336	8007 or 8008
73718	Mri lower extremity w/o dye		Q3	0336	8007 or 8008
73721	Mri jnt of lwr extre w/o dye		Q3	0336	8007 or 8008
74181	Mri abdomen w/o dye		Q3	0336	8007 or 8008
75557	Cardiac mri for morph		Q3	0336	8007 or 8008
75559	Cardiac mri w/stress img		Q3	0336	8007 or 8008
C8901	MRA w/o cont, abd		Q3	0336	8007 or 8008
C8904	MRI w/o cont, breast, uni		Q3	0336	8007 or 8008
C8907	MRI w/o cont, breast, bi		Q3	0336	8007 or 8008
C8910	MRA w/o cont, chest		Q3	0336	8007 or 8008
C8913	MRA w/o cont, lwr ext		Q3	0336	8007 or 8008
C8919	MRA w/o cont, pelvis		Q3	0336	8007 or 8008
70542	Mri orbit/face/neck w/dye		Q3	0284	8008
70543	Mri orbt/fac/nck w/o & w/dye		Q3	0337	8008
70545	Mr angiography head w/dye		Q3	0284	8008
70546	Mr angiograph head w/o&w/dye		Q3	0337	8008
70548	Mr angiography neck w/dye		Q3	0284	8008
70549	Mr angiograph neck w/o&w/dye		Q3	0337	8008
70552	Mri brain w/dye		Q3	0284	8008
70553	Mri brain w/o & w/dye		Q3	0337	8008
71551	Mri chest w/dye		Q3	0284	8008
71552	Mri chest w/o & w/dye		Q3	0337	8008
72142	Mri neck spine w/dye		Q3	0284	8008
72147	Mri chest spine w/dye		Q3	0284	8008
72149	Mri lumbar spine w/dye		Q3	0284	8008
72156	Mri neck spine w/o & w/dye		Q3	0337	8008
72157	Mri chest spine w/o & w/dye		Q3	0337	8008
72158	Mri lumbar spine w/o & w/dye		Q3	0337	8008
72196	Mri pelvis w/dye		Q3	0284	8008
72197	Mri pelvis w/o & w/dye		Q3	0337	8008
73219	Mri upper extremity w/dye		Q3	0284	8008
73220	Mri uppr extremity w/o&w/dye		Q3	0337	8008
73222	Mri joint upr extrem w/dye		Q3	0284	8008
73223	Mri joint upr extr w/o&w/dye		Q3	0337	8008
73719	Mri lower extremity w/dye		Q3	0284	8008
73720	Mri lwr extremity w/o&w/dye		Q3	0337	8008
73722	Mri joint of lwr extr w/dye		Q3	0284	8008
73723	Mri joint lwr extr w/o&w/dye		Q3	0337	8008
74182	Mri abdomen w/dye		Q3	0284	8008
74183	Mri abdomen w/o & w/dye		Q3	0337	8008
75561	Cardiac mri for morph w/dye		Q3	0337	8008
75563	Card mri w/stress img & dye		Q3	0337	8008
C8900	MRA w/cont, abd		Q3	0284	8008
C8902	MRA w/o fol w/cont, abd		Q3	0337	8008
C8903	MRI w/cont, breast, uni		Q3	0284	8008
C8905	MRI w/o fol w/cont, brst, un		Q3	0337	8008
C8906	MRI w/cont, breast, bi		Q3	0284	8008

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO OPPS COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
C8908	MRI w/o fol w/cont, breast,		Q3	0337	8008
C8909	MRA w/cont, chest		Q3	0284	8008
C8911	MRA w/o fol w/cont, chest		Q3	0337	8008
C8912	MRA w/cont, lwr ext		Q3	0284	8008
C8914	MRA w/o fol w/cont, lwr ext		Q3	0337	8008
C8918	MRA w/cont, pelvis		Q3	0284	8008
C8920	MRA w/o fol w/cont, pelvis		Q3	0337	8008

[FR Doc. 2010–16448 Filed 7–2–10; 2:30 pm]

BILLING CODE 4120–01–P